Society generally views obesity as a major public health issue that represents an equal or greater contributor to the burden of disease than smoking (Jia & Lubetkin, 2010). Although researchers debate whether an obesity epidemic truly exists (Gard, 2011), the question of whether obesity is managed effectively within the health system remains largely unanswered. Although individuals living with obesity often express a desire for greater support from their physician or another health professional for weight management (Heintze et al., 2012), most individuals living with obesity do not discuss weight issues with physicians. In a recent national survey of Canadian weight-management practices, fewer than half of the participants classed as overweight or obese had asked their physician about weight loss (Kirk, Tytus, Tsuyuki, & Sharma, 2012). For some individuals, this might reflect a lack of awareness that their weight is a potential health issue, whereas for others it might reflect an unwillingness to raise the issue of excess weight within a system not currently structured to deal with it.

Advice from a physician can act as a motivator for weight loss (Loureiro & Nayga, 2006), yet many health professionals perceive themselves to be ill equipped to identify and deal with issues of weight management and are unsure of their roles and responsibilities (e.g., Forman-Hoffman, Little, & Wahls, 2006). In one U.S. survey, almost half of the participants classed as obese reported that their physician had not prescribed any of the most common weight-management methods (Wadden et al., 2000). According to the participants (all of whom were obese), more than two thirds of physicians had either rarely or never broached the topic of weight management with them. Although we should be cautious about interpreting these findings (mainly because they are not necessarily representative of all individuals living with obesity), persistent tension within the health system plays a role in weight management (Hansson, Rasmussen, & Ahlstrom, 2011). This tension needs additional exploration if we are to generate sustained change in attitudes and practice around obesity management.

Sara F. L. Kirk1, Sheri L. Price1, Tarra L. Penney1, Laurene Rehman1, Renee F. Lyons2, Helena Piccinini-Vallis1, T. Michael Vallis1, Janet Curran3, and Megan Aston1

Abstract
In this research, we examined the experiences of individuals living with obesity, the perceptions of health care providers, and the role of social, institutional, and political structures in the management of obesity. We used feminist poststructuralism as the guiding methodology because it questions everyday practices that many of us take for granted. We identified three key themes across the three participant groups: blame as a devastating relation of power, tensions in obesity management and prevention, and the prevailing medical management discourse. Our findings add to a growing body of literature that challenges a number of widely held assumptions about obesity within a health care system that is currently unsupportive of individuals living with obesity. Our identification of these three themes is an important finding in obesity management given the diversity of perspectives across the three groups and the tensions arising among them.

Keywords
discourse analysis; health care; health care professionals; health care, users’ experiences; health policy / policy analysis; lived experience; obesity / overweight; stigma

1Dalhousie University, Halifax, Nova Scotia, Canada
2Bridgepoint Collaboratory in Research and Innovation, Toronto, Ontario, Canada
3IWK Health Centre, Halifax, Nova Scotia, Canada

Corresponding Author:
Sara F. L. Kirk, School of Health and Human Performance, Dalhousie University, PO Box 15000, Halifax, Nova Scotia, B3H 4R2, Canada. Email: sara.kirk@dal.ca
Is obesity a health issue? Many of us view obesity as a cosmetic or lifestyle issue (Lau et al., 2007) under the personal control of the individual. These perceptions evoke an assumption of failed willpower and an image of self-indulgence, sloth, and gluttony (Puhl & Heuer, 2009). Gender also plays a part, with women more likely to be diagnosed with obesity than men (Bertakis & Azari, 2005). Powerful discourses are thus at play, and individuals living with obesity are caught in the middle, facing judgment by society if they fail to manage their weight successfully and exposing themselves to health professionals who are unable to fully support them (Block, DeSalvo, & Fisher, 2003; Puhl & Heuer). It is not surprising then, that if an individual is unable to make the changes prescribed for weight loss, resentment builds on both sides of the therapeutic relationship (Vallis, Currie, Lawlor, & Ransom, 2007).

If we are to provide adequate support to individuals seeking help for weight management, an additional understanding is required about how we view these issues across the health system and society as a whole (Butland et al., 2007). In particular, it is critical that we appreciate the perspectives of multiple stakeholders (i.e., individuals living with obesity, health professionals, and policy makers), all of whom need to be included in the discussion about how to manage obesity in a health care setting. Research exploring this issue across multiple perspectives is currently limited, particularly within the domain of qualitative health research.

When researchers desire a nuanced understanding of multiple perspectives, they choose qualitative research over quantitative research. For example, Greener, Douglas, and van Teijlingen (2010) explored conflicting perspectives of obesity causation and intervention among overweight people, health professionals, and policy makers through qualitative interviews. They presented their findings across biomedical and socioecological frames of reference, noting a disconnect between health professionals who recognized the need for systemic change in how obesity is managed and lay people who were focused on individually oriented interventions (Jain, 2005). However, we need more discussion to understand the impact these differing views have on shaping the attitudes and behaviors of individuals currently seeking support within the health care system. We also need to discuss these individuals' interactions with health care providers and their influence on broader social, institutional, and political structures for obesity management.

**Rationale**

Our aim in this research was to examine the experiences of individuals living with obesity, the perceptions of health care providers, and the role of social, institutional, and political structures in the management of obesity. Specifically, we sought to answer the following three questions: What perceptions and experiences do individuals living with obesity have about their weight when they interact with health professionals and the health care system? How do health professionals, when assisting with weight management, perceive interactions with individuals living with obesity and the health care system, and how do policy makers responsible for commissioning health services perceive weight and its management within the health care system? From the policy makers’ perspective, what are the barriers and enablers within the current system that inhibit or support the attainment of current best practice guidelines for weight management?

**Methodology**

By qualitatively exploring the issue of obesity from a variety of perspectives, we gained insight into similarities, differences, points of consensus, and tension associated with values, beliefs, perceptions, and practices among key stakeholders. We used feminist poststructuralism as the guiding methodology (Butler, 1992; Cheek, 2000; Scott, 1992) because concepts from Foucault (1983) and feminist theories (Butler, 1992; Butler & Scott, 1992; Powers, 2001) help researchers to question practices that we might otherwise take for granted. By using feminist poststructuralism, we could focus on social construction and include experiences and constructs of gender, abilities, race, ethnicity, class, socioeconomic status, and culture. Applying this methodology also enables researchers to analyze power relations and understand complex relationships between people, society, and institutions (Aston, Price, Penney, & Kirk, 2011).

**Methods**

In 2010–2011, we conducted 42 semistructured qualitative interviews with individuals from an eastern Canadian province who self-identified as being overweight, health care practitioners, or policy makers. In keeping with the aims of the study and the methodology, we used purposive sampling to ensure we included participants who had experienced living with obesity themselves, had worked with clients experiencing obesity, or had knowledge about obesity policies (Patton, 2002). Following relevant ethical approvals (institutional and within each health district from which participants were sought), we recruited participants through a variety of print and media advertisements and through targeted emails via professional organizations. We obtained informed consent in all cases following distribution of a study information package prior to the interviews.
We conducted interviews with 22 individuals living with obesity, 4 policy makers, and 16 health professionals (8 dietitians, 4 family physicians, and 4 nurses). Of those who participated, the majority (86%, n = 36) were women. Specifically, 80% of individuals living with obesity (n = 18), 100% of dietitians (n = 8), 100% of nurses (n = 4), 75% of physicians (n = 3), and 75% of policy makers (n = 3) were women. The mean age was 47 years (SD = 15) for individuals living with obesity, 37 years (SD = 10) for dietitians, 44 years (SD = 10) for nurses, 50 years (SD = 3.5) for physicians, and 51 years (SD = 9) for policy makers. Health professionals reported a range of service from 3 to 30 years. Individuals living with obesity also reported the highest level of education as high school (5%, n = 1), college (40%, n = 8), or university (55%, n = 11). Household income was reported as under $35,000 (15%, n = 3), between $35,000 and $75,000 (45%, n = 9), or over $75,000 (40%, n = 8). Furthermore, using self-reported height and weight, 10% (n = 2) were defined as overweight (BMI of 25–29.9 kg/m²), with the remainder defined as obese (BMI ≥ 30 kg/m²). In addition, 45% of individuals living with obesity reported having one or more comorbid conditions.

We conducted data collection and analysis simultaneously, focusing on the participants’ language and practices as well as on how they perceived their relations with those with whom they interacted. We considered the lived experience of an individual as being the embodiment of beliefs, meaning, and practices both personally and socially constructed. Data collection ended when we reached saturation within each participant group and no new themes emerged (Patton, 2002). In keeping with the feminist poststructuralist framework, we employed discourse analysis to conceptualize how power relations resulted through the interplay of language, beliefs, values, and practices. This interplay was at times conflicting and at other times congruent. In particular, discourse analysis helped us understand how stereotypes and norms about obesity management are constructed (Powers, 2001). For example, we investigated the ways that language, social marketing, and the media influence personal and health care practices through principles of systematization, standardization, and normalization (Corrigan, 1990).

In addition to discourse analysis, the analytical process involved a thematic analysis in organizing and analyzing data (Kvale, 1996; Miles & Huberman, 1994). Our analysis strategy included careful readings of the transcripts and field notes to enhance interrater reliability (Lincoln & Guba, 1985). This involved independently coding the transcripts and identifying emerging themes. We also discussed and analyzed themes for specific meanings that included concepts such as discourse, language, subject position, agency, and relations of power (Cheek, 2000; Patton, 2002).

<table>
<thead>
<tr>
<th>Table 1. Sample Interview Questions According to Participant Group.</th>
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<td><strong>Individuals Living With Obesity</strong></td>
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<tr>
<td>Can you tell me what brought you here to participate in our study?</td>
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<tr>
<td>Can you talk about your overall experience regarding your weight?</td>
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<tr>
<td>Can you tell me about your overall experience discussing your weight with a health care professional (physician, nurse, dietitian, and so forth)?</td>
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A trained research coordinator and research assistant conducted face-to-face interviews at a mutually agreed time and place. They developed a semistructured interview guide for use with each group, following the principles of feminist poststructuralism (Aston et al., 2011). This enabled them to elicit comprehensive and detailed lived experiences from all participants and powerful examples of how beliefs and practices about obesity management created moments of tension, conflict, and discomfort. In Table 1 we provide examples of the types of overarching questions included.

Additionally, with the participants’ permission, the research coordinator and assistant audiotaped interviews and then transcribed them verbatim. The interviewers also wrote field notes immediately after each interview to capture observations, thoughts, reactions, and feelings. They ensured that all interviews were confidential, and changed names to code numbers. Furthermore, they made transcripts available to each participant, allowing him or her to add additional comments or clarification via a follow-up phone call, and attended to the trustworthiness of the findings by using in-depth interviews, field notes, and investigator triangulation during data coding and analysis. An audit trail of the interviewers’ reflexive texts, documenting, decision making, biases, and analytical choices also served as additional strategies to maintain rigor (Lincoln & Guba, 1985).
Results

We identified a number of themes in this analysis, with three key themes emerging across all participant groups. The identification of these three themes is an important finding, given the diversity of perspectives apparent across the groups. These themes thus form the focus of this article: (a) blame as a devastating relation of power, (b) tensions in obesity management and prevention, and (c) the prevailing medical management discourse.

Blame as a Devastating Relation of Power

Blame permeated the discourse across all participant groups. Individuals living with obesity shared feelings of shame and embarrassment with their inability to control their weight on their own. This blaming discourse can easily be seen in messages of “eat less, move more” promoted by health professionals, the health system, and wider society. Individuals living with obesity spoke about the complexities of trying to lose weight, inclusive of cultural, social, and organizational barriers. Despite this insight, however, they placed the final explanation for their weight status on themselves and expressed immense feelings of guilt and shame.

The dominant discourse of obesity as “blaming” negatively affected the self-esteem of participants living with obesity. It also negatively affected their ability to deal with weight management as well. In the words of one woman,

[T]he truth is, if I had been left alone as a child, I would have stretched up to five feet nine inches and been lovely. Instead, I led a life of self-consciousness and depriving myself of anything to eat most of the time, of never ever eating in front of anyone else—because they would look at you like you didn’t deserve it—of trying desperately to do anything to get the approval of the beautiful people in my life [who] thought I should be beautiful too. My beauty-queen mother and my superstar athlete father who just said, “All you have to do is get control of yourself.”

All of the individuals living with obesity had tried multiple methods to manage their weight, with limited or no success. This was extremely frustrating for them and compounded their tendency, wholly or at least partially, to blame themselves for this perceived failure. One individual living with obesity said,

Big people who are trying to diet or maintain a healthy weight are on the edge all the time. They are just waiting for something to demoralize them, to make them feel. . . . Because chances are they have already failed at it so many times, that eighty percent of the time they believe that they are going to fail anyway.

Specifically, individuals living with obesity reported trying modest behavior changes (e.g., eating more fruit, cutting out soda, taking the stairs, walking to the store), more intense behavior changes (e.g., a restricted-calorie diet, joining a gym program), commercial weight-loss programs, and even weight-loss surgery. With the exception of weight-loss surgery, all of these attempts had resulted in failure to lose weight and maintain weight loss over time, leaving people feeling a high degree of frustration with their inability to change their own behavior. The majority of individuals believed that they knew what to do to lose weight, but other barriers overwhelmed their capacity to make these behavioral changes. A few individuals openly stated that barriers interfered with their success; for example:

There are a hundred and one gimmicks out there that people [use] to take your money. Don’t get me wrong: most diets work. If you follow them, you’re going to lose weight. But it’s not the diet; it’s the mental part of it that [we] need help with, and I don’t have any support anywhere for it.

The person quoted directly above was able to identify two barriers that affected her ability to lose weight, but believed that her mental state interfered with her ability to follow diet programs. She therefore believed that she needed support to help her address how to implement weight-management strategies, given this psychological dimension. She knew what to do but not how to do it. Similarly, another individual living with obesity understood what to do to lose weight, but circumstances in her life interfered. This situation deeply affected her emotionally and mentally:

It’s just so demeaning and just so. . . . You know, if you really wanted to, you could just go on the Internet and figure it out. You know, I’m an educated person. I’m not stupid. I understand what I need to do. It’s just there are things in my life that are preventing me from getting there. And for me, making the effort and trying to find programs, trying to do things on my own to make it easier for him [family physician], . . .

Some individuals also suggested that, regardless of the barriers, successful behavior change required an enormous amount of mental and emotional investment. The majority of individuals experiencing obesity continued to articulate a need for some form of support but did not specifically name what that support might be. They described their search for support as a struggle or a “battle”:

Honestly, it is a daily battle. It’s constant, actually. It’s not just daily: it’s every minute of every day. I think, for the average person, they can eat whatever, they can afford to go
for a couple of weeks maybe without doing their proper exercise, eating whatever junk food, whatever they have. I don't think big people can afford to do that.

Health professionals also struggled with conflicting discourses on obesity (individual, environmental, and social). Some focused on individual behavior change and others expressed an understanding of the many environmental and social factors that play a role in obesity causation. Ultimately, through a negotiation of these different understandings of weight management, health professionals continued to be frustrated with what they viewed as an individual’s unwillingness to commit to a change in lifestyle:

Not everybody, but the majority of people that you see are concerned about their weight because we are a weight-obsessed society. [P]eople . . . want the quick fix. They want the Atkins, they want the Weight Loss, they want the South Beach Diet, whatever they want. They don’t want to come and hear it’s all about them, it’s all their fault. They want someone to fix it. Well, nobody can fix it but you.

All health professionals in this study experienced frustration and disappointment with individuals who were unable to lose weight. Similar to individuals living with obesity, health professionals struggled to understand the complexity of the issue, which often led to blaming the individual. Health professionals commented on the unrealistic expectations of people who wanted to lose weight quickly and how their role as a health professional could not possibly be supportive of this. This alluded to a perception of powerlessness among health care providers:

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

The health professionals we interviewed also blamed themselves for not having the answers, and described feeling ill-equipped to assist individuals to make successful changes. One health professional, a dietitian, described her skepticism about the weight-loss program she offered clients:

I feel it was a very frustrating position to be in, because these people were being referred to me from a physician. They didn’t want to be there, a lot of the times, but felt they had to go because that is what their doctor said. And yes, I didn’t have a lot of hope that it was going to work.

The frustrations of health professionals and of individuals living with obesity, along with the complex nature of obesity, have led researchers to question who is responsible for managing this condition. Health professionals and their patients offered evidence that often resulted in blaming themselves, each other, and the system. We observed several understandings about weight management and the meaning of “support” that we wanted to explore more deeply. For example, according to one health professional,

The idea would be a routine check every three to four months, which is medically more than enough, I think, for somebody who is really just trying to lose weight . . . as a preventive measure. Their grandmother has diabetes. They don’t want diabetes, and they want to feel better. So, those people who are fundamentally healthy. Given our staffing situation, I can’t see people once a month who aren’t sick. That just wouldn’t happen. But offer them that monthly check-in to get a weight on an objective scale and then offer to see them on a needs basis.

It is evident from the above quote that staffing and system-level restrictions could affect the decisions health professionals make in relation to providing support to people for weight management. Both individuals living with obesity and health professionals acknowledged the role that ongoing support and follow-up have in relation to weight loss; however, there were differences between the two groups concerning who should provide this supportive care. As evidenced by the quote, health professionals tend to perceive people without comorbid conditions as being “not sick,” and people who are not sick should not receive support. Nevertheless, individuals living with obesity felt that they needed regular support, revealing a tension in expectations on either side of the therapeutic relationship.

In addition to frustration, powerlessness and self-blame were experienced across all three participant groups. A policy maker suggested that even if we do not want to medicalize this condition, the health care system has a responsibility to address obesity and to support people in a safe and healthy society:

Those people that have already suffered at our hands [society], so to speak, in that we haven’t done anything for them. So we’ve let them gain three hundred pounds over the past twenty years and haven’t intervened. We intervene for drug and alcohol abuse. We don’t intervene when people are sitting in a house totally isolated, dealing with mental health issues and eating themselves to death.

The interviews reflected tensions and varying discourses surrounding obesity, such as obesity as a personal issue, obesity as a social construction, and obesity as a
complex health condition. Although there is no single correct discourse or approach to the issue, all participants nonetheless described searching for one. Their search for a simple solution was in contrast to a conceptualization of obesity as complex, and revealed tensions in the approach to addressing the issue. This, in turn, gave rise to the second theme across all three groups, which we identified as the tensions in obesity management and prevention.

**Tensions in Obesity Management and Prevention**

Both the individuals living with obesity and the health professionals did not feel supported by the health care system. They felt that there were no policies or clearly defined roles to prevent obesity through government initiatives or social, environmental, or institutional systems. One health professional stated that he would still try to help individuals experiencing obesity even though he believed he was wasting his time engaging in obesity management, because he did not have anything to offer. This perception highlights the contradictory position of health professionals as experts in obesity management:

> [I]t’s a huge problem, and I think the problem is going to take many years of broad-spectrum education. I haven’t given up on helping people get to more of a better body weight, but you don’t waste a lot of your emotion on it anymore, you know? Because you’re not going to get anywhere. And you try not to become so nihilistic. Sometimes you think, why am I going [to address their weight] when you don’t have anything to offer them?

Health professionals also struggled to know how to approach the issue. This struggle has the potential to create additional tensions, given that people often expect health providers to have ready solutions to their health issues. Both health professional and policy makers were able to offer possible solutions as to how to approach obesity management, which included a focus on the social determinants of health as well as prevention vs. the medicalization of obesity. These approaches were, however, a source of tension, with health professionals and policy makers feeling divided between managing obesity and committing to an upstream approach to health by preventing the onset of obesity. One policy maker said,

> There seems to be this tension out there within health that we shouldn’t be focusing on treating people who have issues; we should [instead] be looking at it from a broad public policy base. I would say do both. Why would we separate the families out who have an issue right now or these kids that with a bit of a support and with those families with a bit of support, we could change the trajectory for them? So yes, absolutely look at the environmental supports. That is going to help everybody, but let’s not forget those families that are really struggling right now, and those kids.

Another policy maker stated,

> We are putting a lot of money behind prevention of obesity through public health social marketing [and] health promotion aimed at the younger generation. We are talking about getting rid of unhealthy food choices in hospitals and schools, and we are doing all of that, but it’s almost as if we’ve abandoned obese adults along the way. It is an ethical issue, and it is [also] a care issue and a health services issue.

Similarly, another policy maker commented that she also struggled with her approach to the issue of obesity. She knew what she needed to do, but it was often difficult for her to implement:

> [W]e’ve got all these obese people and we’ve got to do something about it. It’s not on weight per se; it’s on the underlying behavioral lifestyle and environmental, social conditions that actually caused the [obesity].

We can see from these quotes that having two discourses that seemingly require a choice is problematic to policy makers. There appears to be a struggle to choose one approach over another in addressing an issue that is complex and multifaceted. The health professionals and policy makers identified that neither approach alone would be enough, but they felt immobilized by this tension:

> The tension is coming, and maybe it’s the difference between the public health approach and a more clinical approach. We’ve got all these obese people and we’ve got to do something about it. It’s not on weight per se; it’s on the underlying behavioral lifestyle and environmental, social conditions that actually caused the [obesity].

For myself as a public health perspective, I don’t actually try to focus on obesity because I think from a management and a prevention perspective that we need to be focusing on the underlying issues around physical activity and healthy eating.

Individuals living with obesity also experienced exclusions when attempting to find appropriate support within the health care system. Most individuals in the study began to access this system when they believed they could no longer manage their weight by themselves. Their subsequent experiences often included a belief that the system was not able to support them with obesity management because of a lack of interest or unavailable support and knowledge:

> I’ve had weight problems most of my life. Before it got to this point, I could go try to join programs, you know, spend the money. It didn’t work, trying to go to my doctors, trying to go to people who I think are there to help, and just not getting anywhere with it.
By examining the sentiments in the above quote, we can see that this individual struggled to know where to turn to for support and felt that health professionals were ill equipped to offer it. All participants living with obesity in this study identified a lack of support from their health care providers and the health care system in addressing their weight. Although health professionals and policy makers were able to recognize these tensions, they also articulated how the prevailing medical discourse of obesity exacerbated these tensions, a finding central to our third theme.

The Prevailing Medical Management Discourse

Health professionals experienced many frustrations and contradictions in their experiences with obesity management, and at times questioned the notion of obesity as a disease. Being obese was often in itself not enough to receive health care. Health professionals in this study found it easier to work with individuals living with obesity when they also had another diagnosed chronic condition, such as diabetes or cardiovascular disease. They could then more confidently prescribe a specific treatment regime, although appropriate support was not always forthcoming. An individual living with obesity said,

I started trying to do my own research online, trying to find [a program]. It got really frustrating and upsetting because most things that I found, you have to have bulimia, or you have to have anorexia, or they won’t take you. And to me, I think it’s equally as big a problem if you’re a binge eater or an overeater, as if you don’t eat enough, right, if it’s affecting your health. There’s not much out there. I haven’t had any support, really.

This individual recognized that even though her weight was a symptom of an eating disorder, she was not eligible to receive support within an eating disorders clinic because she was overweight. This conflicting medical discourse, where support was available only for a specifically defined diagnosis, raises the issue of whether obesity is a disease or a risk factor. At the same time that there was a focus on the medicalization of the issue, policy makers were also hesitant to conceptualize obesity within the medical model. One policy maker said,

I think it is part of the culture of medicine and the medical model that we take a look at someone and we want to diagnose them. We aren’t really training [professionals] to get to know the patient’s social determinants of health. We are trained to deal with the issues.

Another policy maker addressed the same issue of medicalizing obesity by problematizing the two conflicting discourses:

I also see the risk of taking us down a more medicalized road, and this is where the distinction becomes, at the far end of the spectrum. There’s certainly some absolutely critical issues around management of people with morbid obesity. However, as for the vast majority of people who are overweight, whether they meet the criteria for being obese or not, the management is around providing environments so they can be more active in their daily lives and eat better.

This policy maker questioned whether medical treatment for individuals living with obesity is necessary. However, if we focus only on prevention, will the needs of all individuals living with obesity be properly addressed? As an alternative to medicalizing obesity, the policy maker suggested addressing the issue of population health and using health promotion to support the majority of people who are not morbidly obese but are still struggling with weight problems.

Similarly, another policy maker also problematized the medicalization of obesity by challenging the meaning of obesity and disease. According to this participant, obesity requires a shift in definition to remove it from the realm of medical treatment. The participant struggled with the term “disease” and offered the possibility of understanding obesity not as a disease but as a factor that leads to other diseases:

I mean, it isn’t a disease. I think it’s a lot of things, most notably probably a failure of the system. But a disease, no. It leads to disease, but in and of itself, obesity is not a disease. I don’t know what it is. I don’t know what I would call it, but I don’t see it as a disease.

These examples illustrate how individuals experiencing obesity, health professionals, and policy makers attempted to rationalize obesity management as a distinct entity within the medical model. Overall, individuals living with obesity sought validation for requiring support in a system that currently does not provide the support they need.

Discussion

In conducting this study we sought to understand the experiences of individuals living with obesity. We also examined the perceptions of health care providers and the role of social, institutional, and political structures in the management of obesity. We identified three themes that were apparent across all participant groups and that highlighted the many tensions that interfere with the provision of appropriate support for individuals living with obesity. These themes permeated the interviews and overlapped with each other, illustrating the struggles that the participants confronted every day. They also provided direction for advancing the dialogue surrounding the role of the
health care setting in obesity management. We did identify other themes within each participant group, but these three stood out despite the different beliefs and practices about obesity management that emerged throughout the interviews with all participants. The way participants expressed these common themes was also central to understanding how contradictions, agreements, and disagreements manifested through relations of power.

The individuals living with obesity who participated in these interviews described their experiences in seeking support from a system that they believed was failing them. They spoke about the complexities they experienced in trying to lose or maintain weight, but when there was no clear reason for their unsuccessful weight loss, they chose self-blame. Despite pointing the finger at themselves, participants still struggled with fully accepting the notion of self-blame, often offering other reasons related to mental health or social environments. Nevertheless, all of the participating health professionals admitted to blaming the obese for being obese.

It was important for us to explore this confession of blame because it enabled participants to understand the complexity of their beliefs. Individuals living with obesity provided many examples of their attempts to manage their obesity through diet, exercise, medication, and visiting their doctors, nurses, and dietitians. They clearly expressed in their narratives their dedication and resiliency in seeking help and support, often for more than a decade. These individuals shared experiences that provided evidence of managing their weight at personal, social, and systemic levels. Throsby (2007) and Greener et al. (2010) also reported blaming and blame-absolving narratives in their work, thereby buying into what Greener et al. described as “more of the same,” or a focus on individual-level interventions for weight management.

Health professionals are mindful that obesity is a complex and sensitive topic of discussion (Brown & Thompson, 2007; Greener et al., 2010), having experienced firsthand the frustrations and struggles when attempting to support clients with obesity management. They blamed themselves for not being able to support individuals living with obesity because of a lack of time, expertise, and adequate referral sources, and felt they had let their clients down. This tension is not surprising given the medical model within which the majority of health professionals operate. The model acts as a barrier to providing client-centered care that is supportive and nonjudgmental. Moreover, the model perpetuates a system that is unable to provide the level of support that individuals living with obesity feel they need (Potter, Vu, & Croughan-Minhane, 2001).

If we start from the perspective that individuals living with obesity experience the health care system from a marginalized position, we can develop an appropriate lens to understand how patients’ interactions with health professionals are power-based. We saw how individuals living with obesity challenged their health care providers’ ability to support their struggle with excess weight, and how they questioned many of the beliefs, values, and practices within the health care system that led them to an overwhelmingly oppressive experience of obesity management. There is presently no effective obesity-management strategy to address the complexity, contradictions, and hegemonic discourses related to obesity management, nor is there any consensus regarding the role of the health system in obesity management (i.e., whether it should be medicalized or preventive). Both appear to be operating, but participants seemed unable to engage effectively in either paradigm.

This conflicting discourse also created a sense for both parties that they needed to make a choice between one approach and the other rather than enabling a situation in which both could coexist. Like those of Greener et al. (2010), our findings highlight the need to reframe the public debate on obesity. However, we suggest that rather than choosing one discourse over another (management vs. prevention; system vs. individual), we should engage aspects of both. This requires not only consideration of socioecological perspectives, but also a greater awareness among health professionals of the need to offer support, not advice.

There are numerous areas we should address to ensure that individuals who seek support for weight management are able to access it in a respectful and nonjudgmental way. There is a clear need for health professionals and policymakers to recognize and account for individual, social, and institutional factors when assessing and implementing support for obesity management. This requires them to carefully listen to and respect the marginalized experiences of individuals living with obesity and to appreciate the relationships between mental health and obesity. Furthermore, relationships between patients and health care providers should be supportive (not blaming), recognizing the widespread prevalence of weight bias in society and working hard to challenge the stereotypes that dominate the discourse on body weight. Although the health care providers interviewed recognized the complex constellation of factors influencing obesity, as has been found in other studies (Leverence, Williams, Sussman, Crabtree, & RIOS Net Clinicians, 2007), this insight did not always come across in their language.

Beyond health care, there is a need for all stakeholders to challenge the social and political culture that currently seeks to blame individuals for a failure to maintain a healthy body weight. If we shift the blame to individuals living with obesity, we underplay the role of the obesogenic environment in the development of excessive weight gain (Alvaro et al., 2011). Instead, we need to
focus on the prevention of disease that moves beyond behavioral change but still incorporates systemic changes necessary to support obesity management. This requires that we create supportive environments through collaborative, cross-governmental policy change and attention to the social determinants of all of our citizens (Havala Hobbs, 2008; Shiell, 2008). It also demands that we make a concerted effort aimed at the public and media to challenge the prevailing social construction of obesity (Lawrence, 2004).

Unlike the recommendations related to addressing blame and providing individuals with a supportive environment, recommendations regarding the medicalization of obesity are less clear. The medicalization of obesity might provide the necessary status required by the health system to direct much-needed resources toward supportive and appropriate obesity management. Alternatively, the medicalization of obesity could also label an individual with excess weight as having a disease, further marginalizing this population. In addition, it might also threaten to direct limited resources toward bariatric surgeries and medical treatments that might not be sustainable. What is clear from this work is that these tensions need more discussion to avoid polarization to an either/or scenario. It was also evident in the language and experiences provided by health care providers that training, resources, and support for weight management were a substantive part neither of their professional training nor of the health care system.

There are several strengths of this study. To our knowledge, we are the first to explore obesity management from these multiple perspectives simultaneously and to analyze the resulting discourse using a feminist poststructural lens. The richness of the data obtained through this approach enabled us to identify three overarching themes across all participant groups, as well as other themes that were specific to each participant group (not presented here). Furthermore, we were able to describe issues of power, subjectivity, and agency, again adding to the richness of these data in understanding the tensions invoked by obesity within the health care setting.

Qualitative research does not show causation and generally does not apply to other populations. Nonetheless, a key limitation of this work is the geographic location (an eastern Canadian province). It is therefore not possible to assume that these findings are applicable elsewhere. Furthermore, as the sample was predominantly postsecondary-educated, middle-to-higher-income women, the findings are not necessarily transferable to all stakeholders in obesity management. We also did not assess the knowledge of participants about the causes or consequences of obesity, seeking only to understand their experiences and perceptions of obesity management.

Despite these limitations, a number of issues relevant not only to obesity management within the health care setting but to the management of other chronic diseases have come to light as a result of our study. Health professionals, whether clinicians or policymakers, can better support individuals living with obesity by anchoring themselves within a client-centered approach. This involves more listening than directing, and helping the individual appreciate the complexity and tensions involved in achieving a healthy weight (i.e., sitting with distress). It also involves using the principles of motivational interviewing to collaborate with the individual to find a personalized plan that is more likely to result in empowerment and self-efficacy than failure and self-deprecation. By employing motivational interviewing techniques, health care providers can engage with their clients and form a more equitable and mutually respectful partnership that ultimately translates into improved health behaviors and health outcomes (Chossis et al., 2007; Pollak et al., 2010).

Alongside motivational interviewing, the “5As” (assess, advise, agree, assist, and arrange) are promising counseling tools for obesity management (Jay, Gillespie, Schlair, Sherman, & Kalet, 2010; Vallis, Piccinini-Vallis, Sharma, & Freedhoff, 2013). The framework guides the health care provider to assess risk, current behavior, and readiness to change; advise change of specific behaviors; agree on and collaboratively set goals; assist in addressing barriers and securing support; and arrange for follow up (Jay et al., 2010). By engaging this approach, health care professionals can offer more client-centered care when used alongside additional strategies such as improved health professional training.

To facilitate this latter strategy of improved training, we developed the rich narratives we obtained in this study into a dramatic presentation, depicting the relationship between a health professional and an individual living with obesity. We highlighted both internal and external dialogue as well as spoken and unspoken tensions identified by the participants. Health professionals are currently using this dramatic presentation as an educational tool to address the tensions identified through this study. Based on early piloting data and feedback, health professionals receiving training through this approach confirm that it offers a powerful medium to raise awareness of these tensions and provoke constructive dialogue to address them. Such an approach is not only helpful for obesity management but for other chronic diseases as well.

Conclusions

Health care workers within the present health care system are unable to provide the support that individuals living with obesity believe they need. Based on our findings, we
identified tensions within the system and three overarching themes expressed by the participant groups. Whatever the causes and consequences of obesity (which will no doubt remain a subject of ongoing debate), individuals living with obesity have clearly expressed their need for support that is respectful, nonjudgmental, and ongoing. In applying the feminist poststructural lens, we obtained data that can serve as both a framework and a language toward obesity and weight management. Researchers and others can use these tools to challenge the prevailing discourses and encourage the provision of the type of support that clients and health care workers demand.

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**Author Biographies**

**Sara F. L. Kirk**, PhD, is a Canada Research Chair in the School of Health and Human Performance, Dalhousie University, Halifax, Nova Scotia, Canada.

**Sheri L. Price**, PhD, is an assistant professor in the School of Nursing, Dalhousie University, Halifax, Nova Scotia, Canada.

**Tarra L. Penney**, BSc, is a research associate in the School of Health and Human Performance, Dalhousie University, Halifax, Nova Scotia, Canada.

**Laurene Rehman**, PhD, is a professor in the School of Health and Human Performance, Dalhousie University, Halifax, Nova Scotia, Canada.

**Renee F. Lyons**, PhD, is Bridgepoint Chair in Complex Chronic Disease Research, and TD scientific director, Bridgepoint Collaboratory in Research and Innovation, Bridgepoint Health, Toronto, Ontario, Canada.

**Helena Piccinini-Vallis**, MD, MSc, CCFP, is a clinician Investigator in the Primary Care Research Unit, Dalhousie University Department of Family Medicine, Halifax, Nova Scotia, Canada.

**T. Michael Vallis**, PhD, is a registered clinical psychologist in the Queen Elizabeth II Health Sciences Centre, and an associate professor at Dalhousie University, Halifax, Nova Scotia, Canada.

**Janet Curran**, PhD, is a clinical scientist at the IWK Health Centre, Halifax, Nova Scotia, Canada.

**Megan Aston**, PhD, is an associate professor in the School of Nursing, Dalhousie University, Halifax, Nova Scotia, Canada.