

© Copyright 2015

Kari G Kennedy

Navigating the American Healthcare System as an Obese Person: Developing  
Effective Community-Based Treatment Strategies for Healthcare Providers

Kari G Kennedy

A thesis

submitted in partial fulfillment of the  
requirements for the degree of

Master of Arts in Interdisciplinary Studies

University of Washington

2015

Reading Committee:

Lawrence Knopp, Chair

Ariana Ochoa Camacho

Program Authorized to Offer Degree:

School of Interdisciplinary Arts and Sciences

University of Washington

**Abstract**

Navigating the American Healthcare System as an Obese Person: Developing Effective Community-Based Treatment Strategies for Healthcare Providers

Kari G Kennedy

Chair of the Supervisory Committee:  
Lawrence Knopp  
Interdisciplinary Arts and Sciences

Obesity is a public health concern associated with increased medical costs and poorer health outcomes, but it is also associated with minority status and this social context has important healthcare implications. Ten interviews were conducted in the Tacoma, WA area to identify common weight-loss barriers, and health literacy and agency emerged as factors that impact health outcomes. Health literacy interacted with both the healthcare system and the weight-loss industry, as interviewees indicated a lack of distinction between the two. Some interviewees indicated that bias and stigma overrode health literacy, an act referred to as *bias-associated suppression of health literacy (BASH)*. Agency impacted the patient-provider relationship and access to community resources, and can be considered an aspect of structural competence. Some

scholars have argued for including structural competence in professional health education to improve patient outcomes. Structural competence education and improved patient health literacy may both improve patient health outcomes.

# TABLE OF CONTENTS

List of Figures .....	iii
List of Tables .....	iv
Introduction.....	1
Chapter 1. Literature Review .....	4
1.1    Current Recommendations for the Treatment of Obesity.....	4
1.2    Lifestyle Modifications: Influences and Barriers .....	10
1.3    Social Inequality and Health Status .....	11
1.3.1    Socioeconomic Status and the Outcome Gap .....	11
1.3.2    Wage, Healthcare, and Obesity.....	14
1.4    Cultural Influences on Obesity .....	17
1.4.1    Physical Activity and the Built Environment .....	17
1.4.2    Alternatives to the Biomedical Model: Fat Studies, Intersectionality, and Biocultural Models.....	22
1.5    Whose Responsibility is it, Anyway? Patient-Provider Interactions .....	36
1.6    In Summary.....	39
Chapter 2. Methods.....	41
2.1    Researcher Subjectivity .....	41
2.2    Study Procedures .....	45
Chapter 3. Health Literacy and Healthy Weight.....	50
3.1    The Impact of Literacy on Health.....	51
3.2    Drugs, Supplements, and Safety Standards .....	54
3.3    Commercial Weight Loss .....	57
3.4    Medical Treatment of Obesity .....	63
3.5    Ideal Weight and Stigma.....	65
3.6    Voicing Questions to Healthcare Providers.....	70

3.7	Framing Obesity as a Social Justice Issue .....	73
3.8	Chapter Summary .....	77
Chapter 4. Agency, Autonomy, and Health .....		78
4.1	Structural Influences on Choice .....	79
4.2	Responsibility and Accountability .....	84
4.3	Autonomy and Identity .....	90
4.4	Agency and Readiness to Change .....	95
4.5	Chapter Summary .....	99
Chapter 5. Conclusions and Significance .....		102
5.1	Summary and Interpretation .....	102
5.2	Study Limitations and Directions for Future Research.....	106
5.3	Recommendations and Implications .....	107
Bibliography .....		111
Appendix A: Allen.....		120
Appendix B: Anna .....		126
Appendix C: Barbara .....		135
Appendix D: Carole .....		142
Appendix E: Joy.....		151
Appendix F: Landon .....		161
Appendix G: Lee.....		171
Appendix H: Richard .....		179
Appendix I: Ryan.....		185
Appendix J: Violet.....		193

## **LIST OF FIGURES**

Figure 1 - Frequency of Key Themes by Participant .....	48
Figure 2 - Participant Locations in the Cliff Analogy .....	76

## LIST OF TABLES

Table 1 - Diagnosis and Management of Obesity, from the 2014 Advanced Framework for a New Diagnosis of Obesity as a Chronic Disease .....	5
Table 2 - Comparison of previous definitions of 'Rural' by study .....	19
Table 3 - Prevalence of self-report as a method of data collection.....	21
Table 4 - Participant Demographics .....	49

## ACKNOWLEDGEMENTS

There are so many people who contributed to the completion of this thesis that listing them all is an intimidating task. The following are not in any particular order:

I would not have been able to complete this study without the generosity of my interviewees. Thank you all for your time and willingness to let me ask a lot of questions! For anonymity's sake, I cannot name you here, but you know who you are!

My awesome writing group – Margaret Lundberg, Peter Benjamin, Tom Hicks, and Emma Allen – suffered through several *very* rough drafts and let me talk through my difficulties over coffee on many occasions. Congratulations guys – we made it!

My experiences with the healthcare system were formed over several years, and I owe a huge debt of gratitude to the many healthcare providers and allied health professionals who generously shared their time and knowledge in order to help me succeed. I am incredibly thankful for the conversations and input I've gotten from several providers over the course of writing this thesis.

Thanks are also due to my committee, for their excellent suggestions and insight. In particular, I would like to thank Dr. Ochoa Camacho for the gift of her time and in-depth discussions on the structure and framing of my research.

I would also like to thank my family for supporting me and encouraging me to keep going even when things got tough.

## DEDICATION

For my dad, who taught me that it's never too early for a five-year plan.

“In the end it is practical, everyday medicine that most interests me – what happens when the simplicities of science come up against the complexities of individual lives. As pervasive as medicine has become in modern life, it remains mostly hidden and often misunderstood. We have taken it to be both more perfect than it is and less extraordinary than it can be.”

- Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science*

## INTRODUCTION

Obesity has been referred to as “one of the most pressing public health disorders in the United States and other westernized societies” (Faith & Kral, 2006, p. 236) and 64.5% of American adults meet the current criteria for weight loss treatment (Stevens, Oakkar, Cui, Cai, & Truesdale, 2015). Obesity in particular, and health inequities more broadly, are recognized as impacting members of race, class, and gender minority groups (Weber, 2006). Currently, the urban poor are the most impacted by the “obesity epidemic”, but the urban-rural gap is progressively narrowing (Brewis, 2011). Individuals who are obese are more likely to be sick (Barr, 2008); once they get sick, they are more likely to have a worse course of illness and poorer outcomes (Hernandez-Boussard, Ahmed, & Morton, 2012). The association between poverty and obesity (Ferrie, 2004) indicates that many individuals who are obese may not possess sufficient medical coverage to allow for adequate treatment of obesity and its related diseases.

In healthcare, dialogues about obesity often include related diseases (referred to as comorbidities) such as high blood pressure, heart disease, diabetes and certain cancers, all of which are considered chronic diseases. These comorbidities are included because “the adverse consequences of obesity derive largely from these conditions, increasing the mortality, morbidity and disability of obese individuals” (Rissanen, 1996, p. 194). With the linking of excess weight and increased disease risk comes the correlation between weight and excessive medical costs, leading to economic concerns regarding national health expenditures and insurance rates (Cawley & Meyerhoefer, 2012). This has in turn resulted in increasing public debate over how best to address America’s “obesity epidemic”, a problem further complicated by the association

of race, class, and/or gender minority group membership with an increased likelihood of being obese.

While obesity is widely viewed as a medical issue in the United States, scholars in the area of fat studies often criticize the current medical treatment model for focusing solely on weight reduction in an attempt to address the issue of obesity. These scholars challenge the construction of obesity as a public health crisis in American society and argue that existing financial relationships between health researchers and the weight loss industry have significantly biased the results of ongoing research (Lyons, 2009). This oppositional view of the characterization of obesity as a medical problem has in return been criticized for ignoring the very real medical problems that individuals with morbid obesity are likely to face.

In contrast with the opposition of fat studies scholars, feminist intersectional scholars argue for the integration of intersectionality theory<sup>1</sup> into the current treatment model (Weber, 2006). These scholars argue that persistent findings of disparate outcomes for racial, gendered, and social minorities, much as for individuals with obesity, indicate that it may be necessary to shift the frame with which healthcare providers view these individuals. Further, understanding the social context that has constructed obesity as an epidemic in this time and place provides a critical view for understanding how obesity develops. Integrating an understanding of social determinants of health into treatment recommendations for obesity may also help to ameliorate implicit weight bias on the part of healthcare providers (Puhl, Leudicke, & Grilo, 2014).

Treating obesity solely as a medical issue places the burden for action on each individual patient, ignores biocultural factors that limit an individual's options, and discounts entirely all individuals without the resources to access the healthcare system. Viewing the current treatment

---

<sup>1</sup> Intersectionality theory examines the ways that individual lived experiences with race, class, and gender intersect in order to understand the experience of an individual within their particular social circumstances.

model for obesity through both a feminist intersectional and a constructivist lens could allow community-based solutions to work in concert with the existing treatment model to improve health outcomes among individuals from all socioeconomic strata. In particular, the feminist perspective allows consideration of individual experiences in what is traditionally a statistics-based, majority-focused discipline. Without addressing the full scope of the genetic, environmental, and social factors influencing the development of obesity, medical interventions may fail to provide practical, long-term solutions: “Most health outcomes are not produced within the health sector and therefore can not be fully addressed by our medical care and public health systems” (Jones, Jones, Perry, Barclay, & Jones, 2009, p. 11). The intent of this study is to place the views and experiences of individuals in conversation with the current body of obesity treatment literature. Integrating social and scientific views on obesity with the goal of improving patient outcomes thus enables an exploration of community-based strategies to complement the existing clinical treatment model.

# Chapter 1. LITERATURE REVIEW

In order to integrate social and scientific views on obesity, this study begins with an understanding of each viewpoint and its philosophical basis. Beyond examining *how* viewpoints differ, this study discusses *why* they differ, which leads to a richer and more complete understanding of the complex processes that each contribute to the development of obesity. For example, the medical treatment model currently used by healthcare providers is located firmly in the scientific paradigm, which tends to view everything with a problem-focused lens that develops the best possible solution for the greatest possible majority of the population. However, this approach may become problematic when attempting to solve complex problems that include aspects from several different disciplines. In the case of obesity, there are cultural, socioeconomic, and medical factors to contend with in order to develop any meaningful solution. Therefore, in addition to reviewing the current obesity treatments and the rationale behind them, this review explores several disciplinary alternatives to the biomedical model.

## 1.1 CURRENT RECOMMENDATIONS FOR THE TREATMENT OF OBESITY

For healthcare providers caring for individuals who are obese, the current medical care model recommends a stepwise approach to treatment. While the Basal Metabolic Index (BMI) standard is used as a surrogate measure for obesity, it is recommended that clinical judgment be applied in determining whether the patient is truly in need of treatment (Reid, 2013). For example, it is common for athletes to present with above-average BMI, but this may be the result of increased muscle rather than fat mass. For this reason, new clinical diagnostic standards have

been proposed which base treatment recommendations on the presence of comorbidities rather than solely on an individual’s weight-for-height (BMI).

Under current guidelines, once the healthcare provider determines that the patient is in need of treatment, lifestyle modifications including behavior therapy, diet, and exercise should be recommended to patients. Pharmacological treatment should be recommended only to patients who do not see improvement with lifestyle modifications alone, and bariatric surgery should be considered only in patients who have been unsuccessful at reducing with pharmacotherapy, and who meet additional criteria including BMI and presence of co-morbidities (Reid, 2013). These recommendations have been further developed into an “actionable framework” (Advanced Framework for a New Diagnosis of Obesity as a Chronic Disease, 2014). A summary can be found in Table 1, below.

Diagnosis and Management of Obesity			
Diagnosis		Complications-Specific Staging and Treatment	
Step 1 – Anthropometric Component – BMI	Step 2 – Clinical Component	Step 3 – Complications-Specific Staging	Step 4 – Suggested Therapeutic Interventions (based on clinical judgment)
25-29.9	<b>Presence/Absence of Obesity Related Complications</b> <ul style="list-style-type: none"> <li>• Metabolic Conditions               <ul style="list-style-type: none"> <li>○ Prediabetes</li> <li>○ Metabolic Syndrome</li> <li>○ T2DM</li> <li>○ Hypertension</li> <li>○ Dyslipidemia</li> <li>○ NAFLD/NASH</li> </ul> </li> <li>• Sleep Apnea</li> <li>• PCOS</li> <li>• Osteoarthritis</li> <li>• Stress Incontinence</li> <li>• GERD</li> <li>• Disability/Immobility</li> <li>• Psychological Disorder or stigmatization</li> </ul>	Overweight	<ul style="list-style-type: none"> <li>• Healthy Meal Pattern and Physical Activity</li> <li>• Lifestyle Modification/Reduced Calorie Meal Plan/ Physical Activity</li> </ul>
≥ 30		Obesity Stage 0	<ul style="list-style-type: none"> <li>• Lifestyle Modification/Reduced Calorie Meal Plan/ Physical Activity</li> <li>• Intensive Behavioral and Lifestyle Therapy</li> </ul>
≥ 25		Obesity Stage 1 (1+ mild/moderate complications)	<ul style="list-style-type: none"> <li>• Lifestyle Modification/Reduced Calorie Meal Plan/ Physical Activity</li> <li>• Intensive Behavioral and Lifestyle Therapy</li> <li>• Consider adding weight loss medications to lifestyle therapy program if BMI ≥ 27</li> </ul>
≥ 25		Obesity Stage 2 (1+ severe complication)	<ul style="list-style-type: none"> <li>• Lifestyle Modification/Reduced Calorie Meal Plan/ Physical Activity</li> <li>• Intensive Behavioral and Lifestyle Therapy with medications if BMI ≥ 27</li> <li>• Consider Bariatric Surgery in patients with T2DM and BMI 35-39.9</li> <li>• Consider Bariatric Surgery in patients with BMI ≥ 40</li> </ul>

Table 1 - Diagnosis and Management of Obesity, from the 2014 Advanced Framework for a New Diagnosis of Obesity as a Chronic Disease

In addition to recommending lifestyle modifications to the patient, it has been suggested that the healthcare provider should conduct a full review of the patient's current medications and consider the possible weight effects of certain medications. For example, medications such as Selective Serotonin Reuptake Inhibitors (SSRIs) and tricyclic antidepressants are known to be associated with weight gain, as are some medications used to treat diabetes mellitus. In many cases, weight-neutral options are available and should be considered first for long-term management of chronic conditions (Reid, 2013).

In cases where lifestyle modifications alone are ineffective, there are many adjunct pharmacological therapies for the long-term management of obesity that have been shown to be effective. These medications are intended to be used as adjunctive therapy in a plan that includes continuing lifestyle modifications (Gadde, 2014). Most anti-obesity medications function as either appetite suppressants or by blocking fat absorption. Appetite suppressants first came on the market in the 1930s, and by 1960 there were five different medications available in this category. The most common appetite suppressant is phentermine, which has "limited long-term data on its effectiveness" (Kushner, 2014, p. 468). Common side effects of this class of medication include restlessness, insomnia, dry mouth, constipation, increased blood pressure, and increased heart rate (Kushner, 2014). These medications are approved only for short-term use – about 3 months – and patients generally return to their initial weight once the medication is stopped (Reid, 2013).

Orlistat, which functions by inhibiting fat absorption in the gastrointestinal tract, was approved for long-term use in 1999. In 2007, this medication was released over the counter at half the prescription dose. While there are no systemic side effects from taking orlistat, it is known to cause issues relating to oily fecal discharge, flatulence, and spotting (Kushner, 2014),

which increase with fat intake and may function as a form of negative conditioning.

Additionally, because orlistat may affect the absorption of fat-soluble vitamins and medications such as contraceptives, levothyroxine, and warfarin, dosage adjustments to these medications may be needed (Reid, 2013).

In addition to orlistat, lorcaserin and phentermine-topiramate were FDA-approved for use in long-term weight loss in 2012. Lorcaserin is a selective serotonin receptor agonist, in the same class as fenfluramine and dexfenfluramine, which were pulled from the market after they were shown to act on the 5-HT<sub>2B</sub> receptors expressed in cardiac cells, causing drug-induced valvulopathies. Lorcaserin is several-fold times more selective for the 5-HT<sub>2C</sub> receptor than for the 5-HT<sub>2B</sub> receptor (Gadde, 2014), and did not show any association with valvulopathies in clinical trials (Reid, 2013). It is believed to increase satiety and decrease food intake by activating pro-opiomelanocortin (POMC) neurons. However, the 5-HT<sub>2C</sub> receptor is non-specific to POMC receptors and is found in other regions of the brain; there is a potential for unintended effects in other areas (Gadde, 2014). Headache, dizziness, and nausea are the most common side effects of this drug group (Kushner, 2014).

The other recently FDA-approved medication, phentermine-topiramate (PHEN/TPM), is a combination of two drugs. As discussed earlier, phentermine was previously approved for short-term use in weight loss; it is also used as an anticonvulsant and as prophylaxis for migraine headaches. Its mechanism for weight reduction is currently unknown. Topiramate was investigated as an independent medication for weight loss, but trials were discontinued after it was shown to cause cognitive impairment and paresthesias. In combination, these medications are used at lower doses to reduce adverse effects, although the most common adverse effects include paresthesias, dry mouth, constipation, dysgeusia, and insomnia. This medication was

approved with a Risk Evaluation and Mitigations Strategy requirement by the FDA due to the increased risk of birth defects; it is contraindicated during pregnancy and women of child-bearing age who are taking this medication should be on active birth control (Kushner, 2014).

Lorcaserin and phentermine-topiramate were FDA-approved with a new provision that weight loss effectiveness should be re-assessed within a few weeks of taking the medication. If these medications are not initially effective, then further use is not recommended. This strategy is intended to identify patients who do not respond to the medication and reduce the risk of side-effects in patients who are not benefitting from medication use (Kushner, 2014).

In addition to the current anti-obesity medications already available, there are two medications that received FDA approval in September 2014. The first medication, a combination of bupropion and naltrexone, is thought to synergistically increase the firing rate of POMC neurons, similar to the action of lorcaserin, discussed further above. Bupropion-naltrexone raised some concerns over small blood pressure and heart rate increases, but the interim results of further trials “did not show a significant increase in major adverse cardiac events” (Gadde, 2014, p. 816).

Liraglutide, currently used in a lower dose for treating diabetes, has previously been shown to induce modest weight loss. It is currently being investigated for use in higher doses for the treatment of obesity. As a glucagon-like peptide-1 (GLP-1) receptor agonist, liraglutide induces weight loss through inhibition of gastric emptying and appetite suppression. Nausea is the most common side effect of liraglutide (Drucker & Nauck, 2006).

In the event that lifestyle modifications and pharmacological treatments are ineffective, patients may be considered as candidates for weight loss surgery. Two of the three most common weight loss surgeries in the United States are “restrictive” surgeries, because they restrict the

amount of food the patient is able to eat. Gastric banding involves the surgical placement of a saline-filled band around the upper portion of the stomach. This band reduces the size of the stomach and causes the patient to feel full faster, thus reducing their food intake. Patients can expect to lose about 40 to 45 percent of their excess body weight within 2 years of the surgery. This type of procedure requires frequent follow up care, as the amount of saline has to be continually adjusted to maximize weight loss while minimizing complications such as vomiting and reflux (Reid, 2013).

Sleeve gastrectomy, another restrictive procedure, involves the surgical removal of approximately 80 percent of the stomach. After surgery, the stomach is only able to hold about 3 to 4 ounces of food, causing the patient to lose weight. Patients can expect to lose about 40 to 70 percent of their excess body weight with this procedure, more than with gastric banding (Reid, 2013).

The third type of weight loss surgery, Roux-En-Y Gastric Bypass (RYGB), is both restrictive and malabsorptive. This procedure involves a reduction in stomach size, but also connects the gastric remnant directly to the jejunum, bypassing the duodenum and thus reducing the amount of calories and nutrients that are absorbed. This procedure has the greatest overall weight loss – approximately 50 to 75 percent of excess body weight – but also carries an increased risk of vitamin and mineral deficiencies. In addition to weight loss, gastric bypass has been associated with remission of some comorbid conditions. Although the mechanism is not yet known, gastric bypass has been associated with remission of diabetes. Initial studies placed the remission rate at nearly 80 percent; however long-term studies show an overall remission rate of 36 to 42 percent at 10 years post-operation (Reid, 2013).

Regardless of whether pharmaceutical or surgical interventions are utilized, lifestyle modifications play a key role in the patient's outcome. Focusing on programs that support patients' lifestyle modifications could be a way to significantly improve the health of both individual patients and of communities as a whole. However, significant income-based disparities have been shown to exist both within and between social groups, and the resources available at each socioeconomic status level impact the effectiveness of interventions and ultimately are a determinant of individual success.

## 1.2 LIFESTYLE MODIFICATIONS: INFLUENCES AND BARRIERS

In order to discuss disparities in health outcomes, we must recognize that there is a social gradient of health. Health status, whether of a population or an individual, is relational – it depends on what you are measuring, and who you are measuring against. For example, although US healthcare is excellent relative to many Third World countries, the US is ranked near the bottom of its peers among developed countries when comparing health outcomes, despite spending a considerably greater sum on healthcare (Barr, 2008). As demonstrated in the Whitehall study (discussed further below), health status falls along a gradient rather than existing as a set point, above which all individuals are equally healthy (Marmot, Rose, & Shipley, 1984). This is a critical concept because it shows that all individuals in society are affected by inequality to one degree or another, and thus have a personal interest in improving the health outcomes of all.

## 1.3 SOCIAL INEQUALITY AND HEALTH STATUS

### 1.3.1 *Socioeconomic Status and the Outcome Gap*

Socioeconomic status (SES) and its connections with both health disparities and obesity have previously been widely explored. Data from the Whitehall study (Marmot, Rose, & Shipley, 1984; for further discussion, see Ferrie, 2004), a study of 18,000 British Civil Servants in the United Kingdom, has been used in support of the theory that there is a social gradient to health, as opposed to a threshold limit (Barr, 2008). In addition to the finding that health outcomes generally fall along a social gradient, Whitehall is a study of fully-employed workers. The Civil Service does not employ anyone in either the top or bottom quintile of the population: The Whitehall Study is not a study of poverty, and the social gradient of health was found to occur even without the inclusion of individuals who lack access to healthcare. All of the study participants have equal access to the same healthcare system, so the results of the Whitehall study – which has now been replicated across several generations and in most of the developed world (Ferrie, 2004) – is not a study of how individuals access the healthcare system. The Whitehall study disputes the idea that disparities are the result of poverty, and refutes the idea that the poverty line serves as a threshold limit, above which everyone is equally healthy (Barr, 2008). There is a gradient rather than a dichotomy of social inequality, and even those who do not consider themselves to be poor experience it.

The relationship between income and health is consistent and has been measured by economists. In fact, the measure of income inequality within a given society is strongly correlated with health outcomes in the same region. Economists express this level as the Gini coefficient, which has been defined as “the decimal fraction of the aggregate income within a

society that would need to be redistributed to attain full equality” (Barr, 2008, p. 87). The greater the Gini coefficient, the wider the health outcome gap is expected to be. The amount of health and income disparity seen within a society is related to the strength of the social networks within the community, sometimes referred to as ‘social capital’. On a larger scale, social capital also reflects the level of engagement with the political process (see discussion in Barr, 2008, p. 88-97).

The relationship between levels of equity and participation in the political process is one that has been addressed in different contexts, including mass media (Alexander, 2010) and a Nobel Prize Lecture (Sen, 1999). A current example of the interaction of political activism and social equity is the ongoing legislation and political debate relating to the Food Stamp program. Food stamps – now officially known as the Supplemental Nutrition Assistance Program (SNAP) – have historically been viewed as a program geared toward people of color, even though the overwhelming majority of individuals receiving welfare in general are white (Edelman, 2012).

Regardless of the debate over who most benefits from SNAP, the intent of the program is to provide lower-income individuals with assistance in affording food. Research indicates that individuals in this situation often choose higher carbohydrate foods because they provide more calories per dollar, and thus have a higher perceived value to families trying to maximize their food budget. Although SNAP does include nutrition education, it differs from similar federally-funded programs because it does not have a mandatory nutritional standard. For example, WIC participants must buy specific brands or items in order to use their benefits, while those using SNAP can use it much like cash. Economists debate over whether market controls in the form of public policies are needed in order to effectively address obesity, such as by enacting nutritional standards in an attempt to push lower-income consumers to buy healthier foods. Where some

economists support broad public policy interventions to address obesity (Drewnowski, 2009), others support public policy changes that address adolescent obesity, but not adult obesity (Finkelstein & Zuckerman, 2008). These scholars believe that while adolescents are not yet capable of being “rational actors” and are thus potentially too influenced by the market, adults are “utility-maximizing” rational actors whose choices should not be made for them; therefore the market should be left to function unconstrained in relation to adults’ choices (Finkelstein & Zuckerman, 2008). In an effort to understand the impact of public assistance programs such as SNAP and WIC, researchers conducted a study and found that these programs, a significant portion of the US population (including an estimated 3.55 million children) would have to survive on less than \$2 a day, a measure of poverty normally used only in Third World countries (Shaefer & Edin, 2013).

Thus, economists advocate for opposing mechanisms to address the obesity epidemic, underscoring much of the ongoing debate in regards to how best to address the issues posed by obesity. The “biomedical paradigm” (Mullings & Schulz, 2006) alternately explains the obesity epidemic as the result of individual choice related to cravings for sweets and fats, metabolic imbalances, the glycemic index and individual differences in insulin sensitivity; individual cortisol-mediated stress responses; and having an addictive personality (Drewnowski, 2009). Each of these proposed mechanisms address the disparities at the level of the individual, and often attribute an individual’s experience to their genetic inheritance, leading to an incomplete and fixed view of the individuals’ culture (Mullings & Schulz, 2006). Further, viewing disease or illness as a result of individual choices enables us to blame the victim. Healthcare providers, for example, could then view the individual as having brought it upon themselves by choosing not to listen to the doctor’s instructions (Fitzgerald, 1994). Similar to economic discussions of the

“good” and “bad” poor (see, for example, Allison, 1994), this also allows for “good” individuals whose weight is pre-determined by genetic factors out of their control, and “bad” individuals who lack the control needed to make healthy choices.

### 1.3.2

#### *Wage, Healthcare, and Obesity*

Providing quality healthcare for any individual is dependent on the individual having both the means and desire to access the healthcare system. Likewise, in order for an individual to enact meaningful lifestyle modifications in order to improve overall health, they must have the resources to overcome barriers to making healthier choices: Telling people to “eat better and exercise more” will not work if people do not have the means to afford better quality food, the knowledge to select and prepare it, and the leisure time to exercise. Further, many individuals in racial, gender, and/or socioeconomic minority groups, have been systematically taught that they are at higher risk for certain diseases: “In other words, we spend a great deal of money widely publicizing to African Americans, Latinos, and Native Americans that they are especially susceptible to diabetes” (Gomez, 2013, p. 7). Others may have experienced repeated prior failures at attaining and maintaining “successful” weight loss, which often creates a barrier to ongoing efforts. These barriers may be particularly difficult to overcome for many in economically and socially marginalized groups, which are disproportionately affected by obesity and associated comorbidities (Ferrie, 2004).

Where affluence is low, obesity risk is high (Stunkard A. J., 1996), and individuals in lower socioeconomic classes often struggle to obtain nutritional food resources. Instead, these individuals are more likely to purchase low-cost, energy-dense foods. These foods enable them to survive, but have been shown to have little impact on satiety and minimal nutritional value.

Thus, individuals may be tempted to eat more because they do not feel full, and people may not be getting the nutrients they need (Drewnowski & Darmon, 2005).

The cost of food has not risen universally with inflation. Instead, from 1985 to 2000, the price of fresh vegetables and fruits increased 120%. Thus, energy-dense foods are comparatively much cheaper for low-income families; “diet quality, both in the US and elsewhere, is a function of social class” (Drewnowski & Darmon, 2005, p. 266S). This is supported by other studies, which have shown that at the highest economic levels, individuals are able to afford more expensive, high-nutrient foods (Stunkard A. J., 1996). Additionally, at high levels of affluence, thinness is seen as an indication of social status, increasing the pressure to stay thin. Differential rates of obesity for men and women have been at least partially related to cultural views within the United States, where it is more acceptable for a male to be heavier. For example, a male may make the economic trade-off of working more hours at the expense of leisure-time recreation or preparing healthy meals without experiencing the same social sanctions as would a female who made the same choices (McLaren, 2007).

People in key hiring positions often perceive obese people – particularly women – as “less neat, active, productive, likely to take initiative... attractive, and healthy than ‘normal weight’ applicants” (Fikkan & Rothblum, 2005, p. 16). Society in general perceives obesity as the result of an individual choice, and thus weight bias in employment might seem to be a superficial problem that the individual has brought upon themselves. While it is true that obese people are perceived negatively in comparison to thin counterparts, there are more subtle influences that contribute to the hiring discrepancy.

Employer-sponsored healthcare is one example of a subtle cause of employment bias. Most health care in the United States is provided through employer-sponsored programs, where

employees pay a cost share. However, in this system, the employer still pays the bulk of the costs, and the associated costs are generally presented as a group average. Employers pay less if they hire individuals who are healthier and less likely to need expensive medical care, effectively incentivizing the practice of discriminating against hiring obese workers (Bhattacharya & Bundorf, 2009). When diagnoses are delayed, diseases are not caught until they have progressed further, at which point they are more difficult and expensive to treat (Hernandez-Boussard, Ahmed, & Morton, 2012). This perpetuates the belief that obese people are driving up health care costs and validates the ongoing employment bias, which makes it even more difficult for obese individuals to find steady employment and healthcare.

While perhaps the easiest to quantify, healthcare cost estimates generally account for only the direct costs of obesity. Direct costs refer to the total dollars spent on obesity-related health conditions, while indirect costs measure “resources forgone as the result of a health condition”, and include things like lost productivity, increased insurance premiums, and lower wages (Harvard School of Public Health, n.d.). A recent study of healthcare costs related to obesity estimated that 20.6% of U.S. healthcare expenditures are obesity-related, and that an obese person’s annual medical costs are \$2741 higher than those of a non-obese person (Cawley & Meyerhoefer, 2012). In addition to these direct costs, obese people often face discrimination in the workplace and educational settings (Pomeranz & Puhl, 2013). In one study, researchers found that not only were obese employees generally receiving a lower wage than non-obese counterparts, but that wage bias varied by gender - wages were 2.3% lower for women, compared to 0.7% lower for men (Baum II & Ford, 2004). One working paper proposed that the wage disparity, particularly for white women, is equivalent to approximately three years’ work experience (Cawley, 2000).

## 1.4 CULTURAL INFLUENCES ON OBESITY

### 1.4.1 *Physical Activity and the Built Environment*

The obesity rate has increased too quickly to be accounted for by genetic change alone (Hill & Peters, 1998); researchers have begun exploring other causes, including the effects of the food environment (patterns of dining out and food shopping) on dietary intake, and the impact of the built environment (manmade structures and infrastructure of cities) on adolescent physical activity levels. Physical activity levels of adolescents in different built environments have been studied in order to determine the impact of the built environment on obesity risk. Studies of the built environment focus on safe walking areas in the neighborhood, adequate recreational facilities, available healthy food options, active travel (such as walking or biking to work) that is supported by the infrastructure, and other factors. In order to further evaluate possible prevention strategies, the Centers for Disease Control began funding Community Transformation Grants in 2011. In September 2012, these grants expanded to enable a stronger focus on smaller communities.

After several previous studies seemed to suggest a link between rural residency and obesity, Lutfiyya et al (2007) determined that rural residency increases the risk of obesity by 25% and established rural residency as a risk factor for obesity. Additional studies of the built environment have studied physical activity in relation to crime and safety (Yen & Kaplan, 1998), street interconnectivity and traffic patterns (Greenwald & Boarnet, 2001), and recreational facility access (Giles-Corti & Donovan, 2002). Synthesis studies, such as those by Dunton et al (2009) and Sandercock et al (2010) then work to combine the results of earlier studies with the

goal of discovering effective universal prevention strategies. In their synthesis, Sandercock et al (2010) examined the significance of conducting a bilateral (urban /rural) versus trilateral (urban/suburban/rural) study, and the assertion of Nelson et al (2006) that even a trilateral study may be too simplistic.

Nelson et al (2006) performed a detailed cluster analysis, identifying six neighborhood pattern types that represented, on a national scale, an aggregate analysis of nineteen factors believed to influence obesity risk. This study found that the three most at-risk groups were those characterized as low-income, racial or ethnic minorities, and rural residents, a finding supported by Lutfiyya et al (2007). Regardless of whether bilateral, trilateral, or cluster analysis is the best approach to resolving the adolescent obesity epidemic, Sandercock et al (2010) identified issues with current research which make data synthesis extremely difficult: There are several different criteria used to define what 'rural' means, and there is no consensus on what constitutes being 'physically active'. Additionally, much of the most recent data is still based on self-report, although GPS based data collection and Electronic Health Records are available. Sandercock et al (2010) addresses these issues but does not suggest a solution, indicating instead a need for continued research.

Most of the studies examined here, whether bilateral, trilateral, or cluster analysis, used data sets generated by the US Census. Many studies - including Lutfiyya et al (2007), which determined that rural residency is an independent risk factor for obesity, and Nelson et al (2006) which performed a cluster analysis - utilize Metropolitan Statistical Area (MSA) to compare urban and rural populations. While based on Census data, MSAs are defined by the Office of Management and Budget (OMB), and are one category in a group collectively known as a Core-Based Statistical Area (CBSA). CBSAs are defined as a core population of at least 10,000 people

(50,000 people in an MSA) and any adjacent territory that is economically linked (usually, this refers to areas from which people commute from or to). Based on these definitions, many studies seem to equate MSA with “Urban” and consider unincorporated area as “Rural”, but the Federal Register states, “The CBSA classification does not equate to an urban-rural classification; Metropolitan ... Statistical Areas and many counties outside CBSAs contain both urban and rural populations” (Office of Management and Budget, 2000).

In a more recent study, Saelens et al (2012) address the issue of residency by utilizing US Census data to calculate the population density of the block group containing the residence of each individual respondent. This method, while not specifically comparing rural and urban areas in the study, allowed the inclusion of neighborhood characteristics and population density of respondents’ residences for comparison, and appears to have resolved the problem of defining ‘rural’. A comparison of definitions used to determine residency in several studies can be found in Table 2.

<b>Definition</b>	Less than 10,000 residents and not incorporated into an MSA	Open country and settlements with less than 2500 residents	Open country and settlements with less than 2500 residents, whether inside or outside of an MSA	No specific definition of rural (metro or non-metro only)	No definition of rural - block group of residence of individual respondent
<b>Source</b>	Metropolitan Statistical Area	US Census Bureau	National Center for Education Statistics	2003 Urban Influence Codes	US Census Bureau
<b>Studies Involved</b>	Nelson et al (2006); Lutfiyya et al (2007);	Casey et al (2008); Moore et al (2010); Boehmer (2006)	Hennessey et al (2010)	Liu et al (2008)	Saelens et al (2012)

Table 2 - Comparison of previous definitions of 'Rural' by study

In addition to multiple definitions of 'rural', there are several definitions of what constitutes being physically active. This contributes to difficulties with synthesis because it means that results from one study are not always comparable with results from another. Of the studies included in the review that reported on the criteria used to be considered physically active, all used different criteria. Liu et al (2008) and Lutfiyya et al (2007) provide an excellent example of the problem this creates. Both studies are based on data from the 2003 National Survey of Children's Health, and while both found that rural residents had a higher risk of obesity, Liu et al found that rural adolescents were more likely to reach the recommended amount of physical activity, while Lutfiyya et al found the opposite. As Liu et al was published after Lutfiyya et al, the authors had the chance to address this disparity. Their discussion included the fact that they had access to the full study results (Lutfiyya et al utilized only the data made publicly available), and the fact that they restricted the ages included in the study to children aged 10-17, while Lutfiyya et al reported on the full data set (ages 5-17). Although Lutfiyya et al considered respondents to have met the recommended amount of activity only if they reported exercising 5 or more days a week for at least 20 minutes, while Liu et al required 20 minutes only 3 or more days per week, this was not addressed in the discussion. The International Consensus Conference on Physical Activity Guidelines for Adolescents recommended 20 minutes a day, at least 3 days per week (Sallis & Patrick, 1994).

A further problem in measuring adolescent physical activity is that it is more often self-reported rather than actually measured. Recently, GPS tracking and accelerometry have been adapted for use in this field, but many studies still collect self-reported data. All of the studies utilizing self-reported data (including height and weight data) discuss the limitations with using this method of data collection (Casey et al 2008, Nelson et al 2006, Lutfiyya et al 2007, Grow et

al 2008, Liu et al 2008). In the studies included here, most obtained both height/weight – used to calculate Body Mass Index (BMI) - and physical activity data via self-report, as shown in Table 3. As shown below, most studies included at least one element of self-reported data. Williamson et al (2012) and Saelens et al (2012) were the only studies included here that measured height and weight. These more recent studies demonstrate a trend towards measured rather than self-reported data.

<b>Author</b>	<b>Height and Weight</b>	<b>Physical Activity</b>
Casey et al (2008)	Self-Reported	Not Reported
Grow et al (2008)	Self-Reported	Self-Reported
Liu et al (2008)	Self-Reported	Self-Reported
Lutfiyya et al (2007)	Self-Reported	Self-Reported
Nelson et al (2006)	Self-Reported	Self-Reported
Rainham et al (2012)	Not Reported	Accelerometry
Saelens et al (2012)	Measured	Not Reported
Williamson et al (2012)	Measured	Self-Reported

Table 3 - Prevalence of self-report as a method of data collection

In the move toward measured data sets, studies have examined the use of Electronic Health Records (EHRs) for obtaining anthropometric data (Schwartz, et al., 2011). While Schwartz et al found the use of EHRs to be highly accurate and efficient, Lutfiyya et al (2007) found a correlation between overweight and obese adolescents and a lack of health insurance, with many of their respondents going more than a year between visits to primary care. This would severely limit the utility of EHRs in low socioeconomic status populations, which both Lutfiyya (2007) and Nelson

(2006) associated with a higher risk of obesity. In order to obtain accurate, current information, both Williamson et al (2012) and Saelens et al (2012) measured each respondent for inclusion into their respective study's data set.

In addition to EHRs, technology has provided another research tool in the form of GPS-enabled devices. These devices, provided to respondents in recent studies (Rainham 2012; Saelens 2012), allow researchers to collect data on both the amount of physical activity and the locations where respondents were most active. This data is then used to study not just *how often* respondents are active, but also *where* they are active. Thus, researchers are able to utilize GPS-enabled devices to directly observe each respondent's interaction with the built environment, and can predict effective, targeted obesity prevention strategies for the rural built environment.

These strategies can now be tested due to funding from the Centers for Disease Control (CDC). In 2011, the CDC began funding Community Transformation Grants, and the program was expanded to focus on small communities in September 2012. These grants are intended to fund programs that achieve measurable, positive change in one of five areas, including weight, proper nutrition, physical activity, tobacco use, and social and emotional well-being. The Small Communities Program focuses specifically on smaller communities, and provides an avenue for examining the impact of policy changes in the rural built environment (Centers for Disease Control, 2012).

#### 1.4.2

#### *Alternatives to the Biomedical Model: Fat Studies, Intersectionality, and Biocultural Models*

Medical treatments for obesity, including long-term medications, weight loss surgery, and follow-up care, are dependent on the ability of the patient to afford health insurance and pay

for services. As a problem that disproportionately affects race, class, and gender minorities (Ferrie, 2004), obesity is a topic of interest to health disparities researchers, and primary care providers continue to seek cost-effective treatment for increasingly complex patients. Thus, the increasing incidence of obesity is a growing public health concern, both in the United States and globally.

#### 1.4.2.1 Intersectionality and Culturally Competent Care

Scientific research has previously attempted to study the health effects of race, class, and gender independently, which some scholars critique as missing the interactions between these factors and incorrectly assuming an additive effect (Mullings & Schulz, 2006). These scholars argue that, by design, scientific research is unable to encompass the full complexity of the factors leading to the development of obesity, and instead support the use of a feminist intersectional framework and the inclusion of qualitative methods to more fully understand the complexities of the problem. The statistical practices and quantitative nature of scientific study focus on bringing the greatest good to the largest majority, while feminist theory and the constructivist viewpoint each challenge the dominant views and bring out the individual voices of those in the margins – an important concept for a study whose population is composed predominantly of those in a race, class, and/or gender minority group.

Studying the issue of obesity in an intersectional frame<sup>2</sup> involves understanding the complex ways that individuals experience the world as a result of their race, class, and gender. In this frame, individual experiences are context-dependent, varying depending on the particular set of social circumstances surrounding the individual. By definition, objective science creates

---

<sup>2</sup> For further discussion of intersectionality theory, see for example, Collins, P. H. (2012) Social Inequality, Power, and Politics: Intersectionality and American Pragmatism in Dialogue. *Journal of Speculative Philosophy*, 26(2), 442-457.

research that is “disconnected from the historical, social, and political processes from which they emerge” (Mullings & Schulz, 2006). Scientific research also tends to view inequality as the result of individuals’ differential access to resources, rather than as a result of group power differences occurring within a broader social structure. Therefore, scientific research tends to focus on individual behaviors rather than on the social processes which generate and maintain these differences (Weber, 2006). This focus on individual actions has consequences for health, particularly in the ahistorical arena of the scientific paradigm: Often, illnesses are attributed to individual lifestyle choices, which may lead to victim-blaming and stigmatization. Further, interventions developed in the absence of historical and social context may fail to identify critical areas that should be targeted for intervention within a specific community. For example, in targeted strategies aimed at reducing the spread of HIV, researchers failed to fully understand the cultural definitions of sex within their target populations, thus limiting the campaign’s effectiveness (Weber, 2006).

A further example of the need to examine the complex interaction between race, class, gender, and health is the way in which these relationships play out in the U.S. healthcare system. Socioeconomic status (often expressed as a measure of income) has been shown to have a very strong association with health status, yet health status has also been shown to vary by race even within the same level of income. And while additional factors that are specific to individuals (such as income level at birth, cultural practices, or migration patterns) can also affect an individual’s health status, some racial/ethnic and gender differences are consistent within income levels (Jackson & Williams, 2006). Therefore, attempts to study socioeconomic status in isolation from other factors, such as race and gender, become problematic.

In contrast with scientific practice's focus on individual characteristics, intersectional research depends upon a broader examination of group relationships and hierarchies that constitute social and political policies. In particular, intersectional research focuses on "fluid, shifting group relations" (Weber, 2006, p. 34) rather than the more fixed, unchanging definitions commonly seen in scientific research (Mullings & Schulz, 2006). In the feminist intersectional paradigm, "health itself is viewed as a condition of communities and societies" (Weber, 2006, p. 34). This paradigm provides a critical analysis of existing power relationships surrounding race, class, and gender; it also provides a framework which allows the researcher to draw connections between individual experiences and the public policies that produce them (Nakano-Glenn, 2002). This is critical because it enables the inclusion of the voice of impacted people while relating individual experiences to broader policy decisions. By relating underlying policy decisions to their impact on individuals, an intersectional analysis can provide support for policy change. Unlike scientific research, which is focused on building knowledge, intersectional research focuses on understanding social processes and relationships, and on building pathways for public action (Weber, 2006).

Some possible pathways to public action include: incorporating factors such as law, economy, education, and the media, all of which act to shape health at the community level; conducting community-based collaborative research; and including multi-method (qualitative and quantitative) research designs in order to address health disparities (Weber, 2006). These recommendations are finding their way into the current body of public health research through the use of Evidence-Based Public Health (EBPH), a multi-method, community-inclusive approach that developed as a response to the qualitative, science-focused Evidence-Based Medicine (EBM) (Kumanyika, Brownson, & Cheadle, 2012). Although EBPH is designed to

incorporate both quantitative and qualitative methods into a single study, the research design of EBPH still does not specifically integrate an understanding of the historical contexts that shape the current social practices of a community, an area that intersectional scholars view as critical to developing fully-engaged research (Weber, 2006).

The nursing community has attempted to address the problem of growing health disparities through the theory of Culturally Competent Care (Chin, 2000). One narrative, which detailed a Hmong family's experience with Western medicine, underscored the need to address health disparities and many of the access problems which the less-wealthy experience in the United States (Fadiman, 1997). Funding for education and training in Culturally Competent Care was provided by Congress in the 2000 amendment to the Public Health Services Act (United States Congress, 2000), and its principles are widely used in many health care practices to assist healthcare providers with providing high-quality care to individuals from different ethnic backgrounds (Brach & Fraser, 2000; Chin, 2000). It is critical to address the needs of diverse cultures because "since 1990, more than half the population growth in the United States has come from immigrants and their children...many of these immigrants, even if they can get to the hospital and pay for their treatment, may find mainstream healthcare culturally inaccessible" (Fadiman, 1997, 270).

Culturally Competent Care has some detractors, chief among them that while many studies have shown improved patient satisfaction with their care, none have demonstrated an actual improvement in patient outcomes: "Although there is substantial research to suggest that cultural competency should work, health systems have little evidence about which cultural competency techniques are in fact effective and less evidence on how to implement them properly" (Brach & Fraser, 2000, 203). Some researchers further found that "[c]omparisons of

culturally competent interventions with interventions uninformed by patients' language and culture are particularly critical, given that the research literature has not been able to firmly rule out the confounders of education, literacy, and class as causes for racial and ethnic disparities" (Brach & Fraser, 2000, 203). The same legislation that funded education and training in Culturally Competent Care also recognized that the majority of the poor and medically underserved individuals in the United States are white, noting that "many of them have the same health care access problems as do members of minority groups" (United States Congress, 2000).

As Barr discussed, health is relational and it is important to take into account both what you are measuring and what you are comparing against (2008). "Cultural competence has a very different meaning for organizations dedicated to serving culturally specific populations than for those dedicated to serving all populations" (Chin, 2000). Culturally Competent Care has been criticized for reducing all members of an ethnic group to an essentialized stereotype, and then producing a checklist to assist medical staff with dealing with all members of that ethnic group (Drevdahl, Canales, & Dorcy, 2008). Some scholars argue that the use of race in biomedical research is uncritical and incorrect (Lopez, 2013). "What explains biomedical researchers' categorization into groups, and then the linkage of those groups to specific health problems such as diabetes, is the social process of making race – of constituting race as socially, politically, and scientifically important" (Gomez, 2013, 2). In other words, the data resulting from our use of race as a research category are intricately entangled with other factors – such as social, political, and economic – that play a role in constituting our understanding of racial groups.

Federal mandates require researchers to collect data regarding patient race and ethnicity; research results are often expressed in a racial dichotomy (black or white). Even the six

categories identified by the United States census do not fully encompass the full range of racial identity in this country: "Data are not collected separately for significant subgroups within "racial"/ethnic populations, yet the ability to capture subgroup differences is essential. With more than 20 identified ethnic groups among the Asian and Hispanic American populations and 365 recognized Native American tribes, significant within-group differences might be masked by aggregating data" (Chin, 2000, 32).

In most studies, race is self-reported by the patient, but previous studies have demonstrated that the effects of provider bias (Barr, 2008) and the overall outcome gap (Gomez, 2013) are determined by the person's ascribed race, regardless of how they self-identify: "[S]ocially defined "race" measures trumped self-identified "race" in terms of predicting health status... In other words, if I identify as Black Hispanic but reported that others usually classified me as White, my health status would approximate that of self-identified Whites" (Lopez, 2013, 193). Therefore, several authors advocate for a better understanding of the effects of race and how it interacts with social class and gender to contribute to health disparities (Gomez, 2013; Lopez, 2013; Mullings & Schulz, 2006).

#### 1.4.2.2 Fat Studies and Health at Every Size (HAES)

Contradicting both the dominant scientific paradigm and the feminist intersectional framing of the obesity problem, fat studies scholars critique the construction of obesity as a public health problem that requires medical treatment. As constructivists, these scholars view the world as context-dependent, finding multiple truths and acknowledging many equally valid views of reality. The existence of the metabolic paradox and the methodological problems

created by the use of BMI as the standard for determining obesity have been highly criticized by some fat studies researchers (Burgard, 2009). This academic area arose out of the size acceptance movement that began with the founding of the National Association to Advance Fat Acceptance (NAAFA) in 1969 (Rothblum, 2011). “Unlike traditional approaches to weight, a fat studies approach offers no opposition to the simple fact of human weight diversity, but instead looks at what people and societies make of this reality” (Wann, 2009, p. x). In the Fat Liberation Manifesto, members of the Fat Liberation Movement were told to “repudiate the mystified “science” which falsely claims that we are unfit” (Freespirit & Aldabarran, 2009, p. 341). Constructivist scholars in the area of fat studies critique the methods used in support of prominent obesity research, argue for situating the discussion of obesity within social and historical context, and find that the “obesity problem” is a construction of the relationships between the pharmaceutical industry and its paid obesity researchers/consultants.

While feminist intersectional scholars promote collaboration with the biomedical paradigm (Weber, 2006), fat studies scholars generally reject the notion of obesity as a medical issue. Instead, they situate the “obesity problem” as a social construct (Burgard, 2009). Fat studies constructs the “obesity epidemic” as a product of the diet industry and the obesity researchers who double as paid consultants within the industry (Lyons, 2009), and critiques the research that claims to demonstrate a link between BMI and disease risk (Burgard, 2009).

According to fat studies scholars, the failure rate of sustained weight loss programs has remained a consistent 90-95% (Gaesser, 2009). However, the use of this figure has been widely and publicly critiqued (Fritsch, 1999) in part because it is based upon a single study done in the 1950s (Stunkard & McLaren-Hume, 1959). Regardless, some scholars raise concerns over the way that the weight loss industry has recently dominated society even without any increase in

treatment effectiveness. Under the current BMI standard, over 60% of U.S. adults are considered overweight or obese. In the medical industry, these adults are thus seen as in need of medical treatment, and this treatment, despite its high rate of failure, is recommended to patients by their health care providers (Lyons, 2009). In an attempt to better separate those patients who are metabolically healthy from those with active disease processes, the clinical treatment guidelines for obesity are changing. However, the issue that fat studies scholars have raised regarding ties between obesity researchers and the weight loss industry remains a concern.

By 2004, the diet industry received 46 billion dollars a year from individuals buying into weight loss products and programs for which there are limited safety and efficacy studies. Drug company money funds much of the research on obesity treatment, and this research is used in turn to support policy decisions. According to some fat studies researchers, the financial relationship between obesity researchers and drug companies constitutes an ethical issue for healthcare providers, who have been handed the responsibility for treating obese patients despite the lack of safe and effective programs for doing so (Lyons, 2009).

In addition to criticizing the construction of obesity as a medical problem, fat studies scholars also critique the methods of prominent obesity literature. In particular, the current standard for measuring obesity is based on BMI, a test which cannot differentiate fat and muscle mass: “If we cannot isolate the variable we are trying to measure, what do the data using BMI mean?” (Burgard, 2009, p. 45). Further methodological challenges include: BMI-associated diseases that are present in individuals with lower BMIs, and not present in all individuals with high BMI; failure of correlative studies to control for all variables known to mediate the BMI-disease relationship; generalization of data derived from clinical populations to the normal population; and the presence of weight-loss-associated health improvements that occur with

lifestyle modifications, even without weight loss (Burgard, 2009). Similar methodological concerns are raised by scientists concerned with the ethical issues inherent in the current research model (Gadde, 2014).

The original study often used as the basis for the “war on obesity” claimed that the cause of 300,000 deaths per year was due to dietary factors and sedentary activity patterns; the causal relationship with obesity was added later by research articles and the media (Lyons, 2009). These challenges to current thinking about the problem of obesity have led to the development of Health at Every Size (HAES), which intentionally shifts the focus toward overall health and away from weight loss.

The continuing influence of the weight loss industry has been attributed to the effects of weight stigma in society. The experience of weight bias brings social pressures and sanctions to individuals who fail to comply with the “norm” for weight. For example, economic sanctions in the form of lower wages and biased hiring practices have been documented in the literature (Fikkan & Rothblum, 2005). Without weight bias, the repeated failures of many weight loss treatments would have made them defunct. Instead, experiences with stigma ensure that these practices are maintained as individuals try to comply with the societal “norm” by any means necessary (Lyons, 2009). When treatment fails, it is assumed to be the fault of the individual rather than the treatment method, in part because the role of public policies and sociocultural factors which act to constrain individual choice are rarely recognized.

There is some indication that weight bias, rather than the physiological strain of being obese, may be causing many of the problems experienced by obese people, as recent research on weight bias which found that it is “just as hazardous to live with a fat person as it is to actually be a fat person” (Ernsberger, 2009, p. 28). Rather than obesity being a biomedical cause of

disease, much of the observed weight-related health disparity is due to experiences with stigma (Ernsberger, 2009).

In order to reduce weight stigma and improve overall health, the HAES model was developed as a way to advocate for healthy day-to-day choices regardless of a patient's weight. In part, HAES is a response to the finding that 91% of health outcomes “have nothing to do with BMI” (Burgard, 2009, p. 43). The existing weight loss research does not demonstrate any improvement in long-term disease risk, but the potential health risks of weight cycling (losing and regaining weight over a person's life course) have been well-documented in the research literature (Burgard, 2009). As a program that emphasizes sustainable long-term health, HAES has the potential to provide the structure for the lifestyle modifications indicated in the current clinical guidelines for the treatment of obesity.

Both feminist intersectional and fat studies scholars raise important points in the study of obesity, and suggest methods for enriching the current understanding and practices surrounding obesity in the U.S. In particular, fat studies and the HAES model view the medicalization of obesity as a moral judgment of an individual's level of health and worth and instead advocate for individuals to take better care of themselves regardless of their current size (Burgard, 2009). The use of a feminist intersectional framework provides a means for moving from an acontextual scientific study towards the practice of implementing interventions in the context of a particular community. Both paradigms suggest the need for a multi-method strategy of inquiry in order to more fully inform our understanding of the complex relationship between obesity, society, and disparities in health outcomes.

#### 1.4.2.3 The Biocultural Model

Although some researchers refer to obesity as a relatively new problem (von Hippel & Nahhas, 2013), anthropological studies chronicle the existence of figurines depicting individuals with excess body fat as far back as the Paleolithic era, including the Willendorf Venus (Thompson & Gordon-Larsen, 2011). This conflict may be explained by the fact that obesity has only recently gained widespread recognition as a public health problem requiring the attention of both public health and medical professionals (James W. P., 2008).

Research into nutritional aspects of the development of obesity has led to the development of five broad categories characterizing differential relationships between human nutritional practices and cultural, social, and economic changes. The process of moving through these stages is referred to as “the nutrition transition” (Popkin, 2011), and it is recognized that different geographical and socioeconomic subgroupings may exist in different stages at the same time. These stages, including food collection through hunting and gathering, famine, receding famine, non-communicable disease, and behavioral change, characterize the varying relationships that exist between food production and consumption patterns. The change in diet that is associated with the increasing prevalence of non-communicable disease, along with increasingly sedentary activity patterns, is common in many of today’s “high income societies” (Popkin, 2011).

While some studies indicate that the incidence of increasing obesity prevalence began in the 1970s (von Hippel & Nahhas, 2013), another study estimates that “the transition to postindustrial BMI values occurred gradually throughout the 20<sup>th</sup> Century” and possibly started much earlier than previously thought (Komlos & Brabec, 2010, p. 636). Medical journals of the time support the idea that obesity was noticeably present in the United States during the late

1890s (National Expansion, 1899). In 1901<sup>3</sup>, a report of a patient with a tumor of the hypophysis (pituitary tumor) ultimately caused many children to be erroneously diagnosed with Frohlich's syndrome, and led to a persistent association between adiposity, pituitary disease, and sexual underdevelopment (Bruch, 1993). Pharmacological treatment options (Kushner, 2014) and the first obesity clinic in the United States (Bruch, 1957) were both developed in the 1930s.

In the 1960s, the "Thrifty Gene" hypothesis was proposed as an evolutionary mechanism by which the body stored excess fat for use in times when food was scarce (Neel, 1992). In the post-industrial economy, the "Thrifty Gene" continued to store excess fat, but without a corresponding period of food scarcity requiring the use of excess fat as fuel, obesity began to emerge as a non-communicable disease with increasing prevalence in society. The "Thrifty Gene" hypothesis is a prominent example of the increasing interest in understanding the genetic causes of obesity: In 1994, the Human Obesity Gene Map was published. As of 2004, 204 genomic regions were identified as possible locations for obesity-related phenotypes. However, there have been persistent problems with replicability in these studies; of the 204 genomic regions, only 38 regions have been found to be replicable in subsequent studies (Faith & Kral, 2006).

Currently, many studies recognize the interaction between genetics and the environment (Must & Evans, 2011) and existing research has demonstrated the existence of the "obesity-mortality paradox": Statistically, there are approximately the same number of metabolically healthy people with obesity as there are metabolically unhealthy individuals who are considered to be normal weight (Ahima & Lazar, 2013). The metabolic pathways by which obesity affects mortality are still questioned by some scientists, particularly in light of conflicting research:

---

<sup>3</sup> The original 1901 report was published in German. The English translation (by Bruch) was originally published in the American Journal of Diseases of Children in 1939, and reprinted in Obesity Research in 1993.

Studies demonstrating higher mortality rates for individuals with obesity conflict with other studies that demonstrate a protective effect conferred on individuals who are overweight or obese (Ahima & Lazar, 2013). Scholars in the area of fat studies argue that since the BMI standard is incapable of differentiating fat mass and muscle mass, there is no way to isolate the variable under study (Burgard, 2009). The ongoing problem of identifying an easily measured variable that accurately predicts health status has led to calls for improved metrics that would enable researchers to better understand the metabolic processes occurring in all individuals regardless of size (Ahima & Lazar, 2013).

There is also an ongoing disagreement among scientists calculating the mortality risks of being obese. Some researchers have tied the existing mortality rates to “dietary factors and activity patterns that are too sedentary” (McGinnis & Foege, 1993, p. 2208), rather than attributing these deaths directly to obesity, as other researchers have done (Allison, Fontaine, Manson, Stevens, & VanItallie, 1999). Where the original research did not attribute deaths directly to obesity, it has sometimes been interpreted as doing so (Kassirer & Angell, 1998), although this interpretation was denied by the original study authors, who stated that “given the contribution of multiple diet-related factors to problems such as high blood pressure, heart disease, and cancer, we noted explicitly the difficulty of sorting out the independent contribution of any one factor” (McGinnis & Foege, 1998, p. 1157).

The difficulty in relating obesity to the influence of any one factor is indicative of the complex process of developing obesity. Thus, researchers have called for the integration of social and genetic factors (Faith & Kral, 2006), and feminist scholars have argued for the inclusion of intersectionality theory with the current model in order to more fully understand the experiences of individuals. For example, although race, class, and gender have each been

individually tied to the development of obesity, feminist intersectional scholars argue that the interactions between these factors are non-additive and require an intersectional analysis in addition to a scientific analysis (Weber, 2006). Fat studies researchers contest the depiction of obesity as a medical disease, a social problem, or the inevitable result of inheritance. They argue that medical treatments, including the use of prescription drugs, inpatient treatment, and surgical interventions, should not be routinely recommended to patients.

### 1.5 WHOSE RESPONSIBILITY IS IT, ANYWAY? PATIENT-PROVIDER INTERACTIONS

The focus on individual-level interactions and the simplified role of personal choice has focused the discussion of patient health on an individual's actions, rather than on the broader social issues that impact the courses of action a patient may take. For example, a patient with a chronic condition – who is more likely to be a member of a low socioeconomic status group – may have difficulty affording the medications to manage their chronic disease. Patients who do not take their medications as directed may be labelled as non-compliant patients, regardless of the reason behind their action. If “the failure to be healthy is someone's fault, then when a person becomes ill he or she may have done something wrong... we use illness as evidence of misbehavior” (Fitzgerald, 1994, p. 197). The persistent belief that obesity results primarily from non-constricted individual choice has played a significant role in the incidence of provider bias, and thus the obesity-related outcome gap. One study found that physicians were less likely to engage in social rapport-building with obese versus non-obese patients (Gudzune, Beach, Roter, & Cooper, 2013).

The potential for bias to impact the quality of healthcare outcomes is real; studies have found that it is already occurring (Hernandez-Boussard, Ahmed, & Morton, 2012). One study

suggested that a possible solution is to "address communication and rapport building skills through continuing medical education training" (Gudzune, Beach, Roter, & Cooper, 2013, p. 2151). Such training could include topics such as social gradient in health and the complex social and cultural factors that impact health, such as employment and educational achievement. This is similar to other researchers' call for incorporating structural competency into health professions education (Metzl & Hansen, 2014).

Multiple studies in medical ethics literature reveal a persistent anti-fat bias on the part of healthcare providers (Gudzune, Beach, Roter, & Cooper, 2013; Hernandez-Boussard, Ahmed, & Morton, 2012). Provider bias has also been found to be racialized and gendered; in the Schulman heart study, no difference in cardiac catheterization referral rates was found for black males, white males, or white females; there was, however, consistently a lower rate of referral for black females (as discussed in Barr, 2008). This finding is reminiscent of the work of feminist scholarship, including the idea that "universal policies for health disparities among women are shaped by the experiences of white women and universal policies for Blacks are shaped by the experiences of Black men" (Lopez, 2013, p. 185). One study found preventive care screening gaps that followed along a weight status gradient, but also noted that the patient's gender and racial minority status varied along the same gradient: it is possible that existing implicit racial bias played a role in the screening gap evidenced in the study (Hernandez-Boussard, Ahmed, & Morton, 2012).

Defining obesity as simply a medical problem for which the answer is to eat less and exercise more renews the practice of victim-blaming and places the fault on the individual, oversimplifying a complex problem and ignoring many contributing factors. Existing public policies, such as agricultural subsidies that impact food prices and insurance mandates that

impact the affordability of healthcare or provide insufficient coverage for patients' chronic care needs, affect the patient's ability to enact meaningful lifestyle modifications. The complex factors involved in the development of obesity extend beyond the clinical setting to include social/cultural and political factors which fall outside the healthcare providers' normal sphere of influence. Traditionally, the family physician is responsible for identifying and treating the underlying medical conditions, and ideally should play a significant role in long-term care decisions and patient education (Arvantes, 2010), yet this approach does not suggest a mechanism for improving the supporting environment that can positively or negatively impact patient choice.

Research has demonstrated that healthcare providers are attempting to provide counseling and patient education, but the end result is the existence of weight-related healthcare disparities: In a study of national survey data from 2005-2007, researchers found that healthcare providers were less likely to provide obese patients with preventive care such as breast exams, pap smears, rectal exams, and prostate-specific antigen testing, all of which are routine screenings for adults (Hernandez-Boussard, Ahmed, & Morton, 2012). As the study found no significant difference in the length of the appointment, they concluded that providers were spending more time on weight-focused counseling at the expense of performing preventive testing.

While there are existing studies which demonstrate an association between excess weight and cancer risk (Calle, Rodriguez, Walker-Thurmond, & Thun, 2003), it is also possible that the association of obesity and poor cancer diagnosis outcomes is a direct result of delayed diagnosis due to reduced preventive screenings (Hernandez-Boussard, Ahmed, & Morton, 2012). Researchers found that not only was the percentage of respondents increasingly female as body mass increased, they were also increasingly from minority groups. In summary, obese patients,

who are more likely to be both female and from a minority race group, are *less* likely to receive preventive screenings designed to detect those conditions for which they are statistically at higher risk (Hernandez-Boussard, Ahmed, & Morton, 2012). It should be noted that the preventive-care disparity exists even for those who have access to the healthcare system, and that the study did not include any portion of the population without healthcare access.

In addition to the implicit bias from some healthcare providers, another example of bias in healthcare can be seen by looking at health insurance. While changing legislation has enabled more Americans to obtain insurance, not all coverage is equal. Most healthcare coverage in the US is employer-sponsored; thus, those individuals with lower socioeconomic position and fewer resources also may receive less assistance in paying for services. Variances in the types of medications or treatments covered is an example of one way that systematic bias may result in health outcome disparities.

## 1.6 IN SUMMARY

From a medical care perspective, understanding all factors involved in the development of obesity is important in order to provide effective solutions. Often, healthcare providers reduce a problem to its simplest parts – “eat less and exercise more” – and when this fails to occur, the patient is labeled as “non-compliant” and, in some cases, may even be denied care because they are acting in a way with which the healthcare provider disagrees (Fitzgerald, 1994). This scenario represents an ethical problem because it results when healthcare professionals impose their personal views on the life choices of others, often leading to negative outcomes.

Standards for medical research and health care practices have been enacted in response to significant events in history. Cultural beliefs and practices play a significant role in the

development of normative health values such as weight, and an ahistorical scientific view may not see these changing practices and values across time. Without a complete understanding of the historical context which has led up to many of the problems faced by individuals in today's society, it is difficult to adequately understand many of the health issues which individuals face. Practitioners who do not have a basic education in socioeconomic determinants of health may fail to grasp the complex issues with which their patients struggle, and thus they are less likely to be effective at treating those problems which society has situated in the medical arena.

In treating patients for obesity, it is necessary to consider whether obesity is a medical problem requiring treatment, a reflection of sociocultural beliefs and practices, or a combination of the two. When developing treatment strategies, health care practitioners should consider whether there are social or political resources that could be combined with medical treatment to build a more comprehensive, community-based approach to improving community health and preventing obesity. This master's thesis considers these issues and asks what might be gained by valuing the ability of patients to offer insights based on their experiences with the healthcare system. By placing patient's voices in conversation with the existing literature, this study seeks both to build a rich and comprehensive understanding of the factors that contribute to the development of obesity, and to discover possible solutions for improving patient outcomes.

## Chapter 2. METHODS

*“You don’t see something until you have the right metaphor to let you perceive it.” – Robert Stetson Shaw, physicist*

Obesity results from a complex combination of factors, including economic, genetic, and medical factors. Our current negative view of obesity is influenced by social conditions (discussed further in *Cultural Influences on Obesity*, p. 17). To understand how these various factors work in combination, and how our social views of obesity impact patient care, this thesis looks at multiple views on obesity and why they view the problem the way that they do. Putting these dissenting views in conversation with one another gives a more complete view of the issue, and will potentially lead to solutions.

### 2.1 RESEARCHER SUBJECTIVITY

Although I have worked in the healthcare system for several years and have a degree in Biology, my personal history with weight plays a large role in why I chose the topic of obesity, and why I chose to approach it through the use of personal narratives rather than attempting to use the clinical gaze to view the topic objectively. My own subjectivity is the result of a long history of weight issues, culminating in a pattern of disordered eating and overtraining (including yoga) that resulted in injury. I first realized the influence that healthcare providers can exercise as a teenager, when a nurse took the time to ask me what one of my favorite foods was, and then suggested a healthier way to prepare it. This showed me that there was a way for me to eat well without feeling deprived, and helped me begin to seek out information about nutrition and food

preparation. My experiences as a healthcare worker and as a patient struggling with weight both inform my approach to this study and the way I conducted my interviews.

My historical experiences are a crucial component of the way I view my research: The results a researcher obtains are driven by the questions they ask and the lens through which they view their data. These in turn result from prior training and life experience. My prior medical experiences working in an Emergency Room, on an ambulance, in a pediatrics clinic, in a surgical sub-specialty clinic, and in multiple family practice offices have given me the opportunity to view patient-provider interactions in a variety of settings over a twelve-year period. Each clinical setting is impacted by obesity in different ways; while family practice and pediatrics are concerned with prevention and overall health, surgical clinics focus on the immediate risks conferred by a patient's weight status. Working on the ambulance and in the Emergency Room entails addressing both emergent medical problems from a patient's co-morbidities and also encountering the physical challenges related to a patient's weight. From these varied experiences, I saw the importance of prevention and effective long-term management of chronic conditions across the spectrum of the healthcare system.

In addition to direct patient care experiences, I have also been afforded a clinical leadership opportunity in a small clinic, and served as an interagency liaison between two large organizations, and these experiences inform my critique of the larger healthcare system. As a master's student studying qualitative methodologies, I realized that unstructured and semi-structured interviewing techniques are routinely used in healthcare settings to obtain a patient's pertinent history. This realization helped me connect my past experience with my current focus, and played a significant role in my choice of study design.

My experiences as a patient led me to value the individual voices of other patients, which led me to examine current medical practices through the lenses of intersectionality theory and constructivism to obtain a more complete understanding of the issue. Constructivist scholars critique the way that obesity is viewed by society and contextualize our current framing of the problem within a historical context. Intersectionality theory (and the feminist paradigm as a whole) gave me a framework for understanding how structural factors influence individual experience (Nakano-Glenn, 2002). In particular, this paradigm's concern for individual voice provided a means for me to put patients in conversation with the literature so that they could tell the stories that quantitative data does not capture.

I was a very active child, yet I was also very heavy. At one point I was so overweight that I had to hold my breath just to bend over and tie my shoes, and by the time I turned 15 I had turned to starvation as the way to reach my 'ideal' weight. I lost 30 pounds in one month during the summer before my junior year of high school, through a daily combination of several hours of exercise and a caloric intake of about 700 calories. I do not remember a time when I was not overweight – even now, as an endurance runner. In elementary school I took gymnastics, horse riding, and martial arts; when I got older I tried volleyball, cycling, triathlon, weight lifting, and marathon running.

In graduate school, I read about Health at Every Size (HAES) and realized that I was the patient they were talking about. However, the way that I view HAES is different because I have lived both sides of the debate that I feel is happening between practitioners of HAES and traditional medicine. This debate revolves around whether there is an 'ideal' weight for everyone, and whether doctors have a responsibility to counsel patients to meet a number on the scale. Traditional medicine argues that there is a significant amount of data that supports the

correlation between health risks and weight, while many HAES practitioners argue that some of the health problems that obese individuals experience are from weight cycling, and that providers should not use weight as the measurement of overall health.

As an obese child (at 15 I was about 65in and 210lbs, which in an adult would equate to a BMI of about 35), I needed to lose weight in order to live a healthy life, but as a heavy-but-active adult, I continue to receive counseling on how to be more active. This is particularly problematic advice because of my history of disordered eating and multiple fractures due to excessive exercising. These issues are not immediately apparent, and time-pressed healthcare providers generally do not look beyond my BMI. For example, I was once told I needed to lose between 20 and 60 pounds and that I should try being more active – 3 days after completing a half-marathon.

As an active child, I got hurt frequently, but I learned quickly that going to the doctor meant getting weighed and then lectured. I stopped going until increasing pain left me with no other option. Working in healthcare, I often see patients who are in the middle of this same experience, and I decided to return to graduate school with the goal of understanding how time-pressed providers can best help their patients under the current pressures of the healthcare system. My own past patient experiences with the healthcare system convinced me that I wanted to include the voices of individuals who had experience with the healthcare system, and so I chose to interview anonymous volunteers and compare their experiences with the existing literature. While conducting interviews, I heard several stories about participants' negative interactions with the healthcare system. As a healthcare worker, this forced to me recognize my own power to contribute to other patients' positive and negative experiences in the future.

The time I have spent working in the healthcare system has convinced me that, although it would be nice for providers to have more time with their patients, this is not a feasible goal for

the immediate future. I have also learned that, because obesity is impacted by social issues, such as economic factors and neighborhood structures, it will not be solved within the medical arena alone. Many interventions are designed by someone from outside the issue without the input of those impacted by it. Instead, I wanted to involve those who have experienced obesity to give them a chance to tell their story and talk about what is helpful for them; these are the resources we should support and develop for the future. Community resources need to work in concert with medical interventions in order to support patients trying to live healthier lives: This has the potential to become the support system for the lifestyle modifications that increase the efficacy of weight loss medications and reduce the risk of post-operative weight gain.

## 2.2 STUDY PROCEDURES

Ten interviews were conducted with participants from the greater Tacoma, WA area. Tacoma is a city of about 200,000 residents, and 2013 census data shows that, relative to the state average, Tacoma's population has a lower percentage of white residents (64.9% versus 77.3%, respectively), and a higher percentage of black or African American (11.2% versus 3.6%), Native Hawaiian (1.2% versus 0.6%), and those identifying as belonging to two or more races (8.1% versus 4.7%) (United States Census Bureau, 2015). Tacoma was chosen as the focus area due to researcher proximity. Study participants included seven females and three males, including one transgender male. Participants were not asked to identify their racial or ethnic backgrounds.

In recruiting community members for my study, I utilized both flyers and snowball sampling. I initially placed flyers in local businesses, including coffee shops, a discount grocery store, and several gas stations in an attempt to recruit individuals from a cross-section of the community. Of the ten people that I interviewed, I recruited only one person from flyers; the

other nine heard about my research by word of mouth. Thus, my research depended heavily upon snowball sampling, which meant that my participants had a higher level of education than I originally anticipated. While they still represent a wide variety of experiences in terms of how they access and interact with the healthcare system, they could not speak to language challenges or basic literacy issues that may also impact health and healthcare.

I struggled with getting out to talk to people about my project, probably because I am strongly introverted. My previous medical training helped me to overcome my strong introversion: It is a struggle for me to insert myself into other's spheres, but once accepted in my role of researcher, it is not at all difficult for me to ask fairly invasive questions. I chose to record my interviews rather than taking detailed notes because I wanted to conduct open-ended, unstructured conversations that allowed each participant to tell me their story in their own words. Similar to obtaining a patient history, each interview began with a general query as to the participant's experiences with weight and healthcare. I then asked clarifying questions based on their responses and used the participant's own terminology in order to help with rapport building. I asked participants to tell me their thoughts on key themes from prior interviews if they did not discuss the issue during their own story. For example, while a few individuals were strongly concerned with the idea of individual accountability or responsibility for weight loss, this was not a significant issue for others. This allowed me to examine whether themes were truly unimportant, or were instead so central to their experience that they were initially not explicitly mentioned. I was thus able to place the experiences of those that did not consider neighborhood safety to be an issue alongside experiences where neighborhood safety is an obvious prohibiting factor for physical activity.

After each hour-long interview, I used Express Scribe to create a transcript of the recording. I then constructed a narrative based on transcript responses, utilizing participants' own words wherever possible while also changing key details in order to maintain their anonymity. The transcript and narrative were then provided to each participant, either via email or in paper form, and each participant had the opportunity to review them and make corrections. Quotations used throughout are excerpted from the transcripts; narratives are included in the Appendix as a way to share each participants' story. Coding of the transcripts was conducted with Dedoose and analyzed using Grounded Theory (Charmaz, 2008). Key themes from each interview were identified and coded, and previous interviews were re-examined as new themes were added. Figure 1 displays the frequency of key themes (those occurring 20 or more times during the interviews) and contains a breakdown of occurrences by participant. Of these themes, the most frequent was "Weight Loss Conversation", which indicates a participant's discussion of weight loss with a healthcare provider. As this was an advertised goal of the study, it is unsurprising to find that it was frequently mentioned. The two most significant outcomes of the study were related to "Weight Bias" and "Accountability/Responsibility". The latter of these was an emergent theme that resulted from the interviews. The former theme, "Weight Bias", had been an anticipated discussion topic, but the willingness of individuals to explicitly discuss personal experiences of bias was more pronounced than expected. The potential for stigmatizing experiences to override an individual's health literacy was an unrecognized complicating factor.

The major themes, shown in Figure 1, were loosely associated into two chapters for further exploration. The first grouping focused on health literacy, dietary and scientific knowledge, and experiences with bias, while the second considered issues of accountability, responsibility, and choice.

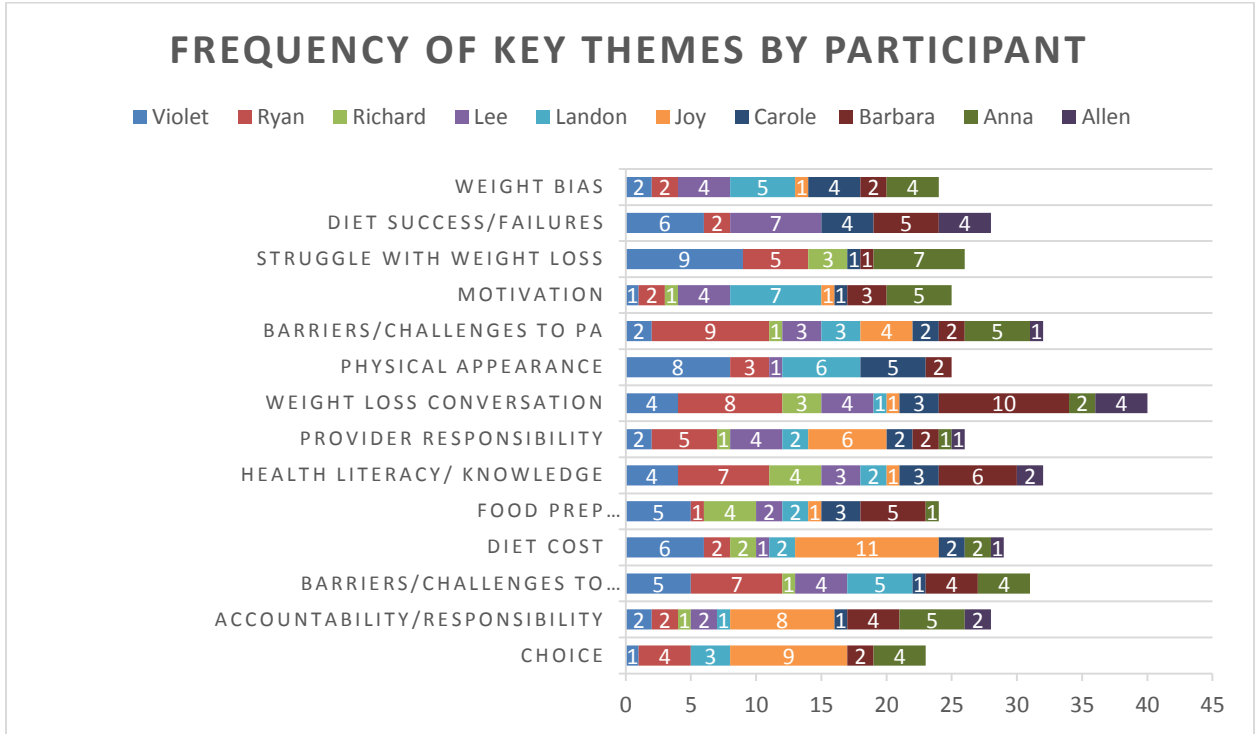


Figure 1 - Frequency of Key Themes by Participant

The goal of each interview was to identify barriers and facilitating factors that influenced a particular individual’s success or failure with weight loss, in the opinion of the individual being interviewed. Individuals participating in this study all possessed some additional education beyond high school, and all spoke English fluently. Table 4 contains a brief summary of each interviewee, including key demographic factors such as education level and employment status, used here as proxies for SES (see discussion p. 51, or for further background see Marmot, Rose, & Shipley 1984). Education status is further modified by whether the individual had a background in science as this contributes to health literacy. Employment type is modified by job class using the criteria from the first Whitehall study (Marmot, Rose, & Shipley, 1984), and the individual’s estimated childhood SES is listed (where known) for comparison with current SES indicated by job status and education level. Table 4 also lists whether the individual felt they had

had any success with weight loss, and whether they further struggled with regaining weight after an initial successful loss.

Name	Sex	Age	Education Level	Science Background?	Employment Type	Employment Class	Health Insurance	Childhood SES	Weight Lost?	Regain?
Allen	M	41	Associate's	No	Full-time	Other	Yes	N/A	Yes	No
Anna	F	30	Bachelor's	No	Part-time (2)	Clerical	No	N/A	No	No
Barbara	F	34	Some College	Yes	Student	Clerical	Yes	Low-income	Yes	No
Carole	F	58	Master's	No	Full-time	Professional or Executive	Yes	N/A	No	No
Joy	F	40	Master's	No	Part-time	Other	Yes	Low-income	No	No
Landon	M	25	Bachelor's	No	Part-time	Other	Yes	N/A	Yes	Yes
Lee	F	62	Bachelor's	No	Retired	Professional or Executive	Yes	N/A	Yes	No
Richard	M	49	Some College	Some	Part-time (Seasonal)	Other	Yes	N/A	Yes	Yes
Ryan	F	35	Some College	Yes	Full-time	Other	Yes	N/A	No	No
Violet	F	25	Technical School	No	Student	Clerical	Yes	Low-income	Yes	No

Table 4 - Participant Demographics

## Chapter 3. HEALTH LITERACY AND HEALTHY WEIGHT

*“People don’t make conscious decisions to ruin their health. They’re just bad habits, and they don’t realize they’re bad because they don’t understand the implications.” – Barbara, 34*

Health literacy refers to a patient’s ability to effectively and actively participate in their own healthcare. The Institutes of Medicine (IOM) defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Nielsen-Bohlman, Panzer, & Kindig, 2004). Health literacy is commonly used when evaluating a patient’s ability to care for themselves when they are diagnosed with a chronic condition; because obesity is commonly associated with several chronic conditions – such as diabetes or cardiovascular disease – the concept of health literacy assumes a particular relevance to the discussion of obesity treatment. Health literacy is also potentially impacted by a patient’s weight status, as adolescents who are obese are statistically less likely to pursue education beyond high school (Fowler-Brown, Ngo, Phillips, & Wee, 2010). The intent of this chapter is to utilize study participants’ experiences to examine the components of health literacy and the factors that mediate its enactment.

As a concept, health literacy is functionally dependent upon both basic literacy and scientific literacy: It includes the ability to discern reputable information sources and evaluate the validity of health claims made for various products and services. Health literacy levels increase with each level of educational attainment beyond high school. In 2003, the most recent year for which data were available, the National Assessment of Adult Literacy found that 49% of adults who did not complete high school were considered to have a below basic level of health literacy, the lowest possible rating (Kutner, Greenberg, Jin, & Paulsen, 2006).

During interviews, two individuals discussed the sense of desperation that impacted the choices they made; although both Ryan and Barbara felt comfortable interpreting research and using it to make decisions about their healthcare, they also both stated that they would have tried “anything” to lose weight. This implies that experiences of stigma and bias may mediate the choices that individuals make regarding their health, regardless of their level of health literacy. While not everyone discussed a sense of desperation, most participants did share personal experiences with weight-related stigma and bias.

Of additional importance, the patient’s comfort level with asking questions of their health provider impacts their ability to participate in their own care. This comfort level, which is influenced by social and cultural factors such as minority status and the patient’s own knowledge level, may also be impacted by experiences with stigma and shame. As the participants in this study all possess a basic level of education, the effect of stigma and bias may be even more pronounced in lower-income populations that also possess limited health literacy.

### 3.1 THE IMPACT OF LITERACY ON HEALTH

Basic literacy is a foundational factor in health literacy because a patient must be able to read and write in the dominant language – primarily English – in order to understand test results and prescription information, and to read informational pamphlets. This also includes being able to complete insurance forms and comprehend eligibility requirements for accessing the healthcare system (Kutner, Greenberg, Jin, & Paulsen, 2006). The lower literacy levels that correlate with membership in lower socioeconomic status (SES) groups is an important consideration in the wake of the Affordable Care Act (ACA), which significantly increased the number of individuals who are eligible for healthcare in the US. This legislation was targeted at low-SES individuals, but increasing eligibility is only part of the issue, as patients have to both

realize that they are eligible, and be able to access the resources to complete the application materials in order to obtain health insurance.

For some patients, language or cultural barriers pose a significant problem and can significantly complicate the process of obtaining care: Though they comprise a relatively small number of healthcare providers, multilingual providers can help with direct patient-provider interactions. There is also some evidence that patients feel greater satisfaction with their healthcare when they are matched with a healthcare provider from a similar background (Saha, Komaromy, Koepsell, & Bindman, 2002). However, a single healthcare provider cannot be responsible for facilitating a patient's entire experience in the health care system, nor does increasing the amount of multilingual providers address the underlying problem of existing educational inequalities for members of race, class, and gender minority groups in the United States today.

Understanding the connection between education and health status is dependent on understanding the depth of interaction between socioeconomic status and educational achievement. Socioeconomic status is usually measured and reported in one of three ways: one's income, occupational status, or level of educational attainment. These three methods have been found to correlate well enough to be used interchangeably as a proxy for socioeconomic status (Barr, 2008, p. 45). Higher educational status tends to result in increased income, which increases an individual's access to the healthcare system, and leads logically to improved health (Barr, 2008, p. 13). This has been borne out by data published in both the Whitehall studies and in the Black Report (see discussion in Socioeconomic Status and the Outcome Gap). This is a potentially significant issue for individuals who are overweight or obese, because there is evidence that those who are overweight or obese have lower average levels of educational

achievement relative to their thinner peers (Puhl R. , 2011, p. 557). Based on this evidence, it is not unreasonable to expect that lower levels of health literacy might contribute to existing levels of health disparities for individuals who are overweight or obese.

All of the participants in this study possessed at least some college or post-high school technical education and spoke English fluently, a likely artifact of both the English-only flyers and the snowball sampling method utilized for obtaining interviewees. This study was intended to give voice to a few individual stories, but it is not sufficiently large as to be generalizable to the patient population as a whole; therefore, it is likely that the demographic group that struggles with basic literacy is simply not represented in this study population. However, one participant, Joy, noticed way that education impacts health: “I have to say, when I think about people I know, it’s really true that the more educated people are, the more likely they are to be healthy and have healthier habits. I don’t know why that’s true, but it really is true.” As a 40 year old woman who holds a Master’s degree but currently works part-time in a physically demanding job, Joy has contact with individuals across the employment spectrum.

Although all participants in this study met the first criteria of health literacy – possessing basic literacy skills – achieving health literacy also means that a patient must be sufficiently scientifically literate as to be able to evaluate available evidence and discern valid medical treatments from targeted marketing. Confusion between evidence-based healthcare and weight loss industry advertising was of particular concern to several participants, and the topic was at least briefly mentioned by nearly everyone. In the words of one participant, “I’m pretty well read and I think that there’s not a lot of literature out there concerning diet and how to manage that that people who are not as educated can find, or discern from the fad diet type things. You’d rather read the fad diet things, what the celebrities are doing, rather than go through a book that

gives you data, and how to manage things.” Richard later added, “There’s also a lot of misinformation out there, put out by the dairy council, the meat council, all this kind of stuff.” Although Richard does not possess a college degree, he has had approximately three years of post-high school education in several different programs and enjoys reading scientific research. He took several different cooking classes growing up, and has continued to educate himself on the components of a healthy diet so that he can cook for his family: His wife is employed full-time and he has taken on the responsibility for meeting the nutritional needs of the household.

### 3.2 DRUGS, SUPPLEMENTS, AND SAFETY STANDARDS

Whether individuals recognize the difference between safe and unsafe methods of weight loss, advertising has only added to the confusion. Ads for prescription medications appear alongside ads for dietary supplements on television, and many people do not realize that Federal regulations govern each product category quite differently. Supplements are treated as a food product with no regulation or oversight. A recent study of the quality of ginkgo biloba products available on the market was only able to verify that 31 of the 40 products tested actually contained ginkgo biloba. While the tests were unable to obtain any DNA from three samples, six samples were confirmed to be completely lacking any of the advertised product (Little, 2014). The lack of oversight and unreliable quality has long been of concern for herbal supplements, including those marketed specifically for weight loss (Barrett, 2006, p. 1756).

Meanwhile, the Food and Drug Administration (FDA) governs all drugs and requires that certain safety and efficacy standards are met before a product can be released to the public. However, the FDA does not perform the safety testing – manufacturers are responsible for providing the safety evidence that ultimately clears their product for public consumption. It is not

uncommon for drug manufacturers to conduct multiple tests but publish only those that showed their product favorably. Outcome measures in these studies were directed at safety and efficacy for one condition, but other uses of the pharmaceutical compound are mined for years in seeking other applications.

A side effect of requiring manufacturers to conduct their own safety testing is that head-to-head efficacy studies are generally not conducted in the United States (manufacturers do not fund studies in which they are not certain to appear favorably). Instead, studies funded by the manufacturer investigate the effectiveness of their product versus a placebo or an untreated control group. This results in many studies that demonstrate whether a product is better than no treatment at all, but provides little information useful for helping consumers choose the most effective product, relative to other similar products. Additionally, when a new product enters the market alongside an existing approved product, efficacy studies may only be required to demonstrate non-inferiority, rather than superiority to the approved product.

While more information is generally considered a positive thing, the increased availability of medical information for general public consumption can also pose a problem: It is possible to misuse correct information. This can prove potentially dangerous in the case of complex medical issues, as patients may wrongly diagnose and treat themselves with over-the-counter (OTC) medications. Even when widely available medical information is generally correct, it may not be appropriate for that particular patient or in that particular instance. For example, although Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) such as naproxen are available as OTC medications and can be found at most grocery stores, the misuse of OTC products and herbal/dietary supplements are the most common causes of acute liver failure

(Goldberg, et al., 2015). This is why it is critical for patients to be able to read, understand, and follow the instructions that come with even “harmless” OTC medications.

In addition to the risk of misapplying otherwise correct information, problems can arise if patients do not know how to evaluate the quality of the source from which they obtain their healthcare information. In 2003, the National Assessment of Adult Literacy found that adults with basic or below basic levels of health literacy were more likely to obtain health information from the radio or television, relative to those with higher levels of health literacy. This may be one reason behind the so-called “Dr. Oz Effect”, which is a term coined after it was noticed that products featured on a television show hosted by Dr. Mehmet Oz showed significantly increased sales following such an endorsement. As a specific example, *Garcinia cambogia* was recommended on the show, despite a lack of evidence of its effectiveness (Barrett, 2006, p. 1758). Dr. Oz also has a radio show, which one participant, Barbara, enjoyed listening to. This is concerning because as a science major, Barbara also has a relatively high level of health literacy: Dr. Oz’s legitimate medical credentials (he is a cardiothoracic surgeon and professor at Columbia University) lend credence to the products he recommends even when there is no evidence for a specific treatment. A study in the British Medical Journal found that Dr. Oz’s recommendations were supported by evidence 46% of the time. Researchers could not find evidence to support 39% of his recommendations, and his recommendations contradicted existing evidence 15% of the time (Korowynk, et al., 2014).

As a result of the statements made on his television show, Dr. Oz was summoned in front of a senate subcommittee investigating the problem of consumer protection in the supplement industry (Hamblin, 2014). Currently, a product’s manufacturer is responsible for verifying the overall safety and efficacy of the product; since the FDA does not regulate dietary supplements,

it can only take steps to remove a product after complaints are received. The Federal Trade Commission, meanwhile, is responsible for investigating false claims made in advertising; however, both agencies lack the resources necessary for enforcement (Barrett, 2006, pp. 1759-1760).

The senate hearing raised concerns about the safety and efficacy of several of the products endorsed by Dr. Oz, particularly given that the low average health literacy levels of his television audience make them particularly vulnerable to false marketing claims. Even if the safety and efficacy of these products were not in doubt, blurring the lines between television advertisements and medical advice from a healthcare provider is still problematic given that the patients most likely to obtain health information from their radio and television also tend to have lower levels of health literacy. If patients do not understand that not all medical advice is applicable to each situation, it may complicate discussions between the patient and their healthcare provider when the patient's local provider disagrees that a product will be helpful or effective for that patient.

### 3.3 COMMERCIAL WEIGHT LOSS

General confusion about which treatments have valid scientific backing and which do not was a common issue for participants in this study; although several of them felt that they were personally able to differentiate between healthy and unhealthy weight loss programs, most participants recognized that it was an issue for other members of society. Notably, one interviewee, Ryan, felt that, although she was able to determine which methods of weight loss were safe, she also felt that desperation played a role in her health choices: "If you've been doing things and you've been trying new things and you're not seeing any results, you start to get to the

point where you want to try anything.” Barbara also talked about her reasons for trying various methods of weight loss, saying, “I didn’t like the way I looked, and I tried so hard – crazy diets. I mean, crazy diets, like literally not eating anything for a few days and drinking like these weird vinegar diets and, you know, laxatives. Anything, I would try anything. It just messes with you after a while.” Patients also sometimes fail to understand the importance of using diet pills safely. Landon recalled experiencing his mother’s attempts at weight loss: “My mom’s an alcoholic, so she was taking the diet pill, she wasn’t dieting – like, eating better food – and she was drinking on top of it, so I remember being really scared.” Landon, who possesses a Bachelor’s degree but does not have a science background, here is speaking specifically about his family background. However, his story illustrates the way that a general lack of health literacy when taking weight loss pills can result in significant risk to patients – and their families – whether medications are obtained by prescription or over-the-counter.

While some patients use OTC pills or herbal supplements, others turn to commercial weight loss programs, many of which are based upon either general caloric restriction, macronutrient (fat, protein, or carbohydrate) restriction, or both. The most restrictive type of diet, referred to as a Very Low-Calorie Diet or VLCD, restricts dieters to a daily intake of less than 800 calories. While VLCDs initially produce approximately double the amount of weight loss compared to a Low-Calorie Diet (800-1500 cal/day) there is no significant long-term difference in weight loss, due to greater amounts of weight regain after stopping a VLCD. Additionally, VLCDs carry a greater risk of gallstones than do other methods of weight loss (Wadden, Byrne, & Krauthamer-Ewing, *Obesity: Management*, 2006, p. 1034). In fact, comparative studies of many different weight loss diets found that there was no data supporting the restriction of any particular macronutrient; instead, the determining factor for successful weight loss was related

solely to the individual's ability to stay consistent while reducing overall caloric intake (Sacks, et al., 2009). Regardless of these findings, the weight loss industry continues to be a major player in the US economy, and patients continue to try various supplements and diets in the hope of losing weight.

In one example, Carole shared her experience trying a weight loss supplement called Zing. A friend of hers had been using the product, and gave her some free samples to try; she quit after the third day due to nausea and lightheadedness. Her friend's response, that those symptoms do happen, and 'You just have to get past that', is indicative of her friend's lack of scientific literacy regarding what constitutes a healthy weight loss program. Common side effects from VLCDs include constipation, headache, fatigue, and dizziness, and initial weight lost while on the diet is not generally maintained once a patient resumes their normal eating habits (Asher, Burrows, & Collins, 2013). Although these diets are generally considered safe "when administered to appropriate persons under careful medical supervision" (Tsai & Wadden, 2005), no participant in this study indicated any degree of medical supervision at any point while on a VLCD. In fact, the closest reference to medical supervision occurred when Ryan stated that she followed a healthcare provider's advice to stop after she began a trial of the Human Chorionic Gonadotropin (HCG) diet.

The HCG diet, initially promoted by Dr. Albert Simeons in the 1950s, involves a combination of hormone shots and an initial daily limit of 500 calories. It is not regulated by the FDA, and there are few efficacy or safety studies. While the amount of HCG given to patients following the typical protocol for this diet is lower than the amount in FDA-approved treatments for other health conditions, HCG use has also been associated with an increased risk of thromboembolism, pleural effusions, and both testicular and ovarian complications (Goodbar,

Foushee, Eagerton, Haynes, & Johnson, 2013). Ryan stated that she began the diet because she believed that the hormone shots would “balance out” her thyroid issues; she did not consult a healthcare provider first. Even in instances where there are studies that demonstrate the general efficacy and safety of various weight loss diets, different diets may not be appropriate for everyone. Diets should be designed with consideration for individual medical conditions. For example, low-carbohydrate diets (such as the Atkins diet) are unsuitable for individuals with coronary artery disease, gout, or kidney disease (Barrett, 2006, p. 1758).

Ryan’s story is only one example of a patient trying a diet that they are not an appropriate match for, and, at least in her case, there was no medical screening to ensure that there were no contraindications for her to be on a hormone-based, calorie-restricted diet. Most nutritional information available recommends that weight loss diets should be individualized based on the particular medical needs of each patient. This does not often occur with commercially-available diet plans, although one participant, Allen, did work with his healthcare provider to determine his goal weight while he was on Weight Watchers.

Several participants tried Weight Watchers, with varying degrees of success. Allen felt that the program provided him with the necessary support to maintain his weight loss and stated that he is very happy at his current weight, while Violet said, “I have a problem with Weight Watchers because they appeal to the masses by being like, ‘oh, you can still eat your favorite foods’, which is probably what got you to that problem in the first place.” Lee also found it difficult to stick with Weight Watchers, saying, “It didn’t include what I have later found to be the major thing for me, and that’s movement – exercise.” Randomized controlled trials conducted to study the long-term outcomes of Weight Watchers found an average loss of only 3.2% of an individual’s starting weight at the two year follow up visit. Researchers also noted

that those who attended the most group sessions also maintained the largest weight losses over the study period (Tsai & Wadden, 2005), which may explain Allen's satisfaction with the Weight Watchers program, as he and his wife still attend meetings regularly.

While Allen found the nutritional information he learned from Weight Watchers to be helpful, other participants had more of a struggle to gain the nutritional knowledge to help them meet their goals. For example, Violet shared how she has adapted to making sure she has healthy food options available even on days when she is out of the house for 18 hours:

[A]ll of my meals need to be transportable, easy to heat, or cold so I don't have to deal with heat. They have to be pre-measured, and things like that. And so I've learned to adapt. And so I'm in school for 12 hours a day, which means that I eat my breakfast at school, I eat my snack, I eat my lunch, I eat my snack, and then I go home and have my dinner. And so, being a full-time student is not conducive to having free time. I sit down once a week and I pre-plan all of my meals, and then I go grocery shopping. I cook all of my meals and then I portion them out and freeze them. And that's how I've made this a maintainable lifestyle for me.

Similarly, Carole cooks on the weekends and then reheats leftovers during the week.

Landon spoke of undergoing a food elimination diet without feeling confident that he understood exactly what to do: "I remember sitting in my apartment like, 'I don't know'. So I just started eating raw food. Particularly, learning how to enjoy lettuce and vegetables and stuff, which was a learning curve for me!" Even though Landon is educated, he does not have formal education in nutrition or a science background, which might have helped him find and evaluate evidence for creating his own nutrition plan. This made it difficult for him to interpret the provider's intent in starting him on an elimination diet, and so he struggled with making the best attempt he could.

Marketing strategies also add complexity to the process of shopping for healthy foods. A recent agreement between Kraft foods and the Academy of Nutrition and Dietetics serves as an example: After making a donation to the Academy's Kids Eat Right campaign, Kraft was able to

change the packaging of Kraft cheese to display the Kids Eat Right logo (Strom, 2015). Kraft foods have frequently been the focus of calls for improving the nutritional content of foods, and Kraft Singles are labelled as “cheese product” because they do not meet the legal requirements necessary to be labelled as “cheese”. The public outcry that occurred after this deal became public knowledge ultimately resulted in the termination of the agreement between Kraft and the Academy. The ways in which front-of-package (FOP) labelling influences consumers has been studied, and there are concerns about the ways in which FOP labelling can be used to highlight only the healthy aspects of otherwise unhealthy foods. Policy makers are still determining the most effective ways to communicate the overall health of various food items in order to assist consumers with making the best possible choices (Hawley, et al., 2012).

Finding accurate nutritional advice is a very common problem, and one that is a greater issue for low-income individuals. For example, one study of individuals eligible for the Supplemental Nutrition Assistance Program (SNAP, formerly referred to as Food Stamps) found that, although a majority of those interviewed felt that it was important to follow dietary guidelines, only 43.5% possessed the requisite health literacy to do so (Song, Grutzmacher, & Kostenko, 2014). Also, although commercial weight loss programs do disclose their success rates and other program information in order to assist consumers in making informed decisions, many of these studies do not account for the substantial drop-out rates associated with these programs, which make reported results more of a best-case scenario rather than a true average (Tsai & Wadden, 2005).

### 3.4 MEDICAL TREATMENT OF OBESITY

Barbara also felt that her weight was related to a lack of knowledge about health-related issues, which led her to make unhealthy choices when she was younger. She ultimately chose to have gastric bypass in order to lose weight, but had complications that made a second surgery necessary. Although she would still choose to undergo gastric bypass, she stated that she wished she had understood the importance of support and had a better understanding of the implications of undergoing the surgery prior to her operation. Richard, who previously worked in a radiology office and had contact with weight-loss surgeons, said that they were “all about the operations. They’re doctors who promote that because that’s their business; that’s what they do. I would hope that people would be able to get more varied input before going to that extreme.” He knows two people who chose to have weight loss surgery, one of whom had to have a colostomy due to complications from the surgery, and he feels that surgery should be a last-ditch effort if nothing else works. Violet also had strong opinions about weight loss surgery, saying “I see a lot of people who are like, ‘yeah, I got gastric bypass a couple years ago,’ or ‘I had the lap band,’ or something, and they put all the weight back on, or they’ve learned to cheat the system and eat the foods they’re not supposed to eat. So I have a bit of a problem with that. I think for some people it’s necessary, but it’s also not something I necessarily agree with.”

These three opinions, although they seem oppositional at first glance, actually work together to illuminate the role of health literacy on the choices each individual makes. In Barbara’s case, she felt that her lack of health literacy led her to making mistakes that she ultimately needed surgery to correct: “I tried so many things for so long, I put myself through so much, and it wasn’t because I didn’t want it and I wasn’t trying hard enough, it was because something else was going on, and the weight loss surgery was kind of like, it kind of made sense

to me.” While her first experience with surgery was not the smooth process she had hoped for, she found a better support program the second time around and was much happier with the results.

Both Richard and Violet advocate for more consumer protection, in the form of increased knowledge and a more detailed discussion of options prior to trying surgery. Violet also alludes to the weight regain that is common after surgery, which may result from a lack of community support and difficulty maintaining the necessary lifestyle changes that some patients experience. During the interview, Barbara repeatedly referenced the ongoing support groups that her second surgeon’s office offered; she continues to attend regular meetings and take advantage of the available resources.

I absolutely did some research on it but I didn’t understand the impact of having a good program behind it. I was just focused on the pros and cons of the surgery, what I would gain and what I would lose with it, but I didn’t really understand the scope because it wasn’t really available. But, it’s so important to have a system where everybody’s knowledgeable.

Barabara emphasized the importance of support in maintaining weight after gastric bypass surgery, and Allen and Violet spoke of the support they received through groups associated with their diet programs. Ryan also spoke of the way that having a friend’s support helped her to maintain an exercise program, and Lee mentioned that she supports herself and uses the goals built into her Fitbit as motivation to stay active and help herself lose weight. In fact, it is recommended that obesity treatment be undertaken in a step-wise manner, where lifestyle modifications, pharmacotherapy, and surgical interventions build on one another (Reid, 2013). While lifestyle modifications including calorie reduction and increased physical activity should be the first step in the process of weight loss, pharmacological agents have been found to be most effective when combined with effective lifestyle modifications (Gadde, 2014). These

same lifestyle modifications are also a critical part of maintaining weight loss after bariatric surgery. Unfortunately, many patients perceive that they have “failed” at weight loss when trying diet and exercise alone, and then move on to trying diet pills without modifying their caloric intake or expenditure. This means that, should they move on to bariatric surgery, they may do so without the support in place to help prevent post-operative weight regain.

### 3.5 IDEAL WEIGHT AND STIGMA

Allen’s story of discussing his weight with his healthcare provider brings up the question of what an individual’s ideal weight should be. Most weight loss plans utilize the Body Mass Index (BMI) as the standard for determining an individual’s ideal weight range based on disease risk determined using the same index, and yet there is also wide acknowledgement that these standards do not work for everybody. They are especially inaccurate for athletes because the calculations cannot differentiate between fat and muscle mass. The Health at Every Size (HAES) movement in particular critiques this as a number-centric method of determining ideal weight, which fails to account for individual variation; in addition, HAES researchers raise questions about known financial ties between the weight loss industry and the researchers who test the efficacy of its treatments (Burgard, 2009). In a time when an estimated 64.5% of US adults are considered candidates for weight loss treatment under the 2013 Guideline for the Management of Overweight and Obesity in Adults (Stevens, Oakkar, Cui, Cai, & Truesdale, 2015), it is important to have an open discussion about the intent behind the treatment recommendations, and the impact that pressuring patients to lose weight may have on their health outcomes. Some HAES researchers have critiqued the BMI standard, saying that correlations between BMI and ill

health ignore many important variables that mediate the relationship between weight and health, such as SES, physical activity levels, weight cycling, and others (Burgard, 2009).

When asked whether she felt pressure to lose weight or if she was happy where she was at, Carole stated, “I’m not happy with where I’m at; if I was 40lbs. less, I’d be a heck of a lot happier... I don’t feel pressure. Umm, no I mean the only pressure I feel is when I go clothes shopping and I look at the size I have to wear. That bugs me. But no, I don’t feel pressure from anybody.” In his interview, Landon also equated weight and happiness when he said, “[M]y identification with weight and health is always attached to how my body looks, it’s attached to my appearance; it’s not attached to how good I feel, the energy that I’ve had, what not. I know the difference now, but when I was younger I didn’t know the difference.” Carole and Landon’s life experiences shape the way they perceive themselves. For Carole, although she denied feeling pressure, she is clearly impacted by the sizing labels utilized by the fashion industry, which influences the way she feels about herself and her clothing. Landon, on the other hand, talks about the connection between health and appearance, and has clearly been influenced by the larger social view that appearance determines how healthy an individual is; this perception is a large part of what HAES practitioners are in opposition with.

These experiences raise the question of whether BMI is a meaningful standard: Many researchers have acknowledged the problems with BMI, but continue to use it because there isn’t another option. In addition to the HAES critique of its use, other researchers have questioned whether solely using BMI as a measurement of health may cause providers to miss risk factors in individuals who are metabolically unhealthy but are within the established weight range for their height (Ahima & Lazar, 2013). As Allen said, his doctor told him he was “right here in the red”

on a BMI chart, but that “my muscle mass and the way I’m built just puts me in the red, and there’s nothing I can do about it.”

In a response to concerns of researchers such as Ahima and Lazar (2013), BMI’s demonstrated inability to differentiate between fat and muscle mass, and the difficulty with trying to broadly categorize patients based solely on weight and height, the American Association of Clinical Endocrinologists developed an “actionable standard” in 2014, with the intent of designing a clinical tool that could help providers identify which patients needed further height and weight counseling or additional medical interventions (The American Association of Clinical Endocrinologists and the American College of Endocrinology, 2014). This framework introduced the category of “Obese stage 0” patients, who are technically still categorized as obese, but are recognized as having no co-morbidities – these are the patients who are obese, but metabolically healthy. This new framework also lowered the criteria for being considered obese from a BMI of 30 to 25 (in the presence of one or more co-morbid diseases) in an attempt to address the health risks of those who are metabolically unhealthy but would not otherwise be considered obese.

Although cut-off points have been established for the ease of labelling, cut-offs in healthcare are somewhat arbitrary and are subject to the data available at the time the cut-off is established. “Optimal” BMI ranges in the US were based upon the need for a global standard; while US doctors argued for the “normal” BMI range to extend up to 28, the representative from Japan pressed for a lower cutoff, eventually it was agreed that 25 would be the upper limit for a “normal BMI” (James W. P., 2008). Also impacting eligibility for treatment is a recent change to the treatment guidelines, which reduced the number of co-morbid conditions a patient must have in order to qualify for weight loss treatment. This guideline change, which occurred in 2013,

reduced the requirement from two conditions to one condition, thus increasing the number of adults who are considered treatment eligible without any actual change in the overall health of the population. This resulted in approximately a 10% increase in the number of individuals meeting treatment guidelines for obesity, relative to the same data processed under the 1998 guideline (Stevens, Oakkar, Cui, Cai, & Truesdale, 2015).

The increase in the number of patients eligible for treatment can be considered in terms of the compensability of care; the previous lack of reimbursement has been discussed as having a dampening effect on providers' inclination to treat obesity (Foster, et al., 2003). Healthcare providers are reimbursed based on the number of conditions they code for, and changing the minimum requirements for treatment eligibility may also make it possible for providers to receive greater reimbursement for providing similar services as before.

Increased reimbursement may enable providers to spend more time working with patients on their weight issues, but this change may serve to increase the pressure on individuals who are now considered obese. Several of the participants in this study shared experiences of weight-related bias, directed both towards themselves or at members of their families. These experiences ranged in severity, but all were significant for the individual experiencing them. For example, Carole shared an experience she remembered from childhood, which while it may seem less severe than other stigmatizing experiences, has nonetheless stayed with her for over 40 years.

Anna shared her struggles with weight and her physical appearance:

[Physical appearance] was a really big issue for me for a really long time. I always, like through school, had a really hard time even accepting myself because I was overweight, and I was really unhappy with who I was. It made me really insecure all through high school and most of college and it took me a really long time to make peace with myself for being pudgy, so I definitely think that that is something that stemmed from the way I was responded to by other people. That's not something I was born with, it's something that I developed as a result

of being treated differently from being pudgy. It took me a really long time to come to terms with that and make peace with myself.

Anna's struggles are a good example of why it is important for healthcare providers to be cautious of further stigmatizing patients in their efforts to provide treatment, which may cause patients to delay seeking care for other serious issues (Wee & Yanovski, 2005). Additionally, it is important to recognize the many complex interactions that work together to produce obesity. Richard felt that "it's a balancing act between genetics, diet, and exercise. If your diet is more calorie-rich, then you need to increase the exercise, especially if your genetics lean toward, you know, being a heavy-set person. It's kinda like a balancing act." This is echoed in the research literature, where one study found that "accurately conceptualizing obesity as both a biological and behavioral condition may help ameliorate some of the negative attitudes physicians (and our broader culture) have about obese individuals" (Foster, et al., 2003, p. 1176).

Even when patients do possess a sufficient level of health literacy, stigma and shame may still play a determining factor in an individual's health decisions. Landon still sees the effect of shame amongst his family, and "that's a big motivator. But what happens is if you don't have enough... shame isn't gonna allow you to get a habit going, that's the thing." Twice in the last year, Landon's disabled aunt has had notes left on her car telling her that "she's not disabled, she's just fat: She should die." Repeated experiences of stigma may result in the desperation that Ryan referred to when she spoke about her motivation for trying weight loss diets even when she knew they were not scientifically valid.

### 3.6 VOICING QUESTIONS TO HEALTHCARE PROVIDERS

*“You are expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment and service plan.” - The Patient Bill of Rights and Responsibilities, The Johns Hopkins Hospital, 2012*

Beyond possessing basic literacy skills and the ability to accurately evaluate scientific studies necessary for health literacy, a patient must feel comfortable asking questions of their provider in order to actively participate in their own care. In a society where educational attainment can be used interchangeably with income level and job classification as a proxy for social status (Barr, 2008), admitting a lack of knowledge may have implications for one’s place in the social hierarchy. Further, in the patient-provider relationship, the provider is generally the better-educated of the two, and thus is also the one with greater status and power, making it difficult for patients to feel comfortable questioning their provider.

Healthcare providers’ negative attitudes toward obese patients have been well documented (Foster, et al., 2003), which may also contribute to patients’ reluctance both to seek care initially, and to voice questions when they do see a provider. Barbara said that when she first started trying to lose weight, she got lots of advice, but none of it was helpful to her. When she decided to have weight loss surgery, she felt that the surgeon wasn’t really listening to her, and she struggled with depression after her surgery. Her experiences with her first surgery led her to find a second surgeon with a better support program, and she had far less difficulty adjusting to life after her second operation.

Ryan recounted a very frustrating experience with seeking healthcare for her weight issues: “When I tell [healthcare providers] what’s going on with me, they assume since there aren’t any results they can see, that I’m lying as opposed to, maybe there’s an underlying issue. Like, it literally took me telling a physician, ‘Look, my mouth is wired shut [due to oral surgery]. Physically I cannot eat, and I’m working out, so what is the problem?’”

Ryan has worked alongside surgeons and other medical professionals for more than 10 years, which has clearly helped her feel comfortable challenging the assumptions and opinions of her medical providers. Barbara, who did not have this experience, chose to proceed with surgery even though she did not feel listened to, and later recounted ongoing struggles – including with medication management – which she did not seek help for until she no longer had a choice.

Lee, who was placed on medication to help manage a mental health condition, tolerated a 5lb-per-month weight gain for a year before she initiated a discussion with her doctor – he never brought up the weight issue. Only after she told him that she couldn’t continue to gain weight as she had been did her provider do additional research to look for another medication to try. They were eventually able to find a medication that helped her condition while minimizing weight gain, which is in line with current recommendations to conduct a thorough review of a patient’s current medications prior to initiating treatment for managing obesity (Reid, 2013).

Landon, who was prescribed a combination of two different medications to start simultaneously, found that the medications worsened his eating habits, causing him to gain 50lbs in 6 months. He stopped taking them on his own, without discussing it with his provider:

I think the reason I was heavily medicated from my doctor to begin with was that I had weighed so much at the time, from my back issue, that I wasn’t doing any activity. And then also that I was Trans, and he’s a very religious man... I’m not saying that it was a conscious decision on his part – but I think, subconsciously, he was like, ‘Oh, this person’s really messed up, so I’m going to over-medicate him’. Not like, purposefully over-medicating, but, I mean you don’t ever start

people off with that level of medication. Ever. And you especially don't not follow up with them, you know?

While it is true that Landon himself could have scheduled further follow-up with this provider if he had chosen to, he instead found another provider with whom he is more comfortable. Whether the provider was aware of it or not, or even intended to display bias, these attitudes are very clear to patients. Both Landon's and Ryan's experiences highlight a lack of emotional rapport-building on the part of their healthcare providers, a finding which is also supported by previous research (Gudzune, Beach, Roter, & Cooper, 2013).

In the face of this perceived lack of rapport, patients have reacted in several ways. If they feel comfortable, they may challenge the provider. Only Ryan, who had years of experience in healthcare, felt comfortable doing so directly, and only after several negative experiences. Lee also challenged her provider, though much less directly than Ryan, by requesting a different medication from her current provider. Both Landon and Barbara chose not to seek further care from the same provider, and eventually found new healthcare providers that they were more comfortable with.

These solutions, whether challenging providers or seeking an alternative opinion, may be difficult for some patients. Patients who have previously experienced significant amounts of stigma, or who believe that they do not have the power to stand up for themselves, may not feel comfortable doing so. Seeking a second opinion incurs both the time cost of finding a new provider and making a second office visit, and the financial cost of an additional co-pay, time off of work, and potentially travel costs. This is not an option for many low-income individuals. This also depends on whether a patient's insurance coverage will allow them to see the provider of their choice, which is not always the case, particularly for individuals with minimum coverage.

### 3.7 FRAMING OBESITY AS A SOCIAL JUSTICE ISSUE

Discussions surrounding health disparities generally focus on unequal health outcomes as evidence for the systemic social issues that face many members of minority groups. However, because the US is fundamentally a meritocracy, it is important to consider the implications of this claim. Framing the argument as an issue of unequal outcomes only emphasizes the fact that some members of society prosper while others do not, to which the counter-argument is that this is the result of variances in individual effort. Understanding the issue of health disparities in this way does not address the fact that individuals do not possess equal access to the healthcare system as a direct result of systemic, institutionalized practices that are ingrained within society. Framing unequal health literacy as a function of unequal access to the educational system, for example, allows for the focus to shift away from unequal outcomes – which are a natural result of individual differences – toward an understanding of how unequal opportunity results in different levels of health, which fall along a social gradient. In this way, we can understand both health literacy and health status as part of a systemic issue, rather than as reflections of individual effort.

When obesity is framed as a problem of unequal access resulting from systemic inequalities, it becomes an issue of social justice. Research into increased diet costs that disproportionately impact lower-income members of society is one way of demonstrating how unequal access to resources has contributed to the obesity epidemic. Some researchers have framed the recent change in dietary patterns in the developed world as part of the nutrition transition (Popkin, 2011); it can also be positioned as part of the epidemiological transition, where improvements to sanitation and other areas have changed the burden of disease from communicable diseases, such as typhoid and pertussis, to non-communicable diseases, such as

obesity and associated co-morbid diseases (Barr, 2008). In the case of both communicable and non-communicable diseases, those higher on the social ladder have the knowledge and access to resources that enables them to avoid disease. Although the specific factors that mediate disease change over time (for example, we currently look at issues such as the built environment or food costs to explain the obesity epidemic), the relationship between SES and health remains because unequal social conditions function as a fundamental causes of disease (Link & Phelan, 1995). Similarly, the Gini coefficient used in economics to measure social inequality has also been found to correlate closely with health status in a given population: As the measure of inequality is for a given area increases, the health of the average citizen decreases (Barr, 2008). This occurs even when more-privileged groups in the US are considered in relation to their international peers (Woolf & Aron, 2013).

Health literacy, which relies upon a foundation of basic literacy, would thus be unequal in populations with unequal access to educational resources. In the Cliff Analogy, used for understanding social conditions impacting children's health (Jones, Jones, Perry, Barclay, & Jones, 2009), a given population is pictured at the top of a cliff, with alternately a fence (to keep individuals from falling off), a net (to catch them partway down), or an ambulance (to treat them after they hit the ground). While the fence, net, and ambulance serve as examples of direct-care interventions, the goal of many public health interventions is to move the population away from the cliff. In terms of equity, this model could be used to show that two different populations are positioned different distances from the cliff, or that one population had a resource (fence, net, or ambulance) that the other did not.

Adapting the Cliff Analogy to the obesity epidemic, lifestyle modifications that prevent weight gain and reduce the risk of disease even in individuals who are overweight are part of

both the fence and the net. Pharmacological and surgical interventions are equivalent to the ambulance at the bottom of the cliff. In contrast, improving the health literacy of those with basic and below basic levels of literacy, would serve to move these at-risk groups away from the edge of the cliff; moving these populations away from the edge of the cliff and nearer to the positioning of populations with higher levels of health literacy would also at least partially address issues of health equity. However, policy interventions take time to develop and implement, and are ultimately best for improving the health of those in the future. In contrast, current medical treatments are available to treat today's patients. A comprehensive long-term plan would be incomplete without considering both immediate and long-term treatment options.

To more clearly examine the ways that different levels of health literacy and healthcare system interactions impact individual health, the relative positions of each study participant along the 'Cliff' are considered in Figure 2, below. Box A is a graphical representation of the original analogy, with an individual positioned near the edge of the cliff, with the net positioned partway down the cliff, and the ambulance at the bottom. Boxes B-K represent the relative position of each respondent, where Box B is Allen; Box C, Anna; Box D, Barbara; Box E, Carole; Box F, Joy; Box G, Landon; Box H, Lee; Box I, Richard; Box J, Ryan and Box K, Violet. Each individual's position relative to the cliff edge is a function of both their health literacy and their ability to advocate for their own health, thus, Anna (Box C) is positioned slightly farther back than Joy (Box F) because, although both are highly educated, Anna's sense of agency is much stronger.

In addition to individual distance from the cliff, each box also contains a representation of that individual's fence, net, and ambulance. The fence in this analogy is representative of an individual's lifestyle modifications, such as physical activity or implementation of nutritional

knowledge to develop a healthy diet, but it also considers whether they have a relationship with a primary care provider, who can also act as a source of ‘fall prevention’. For this reason, both Landon (Box G) and Violet (Box K) have broken or partial fences; although they have each integrated lifestyle modifications into their daily routine, neither has a steady relationship with a care provider. They both have health insurance, so they possess access to the system (and thus have a net and an ambulance in case they fall), but they are not as active at prevention as they might otherwise be. Likewise, Anna (Box C), the sole participant without health insurance, is not in possession of a fence, net, or ambulance. Integrating healthcare system access into the conceptual model of an individual’s position relative to the edge of the cliff provides a visual representation of the interplay of structural and social factors with individual choices, and enables an understanding of the importance of addressing health as an issue of social justice.

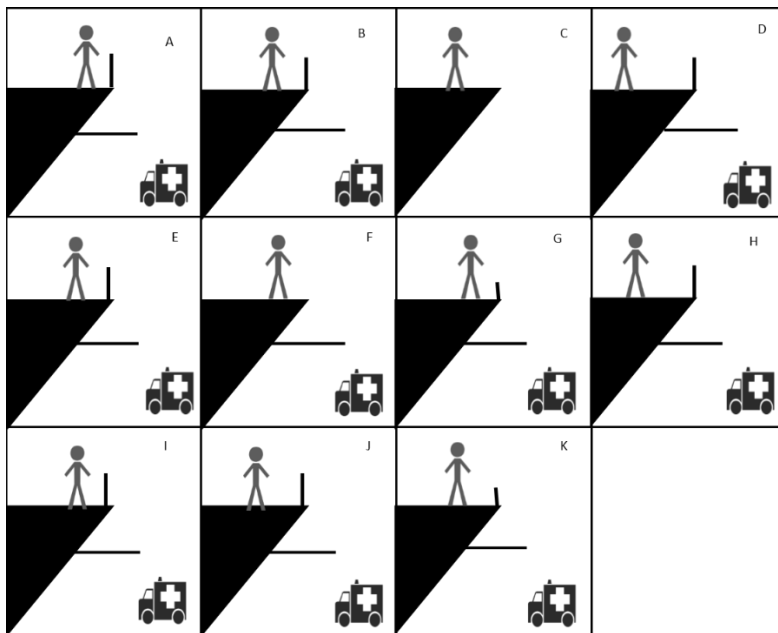


Figure 2 - Participant Locations in the Cliff Analogy

### 3.8 CHAPTER SUMMARY

Health literacy is significantly more involved than a mere measurement of reading level; it requires that each individual possess the ability to communicate fluently in English, apply scientific reasoning and understand scientific concepts as they relate to each individual's health, and the confidence to use these concepts when in health-related decision making. Individuals must discern targeted advertisements from valid, evidence-based strategies, and they must feel comfortable with questioning both the scientific literature and their personal healthcare provider in order to participate actively in their own care. Patient-provider concordance may ameliorate some of the difficulties with accessing care, particularly among members of minority groups, but this alone cannot completely correct the existing health disparities seen in the US healthcare system: Patients must advocate for themselves as they work their way through the healthcare system.

The ability to advocate for one's self is strongly impacted by experiences of bias and stigma, as related by several of the study participants. While there have been methodological problems raised regarding the standards that determine which patients should be recommended for weight loss treatment, many patients still struggle with voicing questions to their healthcare provider. While questioning a healthcare provider may have significant implications for a patient's sense of social status, these questions could also serve as the start of a conversation focusing on meaningful and achievable goals for an individual patient. The outcome of such a conversation depends greatly on the ability of both the patient and the provider to communicate effectively, which is influenced both by the patient's level of health literacy, and their ability to advocate for themselves by asking questions and raising concerns with their care.

## Chapter 4. AGENCY, AUTONOMY, AND HEALTH

*“I don’t know that it’s a choice that I freely made so much as a choice I had to make.” – Joy, 40*

Structural factors, such as inequality in the US educational system, impact patient health literacy, and also impact an individual’s sense of agency, which refers to the belief that we each have the power to enact change in the world. In the context of this study, agency is conceptualized as an individual patient’s sense of ability to make choices that directly impact their health and well-being. In Joy’s quote, above, she is discussing the way her socioeconomic status dictates her food choices, and how that impacts her health. Although Joy is highly educated, this is not reflected in her job status, and she continues to struggle with economically constrained choices.

In healthcare – even in patient-centered medical care – we tend to assume that patients are fully autonomous, and that any failure to comply with instructions results from weakness of will on the patient’s part. Often missing from our conceptualization of patient-centered medical care is the context of the factors that influence the patient, such as differing access to knowledge resources or the capacity to make health decisions without consideration for their financial impact. Most medical and scientific practices focus on the statistical goal of bringing the most good to the greatest number of people. By its nature, this process does not suggest a remedy for those who find themselves in the margins.

Patients with marginalized identities – such as those in race, class, and/or gender minorities – tend to fall outside of our current healthcare model. Even those who do not have a marginalized identity will still find that a statistics-based practice cannot address every issue that arises as the result of their individual circumstances. While statistics provide a useful framework

for addressing broad, generalized issues, incorporating the ideals of intersectionality theory into our current treatment framework builds an understanding of how large social structures influence individual outcomes. Particularly, because intersectionality theory is grounded in the day-to-day lived experiences of individuals (Dill & Zambrana, 2013), this framework eases the translation of treatment recommendations from the academy into real-world practice, enabling healthcare providers to adapt these recommendations for each individual patient. This chapter explores the concept of agency, including social and institutional power relationships that impact the choices available to an individual, and examines the way that concepts such as choice, responsibility, and autonomy impact patient's and society's views on health and the patient-provider relationship. Individual patient experiences are explored as indications of broader social issues, rather than as attempts to critique individual healthcare providers.

#### 4.1 STRUCTURAL INFLUENCES ON CHOICE

“Lifestyle is something one chooses, and life is something that happens to one” (Fitzgerald, 1994, p. 196). Weight is perceived as the result of an individual's lifestyle – their choices – and thus society commonly believes that the responsibility for an individual's weight status rests solely with the individual. However, this approach ignores the structural factors underlying individual choices. For example, the previous chapter discussed the way that unequal access to education leads to unequal health literacy. This in turn impacts a patient's ability to participate actively in their own care due to both a lack of resources and difficulty with accessing information or knowledge relevant to their health. Health literacy also impacts an individual's sense of agency, such as when an individual with low health literacy repeatedly fails to lose weight while using unproven methods to do so. Repeated past failures then become a reason why the patient is unable to lose weight and the patient feels as though nothing they do works – they

have no control over their weight. For example, Barbara shared many of her early frustrations with weight loss. She felt a loss of control; nothing she tried got her to where she wanted to be, and she ultimately chose to have weight loss surgery in order to reach her weight-loss goal.

As Health at Every Size (HAES) researchers have argued, repeated experiences with failure may result in raising significant long-term barriers for patients, particularly by causing them to delay medical care even for un-related issues (Lyons, 2009) as a result of the shame they feel due to their failure to lose weight. Thus, repeated failures decrease a patient's sense of agency and have a negative impact on a patient's long-term health. Further, conceptualizing weight status solely as the result of individual choice ignores the underlying structural issues that contribute to a patient's health problems, leaving healthcare providers treating the symptom (weight gain) rather than the cause (structural inequalities that lead to poor health). At least in part, this is because healthcare providers are neither trained nor empowered to address structural issues. At the public policy level, there is little recognition that chronic diseases, including obesity and its co-morbidities, exist at the intersection of medicine and society; currently, there are no treatment mechanisms designed to bridge the two. Healthcare providers have been handed the responsibility for addressing a problem that exists partially out of their sphere of influence, in much the same way that individual patients are held responsible for events that arise from factors they cannot control: Neither patients nor providers have any influence over the cost of food, nor can they decrease housing costs. They certainly cannot reduce insurance premiums or mandate coverage for needed medical care.

There is one way that providers may be better positioned to make an impact: They are better educated, and their job role allows them to access a certain amount of power in society. This is why some scholars advocate for providers to take a more active role in reducing health

disparities, such as through advocacy (Dannenberg, Wu, & Frumkin, 2013). In order for this to be effective, however, concerns due to lack of time or training in advocacy must be addressed. This could be at least partly resolved by incorporating structural competency into health professions education, as other researchers have suggested (Metzl & Hansen, 2014). Violet spoke of her experience with one provider – later referring to him as the “stupid doctor” she saw when she was fifteen – who failed to fully appreciate the lack of control she had over her eating choices:

I was a homeless teenager, and that's a whole different ballgame as far as nutrition goes. But, I guess maybe he was trying to be helpful by giving me these pamphlets - I totally remember these pamphlets - of like, healthy recipes. For me, it wasn't that easy, because I was living in a homeless shelter. It's like, the access to the food I have is donations and, like, what's made at dinner every night. It's, again, oftentimes cheaper and easier to feed people by doing lots of bleached-white flour products and like low protein, because protein is expensive. Fresh fruits and vegetables are also very expensive, and so when you're trying to feed 20 homeless teenagers... Do you know how much food teenagers eat?

Violet's available choices were very limited at that point in her life, and her story also illustrates the frustration that can happen when a patient is concerned about one issue (homelessness) while the provider is focusing on a different issue (reducing weight by handing her a pamphlet). Without an understanding of the structural issues that underlie the superficial issue that the patient presents with, Violet's healthcare provider wasn't able to recognize or begin to address any of the larger issues impacting her health. This is an example of the impact of structural influences (in this case, the way that both health education and the US healthcare system are structured) on individual patient care.

Joy's story also illustrates the way that social position dictates some of an individual's choices. She grew up poor but became relatively well-off as a result of her marriage. After several years as a homemaker, Joy's marriage ended in divorce, and she has since found herself

struggling economically. When asked whether she felt that people became overweight as a result of their choices, she acknowledged that while some individuals do make poor choices,

I feel like it's not a choice, for me. And, I think it's illustrated by the fact that before I got divorced, and I was middle income, I was always thin and healthy. And then after I got divorced and I was poor, and I had to make not-so-great choices at the grocery store, I gained 60 lbs.

Joy's experience with shifting social mobility also highlights the gendered experience of marriage, which is one possible mechanism for women to change their socioeconomic status. In Joy's case, when she divorced, she had been out of the working world for some time because she had been raising her children.

[W]e like to blame the poor: It's their own fault they're there. And that's really frustrating for me because I know – I can perceive that that's the way that society sees me, because I'm a divorced mother. But I don't see it as my fault that I ended up where I ended up. I was a homemaker for 15 years, and I believed in the security of my marriage and everything. I didn't know that things were going to go the way they went. I found myself in this position, and it was tough. There were a lot of nights when, literally my kids would have buttered noodles for dinner, because that was all I could get. Buttered noodles aren't very healthy, but they're cheap.

One of the major criticisms of low-cost foods is that they tend to be calorie dense, high-carbohydrate foods. Per calorie, these foods are cheaper than healthier options, which are more nutrient-dense. The price gap has increased over time; not only are nutrient-dense foods more expensive, they are becoming relatively even more expensive because the prices of healthy and unhealthy foods are not rising equally with inflation (Drewnowski & Darmon, 2005). In addition to being denied economic access to healthy food, Joy also shared the difficulty of physically accessing healthy food; it isn't always stocked by the stores she can afford to shop at.

If I had my own home, and I had a sufficient amount of money, I would fill my fridge with things like yogurt, bran cereals, even shredded wheat. But I don't have that option right now. A lot of time when people are poor they don't have that option, just like when I get these \$10 gift cards at the dollar store. First of all they

don't have shredded wheat, and if they did, I'd have to take half that \$10 to get that shredded wheat. Versus, if I take that gift card to the dollar store I can get 10 bags of noodles. When you don't have money for food, and you have kids, you're just thinking, "How can I fill their belly so I can keep them comfortable?" You're more concerned with that than nutrition. Even though I would rather see them get the right nutrition, you don't want them to be hungry, and sometimes cheap stuff is cheap for your body, too.

Joy's story is a prime example of the way that structural issues (like poverty) influence the choices available to an individual. Although Joy would rather buy healthier foods, her primary concern was to make sure that her children do not go hungry, and so she made food purchases that maximized the caloric value of her family's food. While Joy did make the conscious decision to purchase high-calorie foods, viewing her increased weight as the result of her poor choices ignores the significant contributing issues that constrained her ability to make healthy choices.

After struggling to find a good job that would meet her family's financial needs, Joy decided to return to school, and spoke of her experience working while going to school and raising two children. She collected \$190 per month in food stamps to feed herself and two teenagers, often going without so she could make sure that her children were fed.

I probably hadn't eaten anything substantial for a couple days because I wanted my kids to be able to eat. I got faint in class, and I went to see the nurse/counselor and I told her I hadn't eaten because I couldn't afford to eat. She gave me a biscuit, like a Starbucks biscuit or something in a wrapper. Best thing I ever ate, though!

The Supplemental Nutrition Assistance Program (SNAP) is one public measure to help lift individuals in the US out of poverty. There are several different levels of poverty that can be used to compare the socioeconomic status of various populations. Extreme poverty is an economic term used by the World Bank to describe global poverty trends, and it refers to the number of households that live on less than \$2 per person per day. In contrast, the current US

poverty line for a family of three is about \$17 per person, per day, and the threshold for deep poverty is \$8.50 per person, per day. Even when SNAP benefits, housing credits, and tax incentives are included in the measure – a best-case scenario – an estimated 613,000 households (including 1.17 million children) are still considered to be living in extreme poverty in the US (Shaefer & Edin, 2013).

Public assistance substantially reduces – but does not completely alleviate – extreme poverty in the United States, even though the World Bank does not report on US data due to the overall wealth of the country. Homelessness, hunger, and other structural issues are ongoing problems for many patients, and healthcare providers should have at least a basic understanding of the barriers that these patients need to overcome.

## 4.2 RESPONSIBILITY AND ACCOUNTABILITY

Raising the issue of structural concerns within the context of health also brings up the issue of responsibility: When a disease is considered to be the result of an individual's poor choices, the blame for their poor health falls on the individual. With a broader understanding of the social context surrounding overweight and obesity – such as the impact of socioeconomic status on the affordability of healthy food options – comes the question of whether the individual or society bears the responsibility for the increasing incidence of obesity in the population. If obesity is contextualized as both a social and a medical issue, what treatment responsibility do healthcare providers bear? To what extent should patients be accountable for enacting these changes?

To be clear, placing obesity (and other chronic diseases) within a social or structural context does not completely take away the role of individual choice. For example, Joy referenced

the fact that she still made the decision of whether or not to eat chips, and Violet discussed some of her friends' less-than-healthy eating habits. Joy particularly spoke about the way that her choices are constrained by her circumstances; the idea of constrained choice is important because it recognizes the very real determining influence that structural forces have on individual choices, without robbing individuals of their agency and ability to make choices for themselves. From a medical care perspective, the role of constrained choice is important because it acknowledges the challenges patients face while simultaneously empowering them to make the best possible choices for themselves, based on the available options. Thus, the patient is not blamed for factors out of their control, but they are also not painted as the powerless victim of circumstance.

One possible model for developing a comprehensive plan to address obesity within its social context is the Social Connection Model (Young, 2011). In this model, all members of society are considered to share responsibility for resolving problems that stem from social issues. This responsibility includes both providers and patients, as both are members of society at large. In particular, this model calls on those who are impacted by a given problem to participate in problem-solving strategies in order to help resolve the issue, as these individuals are best located to see the problem most fully. In the specific case of obesity, those individuals most likely to be impacted are also members of race, class, and/or gender minority groups, and their participation in public policy development will depend on strengthening a sense of agency in groups that have traditionally had very limited power in society and government.

For example, Lee experienced weight gain as a result of a medication prescribed to her by her doctor. Although it is currently recommended that providers conduct a thorough medication review to see if any of a patient's medications can be switched to more weight-neutral options

prior to beginning any weight-reduction treatment (Reid, 2013), Lee's experience was several years ago, before many of these options existed, and she gained 60 lbs. after a year on her new medication.

[T]he doctor, even though I went to see him every 2-3 weeks, he never said anything. He had to have noticed I was gaining weight. For God's sake, 5 pounds a month! It wasn't pretty! And he never said anything. At the end of the year, I went in and said, 'I don't care what happens to me, I can't do this anymore!' ... He didn't say anything about it [until I brought it up]. I'm sure that he knew that this caused weight gain, and when he saw it on me he just went, 'oh, well'. Which I don't think doctors would do anymore. Wouldn't a doctor, I hope now, if you've gained 60lbs in one year, say 'oh, we've got a problem here?' I don't know.

Lee's experience with a provider who would not raise the subject forced her to become vocal about her health needs, even though she was initially quiet even in the face of a 5 lb. per month weight gain. She also struggled to lose weight because, "I didn't feel like I should have to work hard at it because I didn't feel like it was my fault. I felt like it was the medicine's fault, and why should I have to struggle so hard to get it off, when this medicine put it all on?" Like many other patients, Lee struggled with the idea of responsibility because she needed to assign blame before she could move on with addressing the problem. Assigning blame is a way to determine the responsibility for correcting the problem; society does the same thing when they attach blame to an individual rather than looking for potential underlying causes. Although she is referencing poverty, when Joy says, "I can perceive that that's the way society sees me," she is giving voice to the fact that society's views of an individual are generally palpable by the individual.

When a person feels that they are being blamed for their weight, their instinctive reaction is to deny that they are at fault. This is why fat-shaming does not work as a method for reducing the incidence of obesity in the US (Jackson, Beeken, & Wardle, 2014). Lee ultimately discovered that her need to assign fault was the reason why she struggled to lose weight, and as she said, "ok, it happened, it wasn't your fault, but you need to get past it, put it behind you..." It was only

when she was able to do this – in Lee’s case, through hypnotherapy – that she was able to begin actively working to improve her health status.

When Lee began to increase her physical activity level, it was not because someone else made her do it; she set her own goals and began working to achieve them. While she does share these results with her healthcare provider, she generally holds herself accountable for meeting her goals. Participant reactions to the concept of accountability were mixed, mostly due to the differing assumptions inherent with accountability, rather than with the concept itself.

In general, participants had two views of accountability. Participants who were strongly for the idea of accountability talked about it as an extension of agency – that is, they felt that since each of us make our own choices, we are accountable for our choices. These participants felt that they were accountable only to themselves. This view strongly reflects these individuals’ position in the social hierarchy, because each of them have a strong sense of control in their daily lives. Conversely, the two dissenting views, Joy and Barbara, had less of a sense of control. To them, accountability was something they owed to others, which is indicative of their sense of disempowerment. Both Joy and Barbara conceptualized accountability as an outsider (the healthcare provider) directing their goals onto an individual (telling the patient what they need to do to achieve a pre-determined ideal weight). Barbara in particular viewed accountability in a strongly negative light, saying “I’m accountable... What are you talking about? It’s kind of like a fighting word to me.” She instead advocates for a concept of shared accountability, which makes use of more-inclusive “we” terms, rather than having a provider tell the patient what their goal should be.

Joy, who was supportive of the idea of accountability, nevertheless warned that the topic must be addressed carefully by healthcare providers:

[W]ith people who are in the margins and poor and stuff you have to be careful when you talk about accountability, the way you say it... [T]he doctor who's seeing my niece emphasizes more the reward of seeing the weight go down, rather than, "we're gonna hold you accountable for this," because that would rub her the wrong way and she'd be like "screw you, I'm leaving." But that's what it is, it's accountability. You need to be careful though, how you talk about it.

Joy's niece has been overweight her entire life, and has only recently begun to lose weight after finding a healthcare provider who tracks her weight loss carefully. Joy says that the doctor has been helping her niece to find ways to integrate physical activity with her daily life in a way that is manageable for her, and she has also noticed that her niece is making healthier nutritional choices. In helping Joy's niece learn to make healthy choices based on her available options, her provider is enabling his patient to practice agency within her social context and encouraging her to play an active role in her own healthcare.

The remaining participants who discussed accountability all felt strongly that accountability is a given, a normal part of the life experience. Anna was particularly passionate about the subject:

Accountability is not a scary word for me because it's something that everyone should have. You don't get away with not being accountable for your own behaviors in every other situation in life, like you can't go to work and not be accountable for your choices at work; you can't do anything in life, in a relationship, in work, in your personal decisions, and not hold yourself accountable for the choices that you make. That's just a part of life.

For Anna, the idea of not being accountable for her own choices is clearly unacceptable. This is a reflection of her life experience and her general sense of control over her own life. She talks further about prioritizing, and while she recognizes that many individuals have to prioritize, she feels that since she is the one who sets her priorities, she is personally responsible for all of the outcomes.

I can understand why people would be bothered by it, but that's just because they don't want to be accountable for their own issues. Nobody wants to take the blame for their own problems, and I feel like that is one of the things people have problems with in today's society in general. Everybody likes to point the finger at somebody else and say that it's somebody else's problem. And that's something that seems to be happening everywhere, anymore. Not just in weight loss, but what it really boils down to, like the only person who is responsible, who is accountable, for you **is you**. And if that offends you that someone is pointing that out to you, maybe you should take a look at how you handle things in general. Because if that's bothering you, that someone's telling you that your own personal decisions in terms of weight and diet are something that you need to be accountable for, then what else are you not being accountable for? Personally, that's the way I look at it. You are the only one who has control over you. If somebody needs to tell you that, then maybe they do need to tell you that. Clearly, you're not being accountable for something. And whether or not that's because you just have other things that you need to be accountable for that don't include weight loss because you have too many other priorities, or you just are the kind of person who doesn't like to be accountable for themselves in general, either way it's still comes down to you. You are the common denominator.

Anna possesses a very strong sense of agency, as evidenced by her statement that, “You are the only one who has control over you.” She acknowledges the need for prioritization that may focus an individual’s attention elsewhere, but she ultimately still sees the outcome as something that the individual is solely accountable for. It is hard to argue that anyone other than the individual themselves may be responsible for the choices they make. However, this argument does not recognize that outside factors may influence what choices are available, a key component of the interaction between social structures and individual outcomes (for further discussion, see Nakano-Glenn, 2002). Structural factors and individual agency both have a critical influence over health outcomes.

The issue of accountability was also a concern for Young when she introduced the concept of the Social Connection Model. Frequently, the debate over personal responsibility becomes an argument of individual choice versus pre-determined outcomes that inevitably result from larger societal structures. However, Young argues that framing outcomes as the inevitable

result of established social structures robs these individuals of any sense of agency by teaching them that their outcome is pre-determined (Young, 2011). Instead, healthcare providers need to recognize that, while social structures determine the options available to each individual, the individual still makes choices from their available options. Thus, under the Social Connection Model, individuals retain the agency to make constrained choices that are influenced by prevailing social conditions. Framing obesity in this way allows patients to maintain control over their choices and enables them to participate actively in their own care.

The variance in participants' views on responsibility can be resolved thusly; providers are accountable for recognizing and assisting patients with achieving manageable and realistic health goals, patients are responsible for recognizing the ways in which their own choices contribute to their health, and both patients and providers share the responsibility for constructing open dialogue regarding health risks, existing barriers, and strategies for overcoming these barriers in order to achieve improved health. This requires providers to be open to discussing individual goals, rather than recommending treatment based on a universal BMI standard, but it also requires patients to be both vocal and realistic about what they can and cannot accomplish so that they can participate in developing a plan of care that adequately meets their needs.

### 4.3 AUTONOMY AND IDENTITY

In order for patients to be comfortable vocalizing their abilities and admitting their struggles, they have to first feel that doing so will allow them to achieve their goals. To encourage this, the healthcare industry has recently placed an emphasis on patient-centered medical care, which focuses on supporting patient autonomy and enabling patients to be involved in making decisions about their care. However, the concept of autonomy depends on “a model of

articulate, intelligent patients who are accustomed to making decisions about the course of their lives and who possess the resources necessary to allow them a range of options to choose among” (Sherwin, 1998, p. 24). Unfortunately, this is often not the case. As discussed previously, inequalities within the educational system result in unequal health literacy levels, which negatively impacts the ability of some patients to participate effectively in their own care. Some scholars have thus challenged the notion of autonomy in these instances, citing concerns over whether an individual with low health literacy is truly adequately informed to consent to medical treatments. As a healthcare worker, Ryan spoke of her experience encountering patients who did not fully understand what they were consenting to: “Surgically, we go over a consent form and we say 'Do you know what's happening with you?' and people will say yes and sign the form and then it seems like day of surgery, 'Oh, I didn't know this was supposed to happen and I didn't know who was going to be there', and they want to back out.”

The current structure of patient-centered medical care is strongly dependent on knowledgeable, informed patients who are comfortable making critical decisions about their own health. In *Unequal Treatment*, an Institute of Medicine report concerning racial disparities in healthcare, the authors expressed concern that the fast-paced healthcare structure forces providers to rely on preconceived notions in order to reduce the amount of time spent with each patient (Smedley, Stith, & Nelson, 2003). This may increase the impact of implicit bias and result in increasing disparities as healthcare providers have less time to spend with patients. The trend is also concerning because the current model may not allow providers to spend enough time with patients to recognize those who do not possess full autonomy, nor allow them the extra time needed to address the problems that may result, such as Ryan’s story of patients who sign consent forms without fully understanding what they are consenting to. The resulting lack of

informed consent is an ethical issue that is reinforced by the structure of our current healthcare system because it does not make an allowance for the extra time that must be spent with some patients to ensure that they fully understand the procedure they are consenting to.

Identity also plays a role in the healthcare system. Interestingly, in studies of racialized outcome disparities, a patient's overall health outcome is more closely related to the way they are categorized by others than by how they categorize themselves (Lopez, 2013). This is evidence that the common belief that there is an innate difference between racial groups that leads to poor health may be faulty, and that instead some of these disparities may be tied to the way that an individual is viewed. This echoes the concern of the IOM researchers (Smedley, Stith, & Nelson, 2003).

The framework of intersectionality theory (Nakano-Glenn, 2002) provides a framework for viewing each patient individually, which may allow providers to understand the multiple and intersecting influences that impact each patient's overall health outcomes. Membership in a minority group influences the way that each patient views themselves and their capabilities. For example, there is currently a strong push to increase the number of female students that decide to pursue careers in Science, Technology, Engineering, and Mathematics (STEM fields). Women have historically been socialized to exist primarily within the domestic sphere of the home, and while this is changing in more recent generations, it is still a significant factor in society as a whole, and particularly with older generations of patients that are still a part of many healthcare providers' practices.

In particular, the way that an individual is socialized to interact with the public world may impact their care, because patients may have learned to be less vocal about their concerns or may delay seeking care due to concerns about how they will be judged. For example, some

patients may not be comfortable admitting they do not understand something – as Ryan discussed during her interview – or a particular patient may not seek care because they are concerned for the way that they will be treated due to their weight (Hernandez-Boussard, Ahmed, & Morton, 2012).

Whether due to race, class, or gender minority group membership, the way a patient identifies has a strong impact on their ability to practice autonomy and achieve their health goals. For example, if a patient believes that they are someone capable of being physically active, then they are more likely to be successful at meeting physical activity goals. Landon expressed the way that his sense of identity initially prevented him from becoming active:

I didn't really do much scheduled activity in my lifetime, mainly because I never really thought I could. I didn't think that I could run, and I never played team sports... I wasn't just going to rush into a team sport without actually having some type of, I don't know, confidence in what my body could do, because I didn't really think that I could do much of anything.

Landon did not view himself as someone who could be active, and so he wasn't active. Similarly, concerns over being stigmatized due to his physical appearance (in Landon's case, both because of weight and because of gender) caused him to avoid the locker room setting that is part of the gym and team sport experience. This avoidance of stigmatizing experiences is one of the mechanisms that researchers believe mediates the relationship between increased fat shame and weight gain (Jackson, Beeken, & Wardle, 2014). As Lee said: "I really feel, for the first time since this whole process started, that I'm able to do it. I know that I can do it now, because I've made so much progress. And it's easy. I mean, I shouldn't say easy. It's easier than it was in the past. It's something I know I can do now." For Landon, Lee, and Violet, achieving modest initial success helped them to realize that they had the ability to achieve their goals.

Identity also plays a role in maintaining weight loss. For Barbara, who lost a significant amount of weight after having bariatric surgery, it was a struggle to discover how she fit in with society as a result of her change in physical appearance.

People have their own ideas of how overweight people are: They're funny, they're loud, or they're really nice. They're not strong and stand up for themselves, and powerful. They're either really loud and rude or they're really sweet and passive. I don't see a lot of just regular overweight people. It's because I think they feel like they have to make up for something they think they lack: "Oh, well, this guy is funny. If I'm funny maybe he'll want to have me around." Or, "well, so-and-so's a funny one; he's great to have around." It's like creating your own persona, ways for society to accept who you are. So that's what I mean, once you've gotten rid of that physical crutch, then what do you do? Then you're like, "okay, now what am I about?" How do you socialize with people? Am I still the funny one or am I just a regular person? What does regular mean, like an average person? Am I supposed to be really arrogant, am I supposed to be self-confident, am I supposed to be shy? It's just like "who am I, really? What's my role in society now that I'm no longer this obese person?" You do a lot of self-reflection and sometimes it's hard to see who you really are. You need people to help you, like a mental health professional ... saying "okay, this is acceptable, this is a healthy way of thinking about who you really are", just [to] kind of guide you through it. Is this a healthy thought? Am I saying this correctly? Just to help you re-establish your self-worth, your self-perception. Just to help you find out who you are because you're completely different. People, like, men notice you more, who wouldn't normally notice you. Like catcalling. The other day somebody was doing that to me, and my friend was like, "did you hear that guy?" and I'm like, "what are you talking about?" ... and she said, "they were talking to you." And I'm like, "oh, that can't be. That's weird." And [my friend] said, "What do you mean, that's weird?" Because they don't know that I was like that [overweight] before... And then people around you think you're crazy for not thinking that could happen to you, or you're just being weird.

Barbara's change in weight status had a significant impact on her sense of identity and the way she interacted with the world. In fact, she found that seeking mental health advice was an important part of her post-operative support network. Physical appearance is also strongly associated with social status, particularly for women (McLaren, 2007). When Barbara lost weight due to her surgery, she effectively changed a physical marker of her social class. In her experience with catcalling, Barbara is discussing her experience with the way that women are

viewed in society. She had become so used to being viewed as an obese individual that, after surgery, she struggled to find a new way to interact with the world. This interaction is both physical, in terms of things like the way that clothing fits or the way one navigates a hallway or other enclosed space, and emotional, because she struggles with how to respond to events like being catcalled and how to interact in a social environment.

#### 4.4 AGENCY AND READINESS TO CHANGE

Perhaps the biggest social factor behind stigma is the perception that an individual's weight is solely a result of their own choices, whether good or bad. Weight is the result of complex interactions between environment (including the choices an individual makes) and genetics (Faith & Kral, 2006). Individuals who are overweight are generally viewed as having made poor choices: Their weight is their own fault. As a result, the possibility that increased weight discrimination could act to encourage individuals to lose weight was raised, although research instead suggests that increased stigma ultimately promotes further weight gain (Jackson, Beeken, & Wardle, 2014).

The social concept of weight is similar to our idea of the “good” and “bad” poor (Allison D. , 1994), where the “good” poor are those who cannot work as a result of illness or injury. Similarly, illness becomes evidence of improper behavior (Fitzgerald, 1994), and individuals who are shown to have gained weight as the result of a medical condition are often viewed in a better light than those who have no such diagnosis. In this way, social pressures encourage individuals to pathologize their weight, thus attaching a medical diagnosis to a problem that originates from both biomedical and social processes. This places an added expectation on healthcare providers, considering that “given our training and expertise, we health care

professionals are no more competent to treat social distress than other citizens. We cannot fix everything (though we do some things marvelously well), nor can our patients – no matter how intelligent or attentive – prevent all disease and death” (Fitzgerald, 1994, p. 198).

The difficulty caused by assigning a medical responsibility to correct social issues is central to the concept of a patient’s readiness for change. Fitzgerald discusses the process by which issues first thought to be under an individual’s purview (such as weight and smoking status, among others), slowly became the concern of society, eventually becoming problems that must be addressed by the healthcare system. She points out healthcare providers’ lack of training and ability to address social issues and warns of the possibility of “developing a zealotry about health, in which we take ourselves too seriously and ... even deny people charity, empathy, and understanding because they act in a way of which we disapprove” (Fitzgerald, 1994, p. 197).

This denial of empathy and understanding is often palpable to patients, and several shared stories similar to Ryan’s experience with having her mouth wired shut after an oral surgery:

I was like, “Look, something is not right, because I'm physically not able to eat anything. I’m exercising, nothing is happening. What’s going on?” And again they were just like, “Well, you're just going to have to try something. Change it up.” There wasn't any better advice, cause, you know, over the course of two years, they start looking at just, you know, “You're not doing what you're supposed to be doing; you're lying about whatever information you're presenting.” So I was in tears almost after this.

Ryan’s providers made a judgement about her behavior based on the visible result – her failure to lose weight. Carole shared a similar experience with her obstetrician, who noted her pregnancy-related weight gain and dismissed the possibility of twins because, he said, “she’s just been eating too much cheesecake.” In addition to erecting a barrier between himself and his patient, who did not receive his comment well, this lack of concern on the provider’s part could have had consequences for Carole if she had been pregnant with twins. It also decreased the

likelihood that Carole would feel comfortable returning to this particular provider for help if she ever chose to pursue medical attention for weight-related issues.

In response to experiences of bias and stigma, fat studies scholars push back against the social push to lose weight, and claim that one can be healthy at any size. This is often confused with Health at Every Size (HAES), which while based on the same original concept, was developed with healthcare providers and is a movement designed to encourage maintainable healthy choices made in partnership with a healthcare provider. HAES and fat studies differ significantly in that HAES is designed as a cooperative program between patients and healthcare providers, while the fat studies assertion that there is no call to recommend weight loss is often criticized for ignoring health implications associated with increased weight (see discussion in *Fat Studies*, p. 28). The discord between fat studies and the healthcare system is likely to result in an oppositional relationship between patients and providers and may be counterproductive if the ultimate goal is to increase health and well-being.

Healthcare providers walk a difficult line, where they have to address concerns with a patient's weight or physical appearance, without alienating or stigmatizing the patient. Violet shared her experience working in a veterinary office and having a similar discussion with people about their dog's weight, and how easily offended they became. She acknowledged how much harder it would have to be to bring up the issue of the patient's weight, an issue that many healthcare providers do not feel adequately trained to address (Foster, et al., 2003).

In addition to the lack of specific training for dealing with long-term obesity issues, healthcare providers generally do not see their patients outside of the medical office. Ryan feels that she is being accused of lying to her providers because they are only able to evaluate her success based on whether or not she has lost weight between appointments. The practice of

medicine strongly favors available evidence, and so providers are using the only means of evidence-gathering readily available to them – the scale – and using the outcome as the basis for treatment. In scenarios where the claims made by the patient, which are not backed by evidence, directly contradict the available evidence, providers will follow the documented evidence to determine a treatment plan.

There are two problems with this treatment scenario: The underlying assumptions made by the provider, and the definition of what constitutes acceptable evidence. Both Ryan and Barbara experienced significant difficulty with losing weight, they both felt like they made every possible effort, and they have both experienced frustration when attempting to seek care for their weight issues through the healthcare system. In Ryan’s case, she explicitly stated that she felt she was being accused of lying by her healthcare providers, which is problematic because, while the scale can provide evidence of whether a patient has lost weight or not, it cannot provide evidence of why that is occurring: There is no evidence that the patient is lying, or is failing to try. The assumption that the patient is choosing not to take responsibility for their health is rooted in the way society perceives the concept of autonomy:

“Having been taught that they need only to apply themselves in order to take advantage of the opportunities available to them, most learn to think of their success as self-created and deserved. Such thinking encourages them to be oblivious to the barriers that oppression and disadvantage create, and it allows them to see the failures of others as the latter’s unwillingness to exercise their own presumed autonomy responsibly” (Sherwin, 1998, p. 25).

Ryan, Joy, and others all spoke of their difficulty with accessing resources; these difficulties have a significant impact on their ability to make healthy choices. As Ryan stated, even when someone isn’t physically giving it their maximum effort, they might be giving it all they have, mentally. For example, the schedules that both Violet and Barbara keep in order to have nutritious food available to them take a considerable amount of time and effort (see

discussion, p. 57). A patient might be spending their available time trying to coordinate a meal plan, and a lack of nutritional knowledge might prevent them from doing so effectively. Healthcare providers are intelligent, highly educated people, and so it can be difficult to understand why some patients struggle to comply with directives, such as when Landon realized he did not know what he needed to do for a food elimination diet.

Patients also may want to go to a gym or start a fitness program, but feel reluctant to do so because of past experiences with stigma. Lee shared her experience of trying a new gym and being made to feel uncomfortable because the other people in the gym stared at her. Whether in a gym or exercising in public, people who are obese may feel uncomfortable starting an exercise program due to either a lack of knowledge or a concern of being viewed negatively by others. They may feel that they are unlikely to be successful because they have had past experiences with failure, or because they cannot afford a gym membership.

When Anna spoke of her difficulty making peace with herself and her appearance, she alluded to many of the same struggles: She has been unable to lose weight, but she has still found ways to be active and she has taught herself about healthy nutrition. While she isn't at the ideal weight that she may feel she would like to be, she is secure in who she is and she takes responsibility for her own choices – she has a very strong sense of agency that many other patients do not.

#### 4.5 CHAPTER SUMMARY

A patient's sense of agency and autonomy are significant factors in their ability to comply with the directives of health care providers. A patient's identity impacts their agency and autonomy through their interactions with others, and also through their ability to see themselves

as being successful. Landon's story of being less active because he didn't see himself as being active is an example of this problem, but Lee's and Violet's stories of the way that small initial successes helped them realize they could meet their goals are good examples of how healthcare providers could encourage patients to make small changes that ultimately have a big impact on a patient's overall health.

Before a provider is able to successfully work with patients to overcome their barriers, they must have an understanding of the structural factors that create these barriers. Rather than placing the responsibility for this knowledge on individual providers, the structural impact of the healthcare system itself must be recognized. Health professions education should include methods to more fully prepare providers for their future practice, such as by encouraging proficiency in addressing structural issues. Particularly, it is important for healthcare providers to recognize the difference between constrained and unconstrained choice, and the ways in which their (relatively) privileged position as educated members of society may encourage an emphasis on the role of individual choice. This also plays a role in how society views responsibility and the importance of accountability, because individuals are taught that one need only apply themselves in order to succeed. In this view, those who do not succeed must not have made sufficient effort to be successful, and this becomes a reason why an individual's circumstances are their own fault.

Patients who struggle to make changes, whether due to constrained choices, limited autonomy, or a lack of agency, are often labeled as not being ready to change. While it is very true that there are some patients that possess the knowledge and resources to change their circumstances and choose not to do so, it is equally true that there are many who do not have the knowledge or resources to address their health issues. These patients are ready to change, but

may feel they are unable to do so. A more thorough knowledge of structural factors that influence a patient's ability to enact change in their own life would likely assist healthcare providers with recognizing the difference between these two patient populations. Incorporating structural competency into health professions education and training is one possible solution for assisting healthcare providers with recognizing and addressing the many factors that contribute to patients' poor health outcomes. This training might improve patient outcomes and enable providers to create stronger working partnerships with their patients.

## Chapter 5. CONCLUSIONS AND SIGNIFICANCE

*“Maybe there should be some doable suggestions for those people, instead of just saying they’re not ready. That’s like discounting them, or writing them off. There has to be something, but it has to be realistic for people.” – Joy, 40*

Individuals in the US have struggled with obesity for some time, as evidenced by an 1899 article in the Journal of the American Medical Association (National Expansion, 1899). The increasing prevalence of obesity, both locally and globally, has led to focused public health efforts aimed at reducing the incidence of obesity, but the association of weight status and position in the social hierarchy indicates the need for a more complete understanding of factors that influence social status. Intersectionality theory provides a useful framework for viewing the complexities of individual identity that are influenced by race, class, gender, and other factors (Mullings & Schulz, 2006), while viewing obesity through a constructivist lens allows for the examination of how and why obesity has been constructed negatively within our current social context. Examining health and social position through both frames allows larger structural factors to be connected to individual experiences and health outcomes.

### 5.1 SUMMARY AND INTERPRETATION

After content analysis of each interview, two key themes emerged. First, while acknowledging the negative impact of inequitable access to education, experiences of bias and stigma were shared by nearly all participants; in this population, stigmatizing experiences also seemed to have a potential suppressive impact on the way that an individual utilizes their knowledge resources. This impact was only verbalized by those with high levels of health

literacy, who wanted to explain why they tried weight loss methods they knew to be unproven or unsafe; these individuals may hesitate to discuss the use of these products with their healthcare provider, which could potentially have implications for their future health. Second, participants felt that providers and other members of society did not understand the challenges and barriers that they faced (including a lack of agency or difficulty accessing resources). This finding suggests the potential usefulness of incorporating structural competency training into health professions education in order to help providers develop mechanisms for supporting patients in making lifestyle modifications for healthy weight loss.

The reasons why individuals struggle to lose weight are complex and varied. While there have been recent changes in data collection methodologies and clinical treatment guidelines, the trend of increasing obesity prevalence was well-established prior to these changes. A recent estimate shows that approximately 64.5% of the adult population meets current weight-loss treatment criteria (Stevens, Oakkar, Cui, Cai, & Truesdale, 2015). Given that the number of individuals who meet the criteria for obesity treatment has failed to decrease, continued one-size-fits-all approaches are unlikely to be successful. Based on this existing data, it is critical that providers are comfortable applying clinical judgment to determine which patients need treatment and which do not. Providers also need to feel confident in their ability to help patients successfully address the structural barriers that individuals encounter.

Previous attempts to assist providers with recognizing individual barriers and the impact of an individual's culture on their health resulted in the development of cultural competency training, which has been strongly criticized for its tendency to essentialize various target populations (see discussion in Intersectionality and Culturally Competent Care). Recently, some scholars have begun to advocate for the inclusion of structural competency in health professions

education as a means to address this issue while avoiding the pitfalls identified with cultural competency (Metzl & Hansen, 2014). While the practice of being “culturally competent” is often enacted through the use of a checklist, structural competency provides a means for understanding the influence of structural factors on individual health needs. All of the participants in this study indicated a desire for providers to spend more time addressing their individual needs, and structural competency has the potential to prepare healthcare providers to better address this need.

Although basic literacy was not lacking in any of the participants in this study, interviewees did possess varying levels of health literacy. National studies of adult health literacy (Kutner, Greenberg, Jin, & Paulsen, 2006) strongly indicate that there is a need for equitable public policy to address unequal education levels. In contrast with these national findings, the individuals in this study were relatively highly educated, yet the lack of science literacy among many participants still limited their ability to make informed decisions and participate in their own healthcare. This finding supports the critique of some feminist health scholars that discussions of health literacy and agency both assume a particular idealized patient who may not actually exist (Sherwin, 1998). For example, the lack of health literacy made it difficult for many respondents to differentiate between marketing and scientifically validated methods for weight loss, a distinction made even more difficult by commercial weight-loss product endorsement of television personalities with medical credentials.

While only two participants in this study possessed relatively high levels of health literacy, both indicated that, at various times, they would have tried weight loss methods they knew to have limited safety or efficacy as a result of their experiences with bias and stigma. This bias-associated subdued health literacy (BASH) maintains the market position of the weight loss

industry, at the risk of the consumer, by encouraging patients to continue to try potentially risky methods of weight loss. Several of the participants in this study advocated for increasing consumer protection through better patient education and more in-depth discussion of treatment options.

Structural competency training should include education about factors that may influence a patient's ability to advocate for themselves. This additional education for healthcare providers could help providers understand the reasoning behind patients' choices and reduce the tendency to place blame solely on patients. Developing proficiency in addressing structural factors that influence patient health would also allow providers to anticipate patients' support needs. For Barbara, who had to have a second weight loss surgery, the degree of support provided by her second surgeon proved to be a critical part of her long-term success. This support comes in several forms; she has access to a group of fellow patients who provide emotional support for each other, but she also has a mental health provider and takes advantage of the included dietary and physical fitness resources.

Reluctance to enact change due to a perceived lack of support or resource access may be viewed as a lack of readiness to change. Some participants in this study indicated that they struggled with making these changes, and that this struggle was often perceived by others as a lack of effort on their part. Participants also emphasized the need for support in making sustainable changes; it is possible that increasing social support mechanisms in the community might ameliorate perceived unwillingness or lack of readiness to change because these result from prevailing social or economic conditions. Healthcare providers who understand the support needs of their patients may be better positioned to help their patients overcome obstacles and meet health goals. Young's Social Connection Model (2011) provides a framework for

addressing social issues that also impact health by sharing responsibility for action between patients and healthcare providers, but it is also important that these interactions be done in a structurally competent manner that addresses the actual, rather than the perceived, needs of the patient.

Addressing health issues by providing structural competency education (Metzl & Hansen, 2014) and using the social connection model (Young, 2011) provides several possible avenues for action by both patients and providers. This combination makes room for both social and individual areas of responsibility, creates a way for individuals to retain agency while avoiding victim-blaming, and better empowers providers to be able to address the needs of their patients. Specific examples of interventions that address the structural and personal barriers that patients face are discussed further below (see Recommendations and Implications).

## 5.2 STUDY LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

This qualitative study has a small sample size ( $n = 10$ ), which means that several demographic categories are not represented and the results are not intended to be generalizable. Rather than studying a demographically representative sample, snowball sampling was used to identify individuals willing to share their story. The intent of this in-depth qualitative study was to include the voices of individuals alongside the current literature in order to allow these individuals to speak back to researchers. Although their social positions were relatively high, the participants in this study still experienced difficulty with accessing care, interpreting medical directions, and differentiating between marketing and evidence-based strategies for effective weight loss. Given that this study population possessed above-average levels of education relative to the general population, the lack of health literacy and its impact on health will probably be more pronounced in a population-representative study, and future work should

examine this relationship in greater depth. It is likely that more in-depth fieldwork focused on groups and individuals lower in the social hierarchy would yield a different perspective than that of the voices included here.

Ongoing research into the various ways that patients access health resources and build support networks is needed in order to determine the policy interventions that will best support improved patient health. While some research is beginning to investigate the effectiveness of online interventions, this area should be investigated with particular attention to individuals with low health literacy, who may not be comfortable with online platforms for delivering healthcare. These individuals may also lack regular internet access that limits the effectiveness of internet-based interventions.

### 5.3 RECOMMENDATIONS AND IMPLICATIONS

The importance of lifestyle interventions cannot be overstated. For example, as discussed earlier (see Current Recommendations for the Treatment of Obesity), weight loss interventions should be undertaken in a stepwise manner; providers should consider why lifestyle modifications failed and help patients address these issues prior to moving on to pharmacological or surgical interventions, because both of these interventions are more effective in combination with physical activity and a nutrient-rich diet (Reid, 2013). As of 2011, Medicare and Medicaid coverage now includes provisions for intensive behavioral treatments by physicians and other healthcare providers (Wadden, Butryn, Hong, & Tsai, 2014). This coverage may help some individuals obtain access to additional resources and build their support network. Additionally, some healthcare providers are exploring the efficacy of online resources that can support patients' needs, such as a Group Health study that provided participants with online access to a dietician in order to help them lower their blood pressure and decrease their risk of heart attack

and stroke (Green, 2014). This study also found that online access to a dietician may also support patients' weight loss efforts.

Interviews with both Violet and Barbara discussed their ongoing challenges with managing diet (Violet) and post-surgical lifestyle changes (Barbara). These challenges should be discussed openly with patients so that they can be prepared with strategies to overcome them. In particular, Barbara emphasized that patients need to understand the critical role of support systems in achieving and maintaining weight loss. These support networks do not necessarily have to be in-person; for example, Lee uses her Fitbit as motivation to walk more often, and regularly compares her mileage with her daughter, who lives in another state. Violet found a Facebook support group that is effective at helping her achieve her goals. Both of these are examples of online support networks that do not require in-person meetings. One significant take-away from this study is that solutions should be individualized to each patient's circumstances and resources. For example, two participants tried in-home treadmills to assist them with increasing their physical activity. While Carole found this to be an important part of her long-term physical activity plan, Ryan had to get rid of the treadmill because she found that it was unsafe around her young child.

In addition to conveying an understanding of the different needs that result from each patient's unique circumstances, healthcare providers can also build rapport with patients through carefully selected language. For example, interviews in this study were conducted by asking a general question to gain an understanding of the patient's situation. Future questions were then framed using the patient's own language (such as "weight", "fat", or "pudgy") which served to increase rapport and resulted in a greater depth than may otherwise have been obtained. This strategy may allow providers to gain the trust of patients and more openly discuss their

challenges with losing weight. Additionally, there are several intervention strategies that may assist both patients and providers with building a supportive patient-provider relationship:

For healthcare providers:

- Consider developing and facilitating patient support groups, such as the group that Barbara found to be crucial to her weight loss maintenance.
- Participate in community policy discussions to advocate for patient health needs (Dannenberg, Wu, & Frumkin, 2013).
- Emphasize the importance of lifestyle modifications as a foundation before recommending pharmacotherapy or surgical interventions (Reid, 2013). Investigate the reasons why patients are struggling and make appropriate referrals to resources such as nutrition or mental health.
- Recognize the potential impact of a patient's position in the social hierarchy and encourage patients to ask questions as needed. Utilize a 'teach back' method to ensure patient understanding. Include surrogate readers and family members in discussion, and ensure that written patient education materials are at a level accessible to patients (Parker, 2000).

For patients:

- Ask questions of healthcare providers and their support staff to ensure correct understanding of the care plan. Seek out information on diagnoses through reputable sources and ask medical staff for recommendations if needed.
- Bring a family member to act as a surrogate reader or advocate if this is necessary to ensure accurate and effective health communication.
- Participate in a patient advisory council if available. If this is not available, consider developing one in order to develop a forum for addressing patient needs (Agency for Healthcare Research and Quality, n.d.).
- Understand that it is critical to build a healthy patient-provider relationship where patients are comfortable discussing their needs. Consider seeking out a different primary provider if this need is not being met.

The entanglement of clinically meaningful weight loss and weight loss for the sake of personal appearance may cause frustration for some patients. For example, Violet shared her experiences with addressing the unrealistic expectations of her friends, who believed that they would lose weight and look the same as if they had always been thin. She believes that the frustration that results from setting – and then failing to attain – unrealistic goals may cause many individuals to regain weight. Healthcare providers should be prepared to discuss goal-setting with each individual patient.

BMI itself is a clinical – but not diagnostic – tool that is useful as an indicator of the possible need for further intervention, but requires clinical correlation (see discussion in Current Recommendations for the Treatment of Obesity). Due to the concerns surrounding what BMI can actually tell us, and whether it is a useful goal for patients, it is important for providers to help patients set healthy and attainable goals. For HAES providers, this involves helping patients focus their efforts on overall health and healthy behaviors, rather than on the number on the scale.

In both Violet’s and Lee’s experience, it was important to establish small successes early on, as this helped them begin to see themselves being successful long-term. This could mean that a provider may need to help a patient set smaller, more achievable goals when beginning to enact changes in their life. For example, a patient who has a lengthy commute and little time for exercise could achieve 30 minutes of walking daily by getting off at an earlier bus stop (or parking farther away) and walking a few minutes at lunch. It may be easier for patients to find ten minutes at three different times throughout the day, and it is also conceptually easier for people who are not routinely physically active to envision themselves starting out by walking ten minutes at a time.

As Anna said, it is important to be able to visualize success; she struggled with weight loss because she had no mental picture of herself as a thinner person. Landon struggled with being active because he didn’t see himself as an active person. Breaking up physical activity throughout the day is one possible strategy for incorporating physical activity into a patients’ daily routine in a way that is less disruptive to the patterns of daily life. Encouraging patients to make small, sustainable changes is one of the recommendations of the HAES program, and is one that is likely to encourage long-term success and improved overall health.

## BIBLIOGRAPHY

- Agency for Healthcare Research and Quality. (n.d.). *Patient and Family Advisory Councils*. Retrieved April 18, 2015, from Quality Improvement: [https://cahps.ahrq.gov/quality-improvement/improvement-guide/browse-interventions/Custom-Service/Listening-Posts/Advisory-Councils.html#\\_ftn1](https://cahps.ahrq.gov/quality-improvement/improvement-guide/browse-interventions/Custom-Service/Listening-Posts/Advisory-Councils.html#_ftn1)
- Ahima, R. S., & Lazar, M. A. (2013). The Health Risk of Obesity - Better Metrics Imperative. *Science*, 856-858.
- Alexander, M. (2010). *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York, NY: The New Press.
- Allison, D. (1994). A Question of Class. In D. Allison, *Skin: Talking About Sex, Class, and Literature* (pp. 13-36). Ithaca, NY: Firebrand.
- Allison, D. B., Fontaine, K. R., Manson, J. E., Stevens, J., & VanItallie, T. B. (1999). Annual Deaths Attributable to Obesity in the United States. *Journal of the American Medical Association*, 1530-1538.
- Arvantes, J. (2010, May 17). *Family Physicians Play Major Role in Preventing, Treating Obesity, Say Experts*. Retrieved May 14, 2013, from American Association of Family Physicians: <http://www.aafp.org/online/en/home/publications/news/news-now/obesity/20100517overview.html>
- Asher, R. C., Burrows, T. L., & Collins, C. E. (2013). Very low-energy diets for weight loss in adults: A review. *Nutrition and Dietetics*, 101-112.
- Barr, D. A. (2008). *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health*. Baltimore, MD: Johns Hopkins University Press.
- Barrett, S. (2006). Fads, Frauds, and Quackery. In M. E. Shils, M. Shike, A. C. Ross, B. Caballero, & R. J. Cousins, *Modern Nutrition in Health and Disease* (pp. 1752-1761). Baltimore, MD: Lippincott Williams & Wilkins.
- Baum II, C. L., & Ford, W. F. (2004). The wage effects of obesity: a longitudinal study. *Health Economics*, 885-899.
- Bhattacharya, J., & Bundorf, M. K. (2009). The Incidence of the Healthcare Costs of Obesity. *Journal of Health Economics*, 649-658.
- Brewis, A. (2011). *Obesity: Cultural and Biocultural Perspectives*. Rutgers University Press.
- Bruch, H. (1957). *The Importance of Overweight*. New York: WW Norton & Co.

- Bruch, H. (1993). The Frohlich Syndrome: Report of the Original Case. *Obesity Research*, 329-331.
- Burgard, D. (2009). What is "Health at Every Size"? In E. Rothblum, & S. Solovay, *The Fat Studies Reader* (pp. 42-53). New York: NYU Press.
- Calle, E. E., Rodriguez, C., Walker-Thurmond, K., & Thun, M. J. (2003). Overweight, Obesity, and Mortality From Cancer in a Prospectively Studied Cohort of U.S. Adults. *The New England Journal of Medicine*, 1625-1638.
- Cawley, J. (2000, August). Body Weight and Women's Labor Market Outcomes. *NBER Working Paper No. W7841*. Available at: [ssrn.com/abstracts=239096](http://ssrn.com/abstracts=239096).
- Cawley, J., & Meyerhoefer, C. (2012). The Medical Care Costs of Obesity: An Instrumental Variables Approach. *Journal of Health Economics*, 219-230.
- Centers for Disease Control. (2012). *Community Transformation Grants*. Retrieved 11 26, 2012, from <http://www.cdc.gov/communitytransformation/small-communities/index.htm>
- Charmaz, K. (2008). Grounded Theory as an Emergent Method. In S. N. Hesse-Biber, & P. Leavy, *Handbook of Emergent Methods* (pp. 155-172). New York: The Guilford Press.
- Collins, P. H. (2012). Social Inequality, Power, and Politics: Intersectionality and American Politics in Dialogue. *Journal of Speculative Philosophy*, 442-457.
- Dannenberg, A. L., Wu, P., & Frumkin, H. (2013). The Role of Physicians in Promoting Healthier Built Environments. *American Journal of Preventive Medicine*, e71-e73.
- Dill, B. T., & Zambrana, R. E. (2013). Critical Thinking About Inequality: An Emerging Lens. In C. R. McCann, & S.-k. Kim, *Feminist Theory Reader: Local and Global Perspectives* (pp. 176-186). New York, NY: Taylor & Francis.
- Drewnowski, A. (2009). Obesity, Diets, and Social Inequalities. *Nutrition Reviews*, S36-S39.
- Drewnowski, A., & Darmon, N. (2005). The economics of obesity: dietary energy density and energy cost. *American Journal of Clinical Nutrition*, 265S-273S.
- Drucker, D. J., & Nauck, M. A. (2006). The Incretin System: Glucagon-like Peptide-1 Receptor Agonists and Dipeptidyl Peptidase-4 Inhibitors in Type 2 Diabetes. *The Lancet*, 1696-1705.
- Dunton, G. F., Kaplan, J., Wolch, J., Jerrett, M., & Reynolds, K. D. (2009). Physical environmental correlates of childhood obesity: A systematic review. *Obesity Reviews*, 393-402.
- Edelman, P. (2012). *So Rich, So Poor: Why It's so Hard to End Poverty in America*. New York: The New Press.
- Ernsberger, P. (2009). Does Social Class Explain the Connection Between Weight and Health? In E. Rothblum, & S. Solovay, *The Fat Studies Reader* (pp. 25-36). New York: NYU Press.

- Faith, M. S., & Kral, T. V. (2006). Social Environment and Genetic Influences on Obesity and Obesity-Promoting Behaviors: Fostering Research Integration. In L. M. Hernandez, & D. G. Blazer, *Genes, Behavior, and the Social Environment: Moving Beyond the Nature/Nurture Debate* (pp. 236-280). Washington, D.C.: National Academies Press.
- Ferrie, J. (2004). *Work Stress and Health: The Whitehall II Study*. London, UK: Public and Commercial Services Union.
- Fikkan, J., & Rothblum, E. (2005). Weight Bias in Unemployment. In K. D. Brownell, R. M. Puhl, M. B. Schwartz, & L. Rudd, *Weight Bias: Nature, Consequences, and Remedies* (pp. 15-28). New York: Guilford Press.
- Finkelstein, E., & Zuckerman, L. (2008). Weighing the Public Policy Issues (For Kids). In E. Finkelstein, & L. Zuckerman, *The Fattening of America: How the Economy Makes Us Fat, If It Matters, and What To Do About It* (p. NEED PG #). Hoboken, NJ: John Wiley & Sons, Inc.
- Fitzgerald, F. (1994). The Tyranny of Health. *The New England Journal of Medicine*, 196-198.
- Foster, G. D., Wadden, T. A., Makris, A. P., Davidson, D. S., Allison, D. B., & Kessler, A. (2003). Primary Care Physicians' Attitudes about Obesity and Its Treatment. *Obesity Research*, 1168-1177.
- Fowler-Brown, A. G., Ngo, L. H., Phillips, R. S., & Wee, C. C. (2010). Adolescent Obesity and Future College Degree Attainment. *Obesity*, 1235-1241.
- Freespirit, J., & Aldabarran. (2009). Fat Liberation Manifesto, November 1973. In E. Rothblum, & S. Solovay, *The Fat Studies Reader* (pp. 341-342). New York: NYU Press.
- Fritsch, J. (1999, May 25). *95% Regain Lost Weight. Or Do They?* Retrieved from The New York Times: <http://www.nytimes.com/1999/05/25/health/95-regain-lost-weight-or-do-they.html>
- Gadde, K. M. (2014). Current Pharmacotherapy for Obesity: Extrapolation of Clinical Trials Data to Practice. *Expert Opinions in Pharmacotherapy*, 809-822.
- Gaesser, G. (2009). Is "Permanent Weight Loss" An Oxymoron? The Statistics. In E. Rothblum, & S. Solovay, *The Fat Studies Reader* (pp. 37-40). New York: NYU Press.
- Giles-Corti, B., & Donovan, R. (2002). Socioeconomic status differences in recreational physical activity levels and real and perceived access to a supportive physical environment. *Preventive Medicine*, 601-611.
- Goldberg, D. S., Forde, K. A., Carbonari, D. M., Lewis, J. D., Leidl, K. B., Reddy, K. R., . . . Re, V. L. (2015). Population-representative Incidence of Drug-Induced Acute Liver Failure Based on an Analysis of an Integrated Healthcare System. *Gastroenterology*. doi:10.1053/j.gastro.2015.02.050

- Gomez, L. E. (2013). Introduction: Taking the Social Construction of Race Seriously in Health Disparities Research. In L. E. Gomez, & N. Lopez, *Mapping "Race": Critical Approaches to Health Disparities Research* (pp. 1-24). New Brunswick, NJ: Rutgers University Press.
- Goodbar, N. H., Foushee, J. A., Eagerton, D. H., Haynes, K. B., & Johnson, A. A. (2013). Effect of the Human Chorionic Gonadotropin Diet on Patient Outcomes. *The Annals of Pharmacotherapy*, e23.
- Green, B. B. (2014, August 11). *Research shows online care from dietitians helps control weight*. Retrieved from Group Health Research Institute: <https://www.grouphealthresearch.org/live-healthy/all-articles/live-healthy-2014/research-shows-online-care-dietitians-helps-control-weight/>
- Greenwald, M. J., & Boarnet, M. G. (2001). Built environment as determinant of walking behavior: analyzing nonwork pedestrian travel in Portland, Oregon. *Land Development and Public Involvement in Transportation: Planning and Administration*(1780), 33-42.
- Gudzune, K., Beach, M., Roter, D., & Cooper, L. (2013). Physicians Build Less Rapport with Obese Patients. *Obesity*, 2146-2152.
- Hamblin, J. (2014, June 18). *Senators to Dr. Oz: Stop Promising Weight-Loss Miracles*. Retrieved from The Atlantic: <http://www.theatlantic.com/health/archive/2014/06/magic-weight-loss-pills-may-not-exist/372958/>
- Harvard School of Public Health. (n.d.). *Economic Costs*. Retrieved 04 29, 2013, from Harvard School of Public Health: <http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/economic/>
- Hawley, K. L., Roberto, C. A., Bragg, M. A., Liu, P. J., Schwartz, M. B., & Brownell, K. D. (2012). The science on front-of-package food labels. *Public Health Nutrition*, 1-10.
- Hernandez-Boussard, T., Ahmed, S. M., & Morton, J. M. (2012). Obesity Disparities in Health Care: Findings From the National Ambulatory Care Survey, 2005-2007. *Obesity*, 1639-1644.
- Hill, J., & Peters, J. (1998). Environmental Contributions to the Obesity Epidemic. *Science*, 280, 1371-1374.
- Jackson, P. B., & Williams, D. R. (2006). The Intersection of Race, Gender, and SES: Health Paradoxes. In L. Mullings, & A. J. Schulz, *Gender, Race, Class, and Health: Intersectional Approaches* (pp. 131-162). San Francisco: Jossey-Bass.
- Jackson, S. E., Beeken, R. J., & Wardle, J. (2014). Perceived Weight Discrimination and Changes in Weight, Waist Circumference, and Weight Status. *Obesity*, 2485-2488.
- James, W. P. (2008). The Epidemiology of Obesity: The Size of The Problem. *Journal of Internal Medicine*, 336-352.

- Jones, C. P., Jones, C. Y., Perry, G. S., Barclay, G., & Jones, C. A. (2009). Addressing the Social Determinants of Children's Health: A Cliff Analogy. *Journal of Health Care for the Poor and Underserved*, 1-12.
- Kassirer, J. P., & Angell, M. (1998). Losing Weight - An Ill-Fated New Year's Resolution. *The New England Journal of Medicine*, 52-54.
- Komlos, J., & Brabec, M. (2010). The Trend of Mean BMI Values of US Adults, Birth Cohorts 1882-1986 Indicates That the Obesity Epidemic Began Earlier Than Hitherto Thought. *American Journal of Human Biology*, 631-638.
- Korowynk, C., Kolber, M. R., McCormack, J., Lam, V., Overbo, K., Cotton, C., . . . Allan, G. M. (2014). Televised medical talk shows - what they recommend and the evidence to support their recommendations: a prospective observational study. *British Medical Journal*. doi:10.1136/bmj.g7346
- Kumanyika, S., Brownson, R. C., & Cheadle, A. (2012). *The L.E.A.D. Framework: Using Tools From Evidence-Based Public Health to Address Evidence Needs for Obesity Prevention*. Atlanta, GA: Centers for Disease Control.
- Kushner, R. F. (2014). Weight Loss Strategies for the Treatment of Obesity. *Progress in Cardiovascular Diseases*, 465-472.
- Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). *The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy*. Washington, D.C.: US Department of Education.
- Link, B. G., & Phelan, J. (1995). Social Conditions as Fundamental Causes of Disease. *Journal of Health and Social Behavior*, 80-94.
- Little, D. P. (2014). Authentication of Gingko biloba herbal dietary supplements using DNA barcoding. *Genome*, 513-516.
- Liu, J., Bennett, K. J., Harun, N., & Probst, J. C. (2008). Urban-rural differences in overweight status and physical inactivity among US children aged 10-17 years. *Journal of Rural Health*, 407-415.
- Lopez, N. (2013). Contextualizing Lived Race-Gender and the Racialized-Gendered Social Determinants of Health. In L. E. Gomez, & N. Lopez, *Mapping "Race": Critical Approaches to Health Disparities Research* (pp. 179-211). New Jersey: Rutgers University Press.
- Lutfiyya, M. N., Lipsky, M. S., Wisdom-Behounek, J., & Inpanbutr-Martinkus, M. (2007). Is rural residency a risk factor for overweight and obesity for US children? *Obesity*, 2348-2356.
- Lyons, P. (2009). Prescription for Harm: Diet Industry Influence, Public Health Policy, and the Obesity Epidemic. In E. Rothblum, & S. Solovay, *The Fat Studies Reader* (pp. 75-87). New York: NYU Press.

- Marmot, M., Rose, G., & Shipley, M. (1984). Inequalities in Death - Specific Explanations of a General Pattern? *The Lancet*, 1003-1006.
- McGinnis, J. M., & Foege, W. H. (1993). Actual Causes of Death in the United States. *Journal of the American Medical Association*, 2207-2212.
- McGinnis, J. M., & Foege, W. H. (1998). Correspondence: The Obesity Problem. *The New England Journal of Medicine*, 1157.
- McLaren, L. (2007). Socioeconomic Status and Obesity. *Epidemiologic Reviews*, 29-48.
- Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science and Medicine*, 126-133.
- Mullings, L., & Schulz, A. J. (2006). Intersectionality and Health: An Introduction. In L. Mullings, & A. J. Schulz, *Gender, Race, Class, and Health: Intersectional Approaches* (pp. 3-17). San Francisco: Jossey-Bass.
- Must, A., & Evans, E. W. (2011). The Epidemiology of Obesity. In J. (. Cawley, *The Oxford Handbook of the Social Science of Obesity* (pp. 9-34). New York: Oxford University Press.
- Nakano-Glenn, E. (2002). *Unequal Freedom: How Race and Gender Shaped American Citizenship and Labor*. Cambridge, MA: Harvard University Press.
- National Expansion. (1899). *Journal of the American Medical Association*, 1108.
- Neel, J. V. (1992). Diabetes Mellitus: A "Thrifty" Genotype Rendered Detrimental by Progress? *American Journal of Human Genetics*, 353-362.
- Nelson, M. C., Gordon-Larsen, P., Song, Y., & Popkin, B. M. (2006). Built and social environments - associations with adolescent overweight and activity. *American Journal of Preventive Medicine*, 109-117.
- Nielsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (2004). *Health Literacy: A Prescription to End Confusion*. Washington, D.C.: National Academies Press.
- Office of Management and Budget. (2000, December). Federal Register. 65(249), 82236. Retrieved Nov 1, 2012, from [www.whitehouse.gov/sites/default/files/omb/fedreg/metroareas12270.pdf](http://www.whitehouse.gov/sites/default/files/omb/fedreg/metroareas12270.pdf)
- Parker, R. (2000). Health literacy: a challenge for American patients and their health care providers. *Health Promotion International*, 277-283.
- Pomeranz, J. L., & Puhl, R. M. (2013). New Developments in the Law for Obesity Discrimination Protection. *Obesity*, 469-471.
- Popkin, B. M. (2011). The Nutrition Transition and Obesity. In J. (. Cawley, *The Oxford Handbook of the Social Science of Obesity* (pp. 289-302). New York: Oxford University Press.

- Puhl, R. (2011). Bias, Stigma, and Discrimination. In J. Cawley, *The Oxford Handbook of the Social Science of Obesity* (pp. 553-571). New York, NY: Oxford University Press.
- Puhl, R. M., Leudicke, J., & Grilo, C. M. (2014). Obesity Bias in Training: Attitudes, Beliefs, and Observations Among Advanced Trainees in Professional Health Disciplines. *Obesity*, 1008-1015.
- Reid, T. J. (2013). Overcoming Challenges in The Management of Obesity: A Closer Look at Emerging Therapeutic Options. *Journal of Managed Care Medicine*, 37-43.
- Rissanen, A. M. (1996). The Economic and Psychosocial Consequences of Obesity. In C. Foundation, *The Origins and Consequences of Obesity* (pp. 194-201). West Sussex, England: John Wiley & Sons, Inc.
- Rothblum, E. D. (2011). Fat Studies. In J. (. Cawley, *The Oxford Handbook of the Social Science of Obesity* (pp. 173-183). New York: Oxford University Press.
- Sacks, F. M., Gray, G. A., Carey, V. J., Smith, S. R., Ryan, D. H., Anton, S. D., & al, e. (2009). Comparison of Weight-Loss Diets With Different Compositions of Fat, Protein, and Carbohydrates. *The New England Journal of Medicine*, 859-873.
- Saelens, B. E., Sallis, J. F., Frank, L. D., Couch, S. C., Zhou, C., & Colburn, T. (2012). Obesogenic neighborhood environments, child and parent obesity: The neighborhood impact on kids study. *American Journal of Preventive Medicine*, E57-E64.
- Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (2002). Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care. In T. A. Laviest, *Race, Ethnicity, and Health: A Public Health Reader* (pp. 626-643). San Francisco, CA: Jossey-Bass.
- Sallis, J., & Patrick, K. (1994). Physical Activity Guidelines for Adolescents: Consensus Statement. *Pediatric Exercise Science*, 6(4), 302-314.
- Sandercock, G., Angus, C., & Barton, J. (2010). Physical activity levels of children living in different built environments. *Preventive Medicine*, 193-198.
- Schwartz, B., Stewart, W., Godby, S., Pollack, J., DeWalle, J., Larsen, S., . . . Glass, T. (2011). Body Mass Index and the Built and Social Environments in Children and Adolescents Using Electronic Health Records. *American Journal of Preventive Medicine*, 41(4), e17-e28.
- Sen, A. (1999). The Possibility of Social Choice. *American Economic Review*, 349-378.
- Shaefer, H. L., & Edin, K. (2013). Rising Extreme Poverty in the United States and the response of Federal Means-Tested Transfer Programs. *Social Science Review*, 250-268.
- Sherwin, S. (1998). A Relational Approach to Autonomy in Health Care. In S. Sherwin, F. Baylis, M. Lock, M. Bell, W. Mitchinson, M. De Koninck, . . . B. Parish, *The Politics of Women's Health: Exploring Agency and Autonomy* (pp. 19-47). Philadelphia: Temple University Press.

- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, D. C.: National Academy Press.
- Song, H., Grutzmacher, S., & Kostenko, J. (2014). Personal weight status classification and health literacy among Supplemental Nutrition Assistance Program (SNAP) participants. *J Community Health*, 446-453.
- Stevens, J., Oakkar, E. E., Cui, Z., Cai, J., & Truesdale, K. P. (2015). US Adults Recommended for Weight Reduction by 1998 and 2013 Obesity Guidelines, NHANES 2007-2012. *Obesity*, 527-531.
- Strom, S. (2015, March 12). *A Cheese 'Product' Gains Kids' Nutrition Seal*. Retrieved from The New York Times: [http://well.blogs.nytimes.com/2015/03/12/a-cheese-product-wins-kids-nutrition-seal/?\\_r=0](http://well.blogs.nytimes.com/2015/03/12/a-cheese-product-wins-kids-nutrition-seal/?_r=0)
- Stunkard, A. J. (1996). Socioeconomic Status and Obesity. In C. Foundation, *The Origins and Consequences of Obesity* (pp. 174-182). West Sussex, England: John Wiley & Sons.
- Stunkard, A., & McLaren-Hume, M. (1959). The Results of Treatment for Obesity: A Review of the Literature and Report of a Series. *Archives of Internal Medicine*, 79-85.
- The American Association of Clinical Endocrinologists and the American College of Endocrinology. (2014). Advanced Framework for a New Diagnosis of Obesity as a Chronic Disease. *AACE/ACE Consensus Conference on Obesity*, (pp. 1-22). Washington, DC.
- Thompson, A. L., & Gordon-Larsen, P. (2011). The Anthropology of Obesity. In J. (. Cawley, *The Oxford Handbook of the Social Science of Obesity* (pp. 60-86). New York: Oxford University Press.
- Tsai, A. G., & Wadden, T. A. (2005). Systematic review: An Evaluation of Major Commercial Weight Loss Programs in the United States. *Ann Intern Med*, 56-66.
- United States Census Bureau. (2015, March 31). *State & County Quick Facts*. Retrieved April 23, 2015, from Tacoma (city), Washington: <http://quickfacts.census.gov/qfd/states/53/5370000.html>
- von Hippel, P. T., & Nahhas, R. (2013). Extending the History of Childhood Obesity in the United States: The Fels Longitudinal Study, Birth Years 1930-1993. *Obesity*, 2153-2156.
- Wadden, T. A., Butryn, M. L., Hong, P. S., & Tsai, A. G. (2014). Behavioral Treatment of Obesity in Patients Encountered in Primary Care Settings: A Systematic Review. *Journal of the American Medical Association*, 1779-1791.
- Wadden, T. A., Byrne, K. J., & Krauthamer-Ewing, S. (2006). Obesity: Management. In M. E. Shils, M. Shike, A. C. Ross, B. Caballero, & R. J. Cousins, *Modern Nutrition in Health and Disease* (pp. 1029-1042). Baltimore, MD: Lippincott Williams & Wilkins.
- Wann, M. (2009). Fat Studies: An Invitation to Revolution. In E. Rothblum, & S. Solovay, *The Fat Studies Reader* (pp. ix-xxv). New York: NYU Press.

- Weber, L. (2006). Reconstructing the Landscape of Health Disparities Research: Promoting Dialogue and Collaboration Between Feminist Intersectional and Biomedical Paradigms. In L. Mullings, & A. J. Schulz, *Gender, Race, Class, and Health: Intersectional Approaches* (pp. 21-59). San Francisco: Jossey-Bass.
- Wee, C. C., & Yanovski, S. Z. (2005). Improving the Health Care System. In K. D. Brownell, R. M. Puhl, M. B. Schwartz, & L. Rudd, *Weight Bias: Nature, Consequences, and Remedies* (pp. 234-247). New York, NY: Guilford Press.
- Woolf, S. H., & Aron, L. Y. (2013). The US Health Disadvantage Relative to Other High-Income Countries: Findings From a National Research Council/Institute of Medicine Report. *Journal of the American Medical Association*, E1-E2.
- Yen, I., & Kaplan, G. A. (1998). Poverty area residence and changes in physical activity level; evidence from the Alameda County Study. *American Journal of Public Health*, 88, 1709-1712.
- Young, I. M. (2011). *Responsibility for Justice*. New York, NY: Oxford University Press.

## APPENDIX A: ALLEN

### **Deciding to Lose Weight**

I felt like I needed to lose weight because of physical things, like tying my shoes. When you've got a big belly, it gets in your way. Stuff just gets in your way, right? Plus, you just look older and bloaty. I didn't feel right.

I actually gained that weight when I got married. Isn't that funny? Before that I was a normal-sized kid. I wasn't even husky, I was just normal. And then, for about probably 10 years or so I was kinda getting bigger, bigger, bigger. And then I was, like, 270 and I'm like, 'I'm not okay with this.' Plus my doctor would tell me I had high blood pressure-like tendencies, so I had to watch out for that. And the diabetes talk: They said if you get too big, sometimes that'll kick everything over and you're at more of a risk for diabetes if you're bigger. And I was big enough for the doctor to go, 'Hey you should start thinking about this'. So, I thought about it.

The thing that really kicked me over, it was funny: My wife was on Weight Watchers before me, and she made this awesome spaghetti dinner. I remember, I'm sitting there with this big bowl of spaghetti. She had a little teeny bowl. She was like, 'you know what? This sucks! I don't like doing this by myself.' And I was like, 'I'm kind of a fatty, and I should probably lose some weight, so maybe I'll do this with you'. So that was like my whole catalyst for joining Weight Watchers with her, was to support her. Because her goal is to lose weight as well, so we went into it like, together, which was cool. The support structure's huge, it's a big deal. That's why I do Weight Watchers, because it's a good forum.

## **Finding Support**

When I go to Weight Watchers, I go for a different reason [than my wife does]. I go to go with my wife. And, I step on the scale, and usually they're hard core, they're like 'Oh, you're up 3 lbs.' It doesn't matter to me now, because I know that I'm active enough that I stay ballpark where I wanna be. I feel good about that.

[Now] I'm a lifetime member [of Weight Watchers]. Basically you join and then you lose your weight, and then get down to the weight that either the BMI - Body Mass Index - or whatever says you're good at, or your doctor says you're good at. That's your healthy weight, and then if you sustain it for such amount of time, then you become a lifetime member, so that was what I did. It took me like 9 months to drop 80 lbs. I weighed 268lbs at my official weigh-in, and exactly 9 months later I was 185lbs. 185lbs proved to be too light for me, so my doctor actually told me, 'You'll be alright at 200, 205, something like that.' So I just kept it at 200. I think today I weighed 205: I'm considered obese. Because I'm 5' 9", 205, they say I should weigh 167lbs or something like that. There's no way. There's no way. I got down to 185lbs, my dad's a body builder -actually he's a power lifter - and he'd look at me and he'd say, 'You are gone, you need to gain some weight.' So, 200lbs seems to be okay. I'd like to go back down to 190.

My doctors are cool, like I've lucked out. When I was in there to get my ideal weight, my doctor was like 'See this chart? You're right here on the red'. And I'm like 'Oh'. She goes, 'But you're perfectly healthy' and she told me that my muscle mass and the way I'm built just puts me in the red, and there's nothing I can do about it. I think that doctors, they know. I don't think there should be anything negative when you go in and talk to them. I think they're usually supportive.

## Diet

I haven't tracked [food intake] for quite some time, because I know that now it's ingrained in me that I can't just go and eat, like, a couple of double cheeseburgers and some large fries and then a Coke, and then the next meal I'll have a big giant meal and stuff. It's ingrained in me to think to myself, 'Well, I can have those cheeseburgers and fries if I want, but I'm gonna sacrifice a little bit: I'm not gonna drink my coffee drink.' Generally I've been indoctrinated to like, eat a big meal in the morning if I know I'm gonna be active, and then at lunchtime, I won't eat so much: I don't need to. I eat as much as I need, like if I know I'm going on a 60-mile trail skate, I'm gonna eat something big, I'm gonna bring some protein and stuff. I eat what I need to fuel my machine.

It made sense after I was taught. In Weight Watchers, they taught us. What's the saying? You eat like a King or Queen in the morning, you eat like a Jester in the afternoon, like a beggar in the evening, or something, I don't know. But it makes sense because, like, in the morning-time, you need to be awake, you need to be aware. But then as you get into your afternoon-time, not such a big deal cause you're starting to wind down. Evening-time, you really don't need to be eating a big dinner: What are you gonna do after dinner? You're gonna go to bed in a couple hours. So it doesn't make sense, you go to bed with this huge mass of food in you, then you wake up and have breakfast.

You need to be active, and eat, and those have to be equal. I think it's about balance, yeah. It's about fueling myself. I guess it's listening to your body, too But I think it is about a balance thing. You have to find that balance.

I don't typically have a problem with [affording food], just because I eat what I want to. Healthier food is a lot more... I tend not to buy the granola stuff or whatever in the special

section at Fred Meyer. I just buy whatever I'm going to have and then I just moderate. I'll eat a lot of fat-free stuff. Fat-free Pringles – I love fat-free Pringles – and soups and stuff. I don't go for special stuff.

## **Accountability**

The best thing [about Weight Watchers] is you feel obligated, I think, to the other people that are there. It's kinda like that with the meetings. It's more than doing it by yourself, you know what I mean? Like people just download the little app thingy and they're like 'Yeah, I'm just gonna watch my weight now', and they don't tell anybody. And then if they fall off the wagon, they're like 'Oh well, whatever, nobody knows anyway, I'm okay with it'. Weight Watchers is more of a structured environment where it actually kind of pressures you a little bit to keep going. Which is a good pressure because it's healthy; it's a healthy thing you're trying to accomplish.

I think accountability is a very good thing. Accountability is very important, and even those people who are against it, they do it. Everybody does it. Everybody does it. Just like other things that everybody does and don't talk about. But they do it in different ways. Like, 'I'm going to stop speeding', and I just told you that. So I just told somebody that, instead of just thinking it. Everybody does that. I think what they are referring to also, is the little 5 year old in you that says, 'I do what I want. I'm an adult, you can't tell me what I need to do', you know? I turn into that guy, like when my boss says, 'You need to work overtime today'. I step back and I cross my arms and I stomp my feet and I say, 'You're not going to make me do it!' But any other day I'd say, 'Yeah, I'll work a couple hours' overtime; it's cool.'

## **Physical Activity**

I roller skate; that's my chosen mode of maintaining. In the 9 months that I lost weight, I didn't exercise. I didn't do anything, just watched my diet. I got bored one day, and I was cleaning out my garage and I found a pair of inline skates and I was like 'I haven't skated on these in years.' So I took 'em out to the trails and taught myself how to skate again, and then my wife discovered roller derby, and there you go. We started skating on quads. Now my wife has a whole different schedule because she's a derby girl. I've chosen to take mine outside.

I'm usually by myself; some derby girls like to come out with me. I'm kind of a novelty. So, it's funny, yeah it's weird, cause they like to skate inside, and inside is safe to them. Outside? Dangerous! Concrete is a cheese-grater. So, they come skating with me, and they seek me out in the summer time, but in the winter-time, I'm invisible. I'm ok with it because I've got these cool earbuds, like the Bluetooth earbuds, and I just listen to podcasts or books on tape or whatever, and I just go. I'm a creature of habit. I go to work in the morning, either at 3 o'clock or at 5 o'clock- usually 5 o'clock in the morning - and I get off at 1:30. Right after [that], I usually have my skates or my long board or whatever in my truck, and I go straight to a trail.

I do probably 20-25 miles a day 5 days a week, at least. Sometimes 7. And aside from that I do rink skating, just purely for the heck of it, I guess. For people-time, you know? And I long-board. I don't add that in to my mileage. Roller skating is my exercise, that's what I mark down to myself in my mind as 'exercise'. I skate mostly on trails. Sometimes I'll go to Alki in Seattle. I'll park my truck at Alki and then I'll cruise around and I'll go down in downtown Seattle on the viaduct, cruise around on my skates, just do whatever. I do roughly 2000+ miles a year on roller skates. So, I never feel guilty about these [gestures to his drink, laughs] I've been

about 200lbs for 3 and a half or 4 years now. Like it goes up; maybe 208, something like that,  
but I never freak out.

## APPENDIX B: ANNA

I was 190lbs in high school and have always been pudgy. I've always tried to lose weight, though binge dieting has never really been my thing. I've had times where I've spent a ton of time in the gym or really, really watched my diet. I'd lose a little bit of weight, but it was never for any significant amount of time. I've I never really successfully lost weight, but I've successfully gained it: My first year of college, I was miserable and I gained like 30 lbs. instead of the freshman 15. It never went away. Still, I've stayed that weight since college, so since then I've been the exact same weight. When I left college and came back here and started living a more reasonable lifestyle, I became happier with my situation and felt more in control. Then I went back to doing the things that I used to do, like I don't eat fast food, I don't like things with preservatives in them. I'm not gaining any more weight, but I'm not losing it either. I found out a long time ago that if I focused on doing things just because I want to lose weight, it just makes me really miserable. So now I just focus on being active because it makes me feel better, just in general. For me it's more about being strong than it is about being thin because I've made peace with the fact that thin will probably never be a reality.

### **Barriers to Staying Active**

It's kind of always been an issue in terms of time and money, because it seems like whenever I do have the time, I don't have the money. Everyone always says that it doesn't cost money to be active, but I don't necessarily agree with that because every activity costs some sort of money. Roller derby costs the money it takes to buy the equipment to do it. Going to the gym costs the money it takes to pay for the gym membership to get the clothes. Even just going hiking costs the money it takes to get hiking boots, and you have to buy park passes, too. For me

it's about staying active and being able to afford that lifestyle, when I have so many other things I should be spending that money on. And so you have to make those selections more carefully.

Most of the places I've lived I've never felt comfortable walking on the street. Every time I've lived anywhere, I would drive to a park and go walking or something like that. I've never really felt like it was a bright idea for me as a single woman to be wandering up and down the streets in any area I've lived in. Anywhere. When I lived here, as like a kid in high school, I would walk up and down the road and go to the library and back. But, it was never walking just to walk, I always had a destination I wanted to go, and people knew where I was going and where I would be and how long I would be gone. But now as an adult, I don't have that because it's just me, so it makes me nervous to go wander around the streets without anyone knowing where I am or if I didn't come home. So I don't do that anymore, for the same reason I don't like to go hiking alone.

The center issue of weight loss - at least for me - is just having the confidence that there's any point. For a really long time - and still today - I've struggled. I guess that's just who I am. I've made peace with that, but sometimes I feel that's almost a bad thing to have done, a dangerous thing to have done, because then it makes me feel like that's just who I am and it's not going to change. I feel like that sort of holds me back, because I've grown so accepting of the fact that I've always been heavy, that it makes it sort of feel like you go into a gym trying to lose weight and you already are defeated: What is going to be different this time?

People who are thin always have this image in their brain of what they used to look like. I have a lot of friends who've lost a lot of weight, and that's because they started out somewhere that they wanted to get back to. They had this goal in their head of, 'I want to be back to my weight in high school', or 'I want to get back to my weight before I got married and had a baby',

or whatever. They always have this ideal in their head of what they want to reach. But the problem with someone like me is that I've always been pudgy. It's hard to stay motivated to reach a goal that you don't know. There's no practical image in your brain. I can pull out as many models and gym figures as I want, but in terms of being able to picture myself reaching anywhere near that goal, it's not there. There's a sort of mental disconnect between what you wish you could be and actually being able to see yourself being that.

## **Stress**

I'm pretty good at getting healthy foods within a reasonable price range. It took me awhile but I figured that out. My problem is more time stress. Because I work full time and go to school full time, it's hard to find the time to go do anything active and even cook healthily - because that takes time, too. Healthy eating is a lot more time consuming than just grabbing whatever happens to be handy. And then that tends to stress me out which just makes me eat worse. When I get super stressed all I want to do is just sit and hide in the corner and eat. Either that, or I want to go work out. But the problem is that when I'm in school, I don't have the option of going and spending an hour at the gym because I have too much homework to get done. So it becomes this vicious cycle where I want to go work out because I'm super, super stressed, and working out helps me feel less stressed. But I can't leave my couch because I have piles and piles of homework all around me. And so the only thing I can do to make myself feel better is munch, and the next thing I know, I need to go to the gym because I've munched too much, but I can't go to the gym because I have too much homework, and it's just this gigantic crazy nightmare cycle. And, while finding cheap food's not stressful, when life things happen like my car breaking down and my alternator going out, I don't have any sort of cushion for that kind of thing because I don't

have any money. So when that kind of thing happens, the life stress, the financial stress that is caused by that, just tends to derail everything, because it's so stressful that I don't know how to respond to it without imploding a little bit. That, I'd say, is definitely a huge part of not being able to maintain the healthy lifestyle I really want to.

## **Healthy Eating**

I only eat things that are in season. 90% of the time things that are in season are cheaper because there's more of them. So if you get really attached to one type of fruit or want to have a vegetable and that the vegetable you eat or fruit you eat, you tend to have a lot harder time doing things economically, because those things get more expensive if they're not in season. So if you are trying to buy the same kind of apple every single day, you're not going to be able to get the cheapest price all the time, whereas if you are someone who will eat in season, 90% of the time your produce will be a lot cheaper. People always think that farmer's markets are more expensive, so they won't go there, but most farmer's markets, if it's something that's in the high season, they have more of it than they know what to do with anyway, so they price it really reasonably. It's almost always at least on-level with grocery store prices. I think that's one thing that people have a misperception of, is that if it's a farmer's market and it's fresh, it's going to be super expensive and I'm not going to be able to afford it. But if you shop smart, you find just as good a price at the farmer's market as a grocery store. And I always really try to stay away from anything that comes pre-packaged, anything that's already done for you. The steamer things, although they're really nice in terms of accessibility and getting things done quickly, they are almost always more expensive because they're charging you to do something that you could do yourself, so you're paying more up front for something that is not hard to do on your own. So in

terms of buying frozen vegetables and fruits and things I could just do myself, I tend to just not buy them. That usually helps, and then you know, I don't get the fun stuff. I can't afford the fun stuff, so I don't eat the expensive pork, I don't eat expensive steak: I stick with the boring foods like chicken and tuna.

I've never really had a discussion about healthy eating with a healthcare provider, but when I started seeing a personal trainer, she mentioned that I was flirting with the obesity line. She's the first person who's ever talked to me about weight in terms of how to control it and why it needs to be controlled. It was actually super helpful, because I've always eaten really healthfully, but she was the first person to ever point out to me that not only does the nutritional quality of what's in your food matter, but also how you eat it, and the importance of having equal amounts of protein and carbs. Although I've always felt that I eat really healthfully, the vast majority of what I ate was always really carb-heavy. I ate a lot of fruits and vegetables and stuff like that, but I was never really a protein eater. I'm still not really a protein eater. Her pointing out to me the importance of having those balances was really interesting to me because that's not something that I've ever had anyone mention to me before.

## **Choice**

Personally, I tend to think that someone should take responsibility for their own decisions, so I don't know that I would disagree that people are the way they are because of the choices that they've made. I made the choice that having quality of life and enjoying the foods that I want to enjoy and doing activities that I want to do as opposed to spending my entire life in a gym or spending my entire life working out is a choice that I made. The fact of the matter is, other things were more important to me. I decided that school was more important, and work was

more important, than working out. And those are choices that seem like 'no duh' choices. I mean, who is gonna say I'm gonna quit my job so I can spend all day at the gym and get thin'. Nobody, but it's still a choice. It's still a decision that you decided to make. Whereas people have sort of turned the idea of choice into a negative, like 'you're just choosing to not try', it's not really that, it's just that there are certain choices that you do need to make. There are priorities, and some priorities are higher than others, and for me, being thin was a priority that I was never willing to make my first priority. And as a result of that, I've never been super thin. But I don't think that's something people should be blamed for or ashamed of.

I accept myself as I am. But I also accept the fact that I shouldn't be content to let myself stay where I am. You should always be trying to improve yourself in every facet of your life. Being content with yourself doesn't mean letting yourself go. All being content with yourself means is that you are okay with where you are at now. You can make peace with that, but it shouldn't be okay for you to work towards being more unhealthy. Making yourself okay with your weight does not mean being okay with continuing to get more overweight, it just means that you don't hate yourself for who you are and what you are. I made peace with my weight a long time ago but I have never said it's okay for me to just give up, eat as much as I want, and never go outside, and become a hermit who's too big to leave their house, because I was so okay with my weight that I let myself be okay with my weight straight up to 700lbs. There needs to be that push towards being healthy.

I have a real hard time holding myself accountable to do the kinds of workouts I need to do, and eat the way I need to eat. That's where it comes down to, once again, my priorities and my choices. For me, holding myself accountable for going to the gym every day or eating super healthily every day conflicts with my need for homework time, and the time I spend at work, and

the amount of time I spend at school. Those things are conflicting with my schedule, but it's still up to me to decide what I let slide. That's still my choice, my decision, that's still me accountable for my behaviors. If I make the decision to put homework in front of working out, that's my choice. It's the right choice for me, but it's still my choice.

### **Self Confidence and Image**

I had a really hard time even accepting myself because I was overweight, and I was really unhappy with who I was. It made me really insecure all through high school and most of college and it took me a really long time to make peace with myself for being pudgy, so I definitely think that that is something that stemmed from the way that other people responded to me. It took me a really long time to come to terms with that and make peace with myself. So in terms of being judged differently for being fat, I feel like people who are fat 90% of the time judge themselves differently. If you can't even take yourself at face value and appreciate yourself for who you are, I feel like that is sort of where it needs to start.

I feel like that's an issue women struggle with in general: Women are constantly comparing themselves in every manner of their lives, and it takes a really long time for women to decide that they're ok the way that they are. Being fat is just another way that women can judge themselves. In my personal experience, it took me a long time to stop judging myself for being heavy, and looking at myself differently. If I can't even do that, how am I supposed to expect other people to not look at me differently? I'm not even necessarily sure, even to this day, if it's other people who are perceiving me differently for being heavy, or if it's me projecting that perception on them.

Most fat people I know - even myself - tend to either hate themselves for being overweight and see themselves as a failure because they're overweight, or they go the complete opposite direction, and think that 'I'm fat and fabulous' and there's something okay with being overweight. It took me a really long time to recognize that there's a middle ground in that. I don't have to embrace being heavy and be totally satisfied because I'm heavy, or hate myself for it. It took me a really long time to figure out that there is sort of this center area, where you can sort of make peace with who you are, but still not necessarily embrace it and give up on the idea of being healthy and being fit; just work on what you can control. I'm always going to be pudgy probably, but I should still try to at least do what I can.

With online dating and stuff like that, you can label yourself as 'active' and yet the second someone sees you in person and realizes you're not a size 4, they automatically assume that you lied. That's always something that's really bothered me, that it doesn't matter how active I am, just the fact that people see me and I'm not a size 5 - or, you know, 'smaller' - they automatically assume that I must have lied, that I'm not active, that I don't go outside. Because it's impossible in their mind for me to be physically active and still be heavy.

I always have to convince everybody that I hang out with that when I say I want to go out and do roller derby or I want to go out and go hiking, when I want to go do something physically active, that I actually want to. People always seem to think that the fact that I'm a size 16 means I can't possibly be as active as I say I am because there's no way I would be as heavy as I am if I was actually active. I spend most of my time having to like convince people that yes, I do hike. Yes, I want to go hiking. Yes, I do derby. Yes, I am active; I do go to the gym 5 days a week. Because the mental perception people have about people of my size is that I sit around on a couch all day and eat Cheetos. So I think that's where the problem is, is that society in general

seems to draw this direct correlation between 'thin' and 'healthy', and those two aren't necessarily the same thing.

## APPENDIX C: BARBARA

### Early Struggles with Weight

I think my weight issues come from a lack of knowledge. I made some unhealthy choices when I was younger. I was the only one in my family who was heavy, but we all ate the same meals. When I started trying to lose weight, I got lots of advice, but none of it was helpful. I didn't feel like I had effective tools or a support system. I tried Weight Watchers, diet pills, and crazy exercise routines, but I never got to where I wanted to be.

It was because there was something that I couldn't control. I tried so many things for so long; I put myself through so much, and it wasn't because I didn't want it and I wasn't trying hard enough, it was because something else was going on. I went to a doctor for 6 months, every month, and a nutritionist. I tried so hard: I mean, crazy diets, like literally not eating anything for a few days and drinking like these weird vinegar diets and, you know, laxatives. Anything, I would try anything. It just messes with you after a while.

My OBGYN suggested that I try gastric bypass, because he was worried that I might not be able to have children if I didn't lose weight. I was 298lbs when I had the surgery, and I had dropped to about 180lbs a year later when I got pregnant. After my son was born, I struggled to lose the baby weight, and so I was told to eat about 1,000 calories/day. Even though I was actually eating closer to 1200-1500 calories a day, I was also spending 2-3 hours a day in the gym, but I only lost about 15lbs after 6 months.

When my husband and I moved to California, I regained some weight. I also started having bad side stitches that got worse as I gained weight. When we moved to Michigan, a doctor gave me Adapex to help me lose weight, which helped for a while but then stopped working. By this time, I was taking so many medications I was having trouble keeping them all straight – my depression

medication made me feel very confused – and I woke up in the Emergency Room after an accidental overdose.

When we moved to Washington, I started doing research on bariatric surgeons and ended up at Puget Sound Bariatrics. Due to my side stitches, they did an endoscopy, which showed that I would eventually need to have a revision of my earlier surgery. They wouldn't do my surgery because my accidental overdose meant that I was labelled as a pain medication addict in my medical chart. Instead, I found a new surgeon who did my revision in April 2014. At the time of my surgery I was around 250lbs, and now I am around 170lbs. The revision took about 12 hours because of all the scar tissue – the cause of my side stitches – the surgeon had to remove. My new surgeons' office has a great support group, which has been helpful. I've had less difficulty adjusting to life after my surgery, even though my second surgery was malabsorptive and requires a complex nutrient intake plan. I take a multivitamin 4 times a day, calcium 5 times a day, and drink 5 or 6 protein shakes a day; I have to space these out throughout the day because my system can't absorb it all if I take in too much at any one time.

### **Adjusting to Life after Bariatric Surgery**

There are so many rules. The first thing I do in the morning is take vitamins. I drink a protein shake when I get to class, and have another one when class is over. I go home for lunch and more vitamins. I think about protein shakes and vitamins all day. You have to be prepared: I have protein shakes in my bag, the things I need when I'm not at home. The last thing I do at night is take more vitamins. I still have constant struggles – I get physically ill and experience dumping syndrome. I still struggle with emotional eating, and I have to remind myself that you eat to live, you don't live to eat. When I first decided to have bariatric surgery, I didn't

understand the impact of having a good support program. I was just focused on the pros and cons of the surgery, what I would gain and what I would lose with it, but I didn't really understand the scope of it. But, it's so important to have a system where everybody's knowledgeable. There are different aspects of the surgery, different types of surgeries. It's so important to have a surgeon who performs and understands all the different types of surgeries available.

Thanks to the surgeon that did my second surgery, I have the support group. If you have any nutritional questions, you can email them, and they send monthly newsletters with ideas. They have support groups and they have programs, like competitions or contests. They encourage you. You get to talk to people and they support each other, you have the same problems they do, and it's not so isolated. You feel more comfortable with yourself because you know you're part of – amongst other people who have the same situation. So you get some advice, some perspective. You get perspective on yourself and understand things a little bit better. I really need the bariatric support group for reassurance, and counseling helps, too. I think that it's also really important to have goals in life and take small steps toward achieving them. Don't be afraid to try new things.

I used to be really big, but people who know me now don't see that. Am I supposed to act differently now? I constantly question my self-image and self-concept: Having weight loss surgery is like reinventing yourself. It's like you're a whole new person. It's very interesting, you can literally become this new person. People have their own ideas of how overweight people are: They're funny, they're loud, or they're really nice. They're not strong and stand up for themselves, and powerful. They're either really loud and rude, or they're really sweet and passive. I don't see a lot of just regular overweight people. It's because I think they feel like they have to make up for something they think they lack. It's like creating your own persona, a way

for society to accept who you are. So once you've gotten rid of that physical crutch, then what do you do? How do you socialize with people? Am I still the funny one or am I just a regular person? What does regular mean, like an average person? What's my role in society now that I'm no longer this obese person?' You do a lot of self-reflection and sometimes it's hard to see who you really are. You need people to help you.

### **The Importance of Community**

My husband is from Turkey, and they would go to the farmer's market every weekend and get their fruit and pick it out. His mother taught him that. In Turkey, they live in communities. You have neighbors and relatives everywhere, so you just walk to their house to go visit. You have other people around you, and they can give advice or they can give the support that you need, but here, you're more isolated. There's not really people around you a lot, especially if you don't know the people who live in your neighborhood or your complex to kind of give you that support. And you don't really go to people's houses anymore, you meet somewhere. It isn't personal anymore.

Some families move here to the United States, and then their children become overweight. They're still feeding them what they grew up with, but it's a different culture here. You don't walk everywhere like you do in Turkey; it's different here. But parents still say, 'this is what I grew up with. This is the type of food that I grew up with, and it's healthy, so this is what I'm going to feed my children.' There has to be some education there, explaining this isn't the same as when you were growing up. They say American diets make you fat, but they're doing the same diet, and their children are becoming fat too. Or they themselves are becoming fat.

Since they're learning how to acculturate themselves here, they're not really teaching their children healthy lifestyles, they're just kind of winging it. And now their child is overweight.

The thing with that is, in the different cultures, it's also more involved. You're not going to the store and you're not buying all these different things for a holiday. Normally, you do it at home and it's a group effort. But here you can just buy everything and do everything, just throw it in the microwave. There's no effort involved, and that's the problem. It's so easy access now, our culture is really lazy. We're obsessed with fast and easy, quick. If you have to make your own pizza, you're not going to want that damn pizza. If you have to make your own dough, make it rise, roll it out, shred the cheese, cut the vegetables. Yeah, you can get a can of tomato sauce, but... You're not gonna want that pizza, cause it's gonna be like 4 hours later! And, that's what I'm saying, like if people had to put in the effort for it, they wouldn't want it. The mentality of instant gratification in our culture is a huge problem.

## **Parenting**

Now that I'm a parent, I want to make sure that my son learns good habits. It can be expensive, but we make sacrifices. Growing up, I ate whatever my mom gave me: I didn't have a choice. I grew up in a small town with a big family, so the food had to be budgeted carefully and we worried more about getting enough food than we did about making sure that food was healthy. I don't want my son to have the habits that I grew up with, so we don't drink soda at home – but it's the first thing he grabs at social functions. He really likes junk food, so I tell him that these have chemicals that tell him it tastes good, but it's not food. It's junk food. I don't want to deprive him, so I do what I can. Now, I think about what's in school lunches. They make the menus available in advance, so I make similar food for my son to bring to school, with whole

grains, fruits, vegetables, proteins, water, and whole milk: All-natural ingredients with no sweeteners.

When I take my son to the doctor, they usually want to talk about weight, but the conversation usually starts with a recommendation to drink less soda or cut back on junk food. We don't give him either of those things. It's insulting: Ask me what we eat, don't assume that we're unhealthy. I think that doctors need to spend a little bit more time evaluating the food situation, and maybe make referrals to nutritional services, government agencies, or additional education. If a child is not healthy because the child's obese, it's not the child's fault. We need to look at the issue, what's going on. So let's figure out how we can make this better or who you can talk to. The doctor should have some really reliable resources, some practical resources. Identify with the patient, figure out what their goals are, and show them you genuinely care.

I firmly believe in leading by example and showing children what is good to eat, even though you may not like it very well. Things are sometimes acquired, like Brussels sprouts. They smell like crap when you bake them in the oven, but they're really good if you put some lemon juice and olive oil on them. You have to really experiment with foods. It's an effort. It's not easy. You can always get a frozen dinner at the store, but how is that teaching your child how to make healthy choices, and why we make healthy choices? It's important. You have to establish these habits, and I just hope that my son continues with them, because I didn't have that when I was growing up. I didn't have the option [of eating healthy foods]; it wasn't important when I was growing up.

Where I grew up in Indiana, it was hard to be physically active because it was too hot in the summer and too cold in the winter. Here in Washington, there are lots of options for being active. My husband tries to run every morning. He's active. My son sees that, and I love it

because he knows that his dad is running. We definitely need to be more mobile as a population. Get moving, it makes a big difference. You feel so much better, your endorphins are going. It makes you feel better. You don't understand how encouraging it is to see people running down the street or riding a bike. If you have like a YMCA or something you can walk to, a Boys and Girls club, some type of place you can go closer, that's affordable, absolutely do it. We have a workout center here in our apartment complex - it's kinda old, but it's an option!

## APPENDIX D: CAROLE

### **Growing Up with Weight Issues**

I was never a chubby person, but I was never skinny either. I kid that in my father's family, they're all built like lumberjacks, and I took after my father's family. I'm the oldest of two daughters; my sister is the skinny one, which still annoys me to this day. I mean, she's over 50 and she's finally put on a little weight, so now she just looks the thin side of normal, as opposed to, you know, stick thin. There was a guy that I had this crush on in high school, who told me once I had legs like logs. Unfortunately, this was very true. My grandmother, who was very thin and tiny, still had legs that looked like logs. It's a family failing, what can I say? I was 16 when I got the comment about my legs. I'm 58 now and I still remember it. So, it was very memorable. I was pretty devastated at that moment, but I've seen recent pictures of him on Facebook, and he makes me look thin now.

The first time in my life that I gained weight quickly was when I went off to college at 17. I gained almost 10 lbs. in, I don't know, six months. It was pretty fast. But I think that's because my mother wasn't watching over what I ate anymore. Then I had two kids; my youngest was born when I was 25 and I gained a heck of a lot of weight with him. I think I gained almost 50 lbs. when I was pregnant with him. But by the time he was 3, I had lost it all, and I weighed less at that point - I was 28 years old - than I had at any time since I reached my full height.

Of course, I was also doing aerobics six days a week and running and everything. I see pictures of myself and I just think, "My gosh! You had leg muscles!" I mean, as in leg definition! I have a picture - it's still hanging up on my wall - of my youngest and I at the beach. I was wearing shorts and I had leg definition. It was like, "Oh my gosh, this is my favorite picture of all time!" Otherwise I had the curly perm from the 80's going: The rest of the picture is horrible.

But those legs... yeah! I actually got into a pair of size 7 pants during that time. Which for someone who is my size, that's pretty darn impressive, because I'm 5' 8" and I don't have little bones. So, yes, it was very impressive. I kept them for a long time, even after I couldn't get in them anymore just because I was so impressed that I actually, at one point in my life, could.

Since then, I think my weight has gone up and down, and up and down, and up and down. It hasn't been huge amounts, umm, but it has gone up and down. But I've always been pretty active, I've always exercised. I've always done something. I taught yoga for about 4 years, and I was really, really faithful with it, until I went to graduate school. Let's put it this way: I weigh 45 lbs. more now than I did the day I started back to college almost 6 years ago. Sedentary life does not bode well for your weight, and it's impossible to be a good student without being pretty sedentary.

### **Cooking and Nutrition**

My mom taught me healthy eating habits. In a very odd sort of way, because for as long as I can remember, my mom always worked at least part-time. I also grew up in the 60's, and instant food was a new thing. For some reason, my mom thought she was a good cook, but if it didn't come from a box, she didn't really make it. When I think about food growing up, everything was square. So, there were boxes, there were - I don't even know if they still make this, but you'd go to the grocery store to buy frozen vegetables, and they came in little boxes, like little freezer boxes wrapped in wax paper. I'm sure they don't do that anymore! We always had like 2 vegetables at every meal; she was very good about balancing things. But, still, everything came out of a box. To the day she died, she still did most of her cooking out of boxes. Although we had moved from the frozen boxes of vegetables to the bags in the freezer. Now, I have no

problems with frozen vegetables; if you aren't going to have them fresh, it's the best way to eat them. I never ate a canned vegetable until I married my husband, who would only eat canned green beans and canned corn. That was it as far as vegetables.

I like to cook, I really do enjoy cooking. Now I pretty much cook on the weekends and then we eat leftovers during the week. That works. We don't eat a lot of processed food, so I don't have a lot of boxes in my cupboard. We really don't have any problem with affording healthy food, but most of what I cook is from scratch, so it's cheaper. I mean, when you're buying big boxes of spaghetti or lasagna and making your own, as opposed to buying frozen lasagna and pizzas; those things aren't cheap.

I did a lot of reading on how to balance your diet without meat. I was vegan for a year, and that took even more reading, because you have to be really careful, not just about protein, but then you're looking at calcium, and you know, other things that you're missing, by not, you know. I developed this weird pain in my arm that I couldn't figure out. No one could figure out what the deal was. And for some reason, I read this article about, umm, when you have low blood calcium, that it can cause muscle pain, and so I thought, just as an experiment, I added cheese back into my diet for a week. And within a week it was gone and it never came back. So I gave up being vegan. Besides, I really did miss cheese!

A couple weeks ago, I made this huge thing of chili, and just put it in the fridge: We ate it all week. It works for me because honestly, I don't care what I eat. As long as I don't dislike it, I'm happy. I could seriously eat chili five days a week and be perfectly happy with it. My husband can't do that, and so sometimes we'll get to Thursday, and he'll just say, "I can't face it again." He'll either come up with something else or he'll text me on my way home and say, "I'm

making oatmeal, do you want some?" Depending on how tired I am, I will either say, "Sure that's fine," or, "No, I'll finish the chili."

### **Physical Activity**

I walk outside when the weather's nice. I'm a real baby about the weather. I don't like to go outside in the cold. So, pretty much I walk in the summer. I do have a treadmill, and I am on it every morning by 5:45. I aim at 5:30, but by 5:45, so I do at least 40 minutes. I have to be in the shower by 6:30 or I don't make it out the door. So if I want breakfast... I aim at 45 minutes, but it all depends on when I actually get on the treadmill, whether I actually get the 45 or not. And then when it's not raining here, I walk at noon for 20-25 minutes.

Safety isn't really a concern for me: I have in the past walked at night. I have walked early in the morning. I'm just a real baby. I mean, there have been times where I haven't felt really comfortable, but I think that comes more from my upbringing than it does my environment. I've never felt unsafe - my mother is one of those panicked people, "You can't go outside, there are people out there!"

### **Pressure to Lose Weight**

I'm not happy with where I'm at; if I weighed 40 lbs. less I'd be a heck of a lot happier. But I don't feel pressure. I mean, the only pressure I feel is when I go clothes shopping and I look at the size I have to wear. That bugs me. But I don't feel pressure from anybody. Although occasionally my husband will buy ice cream and he'll kid me: He says "I'm gonna eat this after you go to bed, because I don't want to tempt you." Ice cream is not really a big pull for me, but after he says that, it's like, "Well, that's fine; you eat it after I go to bed. I'm just gonna go have

some right now.” My husband and I are like night and day in lots of things, like our family backgrounds. My father’s side of the family is all built like lumberjacks, but my husband’s family are all slighter people. So my husband may be 6' 1", but my bones are bigger than his. And he's definitely on the thinner side than I am.

When you struggle with your weight, you do kinda feel a bit like a target sometimes. You know, it's like when you are sitting anywhere, and you are eating dessert, and you know, somebody, some skinny little person next to you is just going, “Oh, I can't eat that much, it's just too rich!” It's like, “Oh, just shut up! You want it, or you don't want it!” But really, does it make you a better person because you won't eat it? Why don't you just say “No, thank you”? Why do we have to hear the nonsense? I imagine a lot of people get hit with that kind of stuff, but there’s something that come with age, that suddenly, you're not willing to put up with people's nonsense anymore. And so, it's like, “This is my life, and this is my decision, and that's it.”

### **Discussing Weight Loss with Healthcare Providers**

I just went in 2-3 weeks ago for my annual checkup with my gynecologist and she and I talked about it a little bit. I appreciate her because she’s close to my age and we've known each other for 20 or 25 years probably. We chatted about weight loss and how difficult it is, when you hit my age, to lose weight, but it was more commiserating than anything else.

She asked if I exercised, and I told her I did. She asked if I was still a vegetarian, and I told her I was, and I said I've tried cutting down on carbs, I've tried raising protein. It works, to a certain extent - I did lose almost 9 lbs. last fall. I cut out bread and cereals and things like that. And then I went to Canada, where they have the most amazing scones! I fell totally off the

wagon and have not been able to get myself back on it since! Those 9lbs. are back. Thankfully they didn't bring friends! Actually, I think I only gained back 7 of them.

We talked more about how, basically by the time you hit my age, what you eat becomes much more important, because using exercise to get it off, which always worked for me in the past, doesn't really work as well anymore. And then we also commiserated about the mess that your metabolism becomes after menopause.

I had a male obstetrician, but after he had delivered my kids, I just decided that I was done with male doctors. While pregnant with my second child, I went in for one of my checkups, and I had gained 10 lbs. in that month. I remember the doctor and the nurse were in the room, and the nurse said to the doctor, something along the lines of “That's a lot of weight awfully fast, should we look for twins?” The doctor looks right at me and says, “Nah, she's just eating too much cheesecake.” And, although I did have a fixation on cheesecake when I was pregnant, I remember I was so embarrassed. I thought, “Are you kidding? I've been throwing up every day for months; I can finally keep something in my stomach again, and you're telling me I'm eating too much cheesecake?” So of course, on the way home I did stop and get a piece. I was 24 years old, and here's this man who delivered my first child. I really liked him; he was a very nice man. But I just remember being so humiliated. Now if someone were to say something like that to me, I'd just look them in the eye and say something like, “And you're so perfect?” or “Who do you think you are?” But I was young and I wouldn't have said those things. I just remember being really embarrassed by it.

## **Health Literacy and Education**

It's not necessarily that because you have more education you're smarter than the average person: It's the fact that you have that education sort of tells you something about the person. Because you don't get it without a certain level of curiosity, you know, the willingness to work hard. I'm an information junkie. So, if there's anything that I want to know about, I don't quit until I know everything I can possibly know about it. Or at least, to the point where I feel like I know enough that I'm satisfied.

I've always been this way, well before I had a Master's or even a Bachelor's degree. But, I was raised in a house where education was very important. My mom got her Master's when she was 64. As long as I can remember, not only was she working, but she was always going to school. So finally, well, she started working full-time as a teacher when I was in 7th grade. But even then, she was taking classes, she was doing things - my mom was a big reader, too, so that comes from my background. I mean, the very fact that I finally went back to school and finished my Bachelor's and my Master's is really just sort of the end result of the fact that I've been like this all my life. And I've been like this all my life because of the way I was raised.

My husband and I sort of fell into becoming vegetarians, which sounds funny. We didn't just get up one day and say, "Well, that's it, we're not eating meat anymore." We've been slowly cutting it out of our diet for I don't even know how many years. So I was learning what could take its place, and then we went on vacation. That vacation is sort of the tale of two steaks. At the beginning of the vacation, I had this fabulous steak. I mean it was the best steak I've ever eaten in my life. A week later, we went back to the same restaurant, and I had the worst steak I've ever had in my life. There wasn't anything wrong with it; it's not like it had gone bad, it was just awful. Three months later, we kinda looked at each other and said, "You know? We haven't

eaten any meat since that steak.” We just never wanted it: I was giving chickens away to my daughter-in-law because I was afraid they were going to go bad sitting in the freezer. My husband still refuses to call himself a vegetarian; neither one of us has eaten meat in 8 years. He just doesn’t eat meat. And he’s pretty darn close to a vegan, too; he’ll eat cheese occasionally, but that’s it. He won’t eat eggs or anything. But he won’t call himself a vegan, either.

I have a friend who I’ve known for 30 years. She’s been heavy all her life - not hugely obese, but definitely heavy. About three years ago, roughly, she got involved in this multiple-level marketing thing. They sell this product called Zing. It’s a series of products, and I think the company is called Zingular. She’s lost about 45 lbs. and she’s kept it off for about a year and a half or so. She’s very involved in selling this stuff. About two years ago, I was feeling really disgusted with my weight, so I called her up and said, “So, I want you to come and tell me about what you’ve done. I want to hear about it.” I was getting bombarded with it on Facebook anyway; I figured I might as well learn about it.

She came and met with me, and we talked about it. She gave me all this information, and she also gave me free samples. I tried the product, which made me lightheaded. I’m glad it worked for her, and I’m glad she took the weight off, but this is not how you wanna lose weight and be healthy. Basically it was a 500 calorie a day diet where you also had ‘eat days’ where you had protein, but you’re only looking at adding maybe another 300 calories of protein. So any way you look at it, even if you’re cheating and eating the upper end of everything, you’re looking at probably no more than 1,000 calories. She called me after a week, and she said, “Well, did you try it?” and I said, “Actually I did.” And she said, “Well, how did it go?” because you’re supposed to lose like up to 8 lbs. the first 5 days and all this nonsense. And I said, “Well, I did lose 3 lbs.” She said, “That’s great!” and I said, “No, I quit on the third day, because I was

nauseated and lightheaded.” And she said, “Well, yeah, that happens sometimes; you just have to work through it.” And I said, “I have a life, and I can’t do this.”

She was great about it. I saw her at Christmas, and of course she's still skinny and I'm still heavy. But I can't see the point - no matter how much I'd like to lose the weight, I can't see the point in ruining my health to do it. I would rather be healthy and heavy, than skinny and unhealthy. I don't care how short-term you're looking at, this was not a good thing. And then eventually you have to stop doing it. You can't do it for very long, and I couldn't see how this could work. I could see where someone could make a great deal of money off of it. And then, if you could convince everyone you know to go along with it and buy the stuff from you, then you can make a great deal of money, too. But I just couldn't see it being a long-term good thing.

## APPENDIX E: JOY

### **Experiencing the way that social status impacts health**

When I was married, my husband was in the Army and I had Tricare. There's more of an emphasis in the military on fitness - I think even for the spouses and families - and it's a better level of medical care. In all the years I was married, I never weighed over 145, and when I weighed 145, I was mortified. After I got divorced, I just slowly gained weight. I went from, 140 at the time that my husband and I divorced, and now I literally struggle to stay under 200. When I was married, I was healthier, I had better healthcare, and I *knew* I had healthcare; if there was ever a problem, I would have a way to take care of it. Once we were divorced, I lost my healthcare and there was a period of time where I didn't have any healthcare. I couldn't eat the same because when you don't have money, it's a lot easier to buy a box of macaroni and cheese than it is to get a roast to cook in your oven.

I didn't eat the same, my stress level was higher, and I struggle now just to stay under 200 lbs. I've had intermittent healthcare, and my first [surgical] experience was pretty decent. They treated me well, almost like they didn't know I was a Medicaid patient. I didn't feel like I lacked any dignity at all. Recently, I had my gallbladder removed. I'm on Medicaid, and before my surgery, I never saw the surgeon. He did not come to see me until 24 hours after the surgery. The nurses kept saying, "We're gonna try and get him in here, we're gonna try and get him in here, but they finally had to do the anesthesia. I never saw him until 24 hours after the surgery was done. But during my first surgery [for endometriosis], I saw the surgeon before. He was there before I saw anesthesia, and he was there before I actually went under. So, I don't know if that has anything to with my status as a patient, but I definitely got the feeling that the [second] surgeon didn't care as much. My first surgery was done laparoscopically and you couldn't even

see anything on my belly button. It was done really, really well. This surgery, the guy totally massacred my belly button. It's just – the incision is bigger than my belly button and my belly button is all sunken in now. It's just like it was dug out or something. It was a different experience. When I had the gallstones, they said, "it's the 3 F's – forty, fat, and female". I'm extremely thankful for Obamacare, because without it I'd be completely screwed. I make less than \$800 a month. When I had to have my surgery, I was out for that entire month. From September to halfway through October I made \$110 because of my surgery. That's the other thing that sucks when it comes to poor people and surgery. My doctor got so mad at me when he found out I went back to work a week and a half after surgery!

I never had any health issues prior to getting divorced. I never had a hospital stay other than giving birth to my two children. My two births were completely normal. I never had one single solitary health issue that caused me to be hospitalized. Nothing. No surgeries, nothing. And then afterwards – and I really believe it has a lot to do with the stress of poverty – I have had 2 surgeries and 5 hospitalizations in a 7 year period. I've had several pulmonary embolisms, unexplained illnesses that caused me to be hospitalized because I was just that sick, and surgeries for gallstones and endometriosis. I have Factor V Leiden, which is a genetic blood clotting disorder, which means I've had it my whole life. But not through any of my pregnancies or anything was it ever detected. I never had a problem with it. So, I believe that it's also stress that brought that to manifestation. I really do believe that.

In my family – and my whole entire family is poor – I'm actually the thinnest. I have one sister, my oldest sister, she's got Type 2 Diabetes Mellitus, and high blood pressure; she's seriously overweight. My other three sisters are overweight. I'm the thinnest one, and I don't think of myself as thin. Anyway, I believe it has to do with poverty – we were always poor. For

example, the people my daughter lives with are wealthy, and they do all their grocery shopping at Metro Market. They buy all organic, everything. They don't buy anything that has preservatives or anything fake. But I've gone to Metro Market. I could never shop there, ever. I could never shop there. And so, living with them, my daughter just looks healthier and seems healthier. She just looks better: Her skin is clearer. Her skin is cleared up and she just looks brighter, healthier. She's lost like 10 pounds since she went to live with them. The family she lives with cooks all the meals from scratch. They don't do fast food. I certainly would never see a box of Kraft macaroni and cheese in their house. I mean, she buys all the stuff fresh and makes everything from scratch.

### **Parental Responsibilities and Poverty**

When I was married and I had the privilege of being a homemaker, of course I cooked. All the time. But if a mom has to go to work – and if you're poor, the mom works, even in two parent households – you don't have the time. Even if you did have the time, you might not have the inclination because you're so tired. Which is what my life was like, once I became a single parent and had to work, and I was going to school. You don't have the same kind of time to cook. And, you're the only one there, so who else is going to do it?

When I was married, we always sat down to the dinner table at night, every night, all four of us, and had dinner as a family. When I was working and going to school and my daughter was working and going to school, and my son was involved with school, that never happened. For a while, while my kids were both still young, we got SNAP – the food benefits. But, I had two teenagers and myself and they gave us \$190 a month. That was supposed to feed us for a month!

Also, when I was married, and was financially secure, we also did all kinds of outdoor activities as a family, because we could afford to and we had the time. I mean, we were *always* outside playing with our kids. We'd organize dodgeball, kickball, baseball, everything in the whole neighborhood. And we always went for walks after dinner. But, you know, when you're just struggling to get by and you have to work jobs that are manual labor, you just don't have the same energy level. You get tired out. I suppose that also has to do with how you eat, because you're not going to get the same kind of energy from boxed food and stuff than you do from stuff that's prepared. You just don't get the same nutrients.

One thing that always frustrates me is the commercials on TV about starving children. When we were at our worst, I would not eat so my kids could eat. One time I went to school – I was going to Pierce College at the time – and I probably hadn't eaten anything substantial for a couple days because I wanted my kids to be able to eat. I got faint in class, and I went to see the nurse/counselor and I told her I hadn't eaten because I couldn't afford to eat. She gave me a biscuit, like a Starbucks biscuit or something, in a wrapper. Best thing I ever ate, though! There was a program where you could get a \$10 coupon for the dollar store, and I went and got noodles and stuff. You can't do much with \$10 but it was better than nothing, and it was nice that they gave it to me.

We like to blame the poor: It's their own fault they're there. And that's really frustrating for me because I know that's the way that society sees me, because I'm a divorced mother. But I don't see it as my fault that I ended up where I ended up. I was a homemaker for 15 years, and I believed in the security of my marriage and everything. I didn't know that things were going to go the way they went. I found myself in this position, and it was tough. There were a lot of

nights when, literally my kids would have buttered noodles for dinner, because that was all I could get. Buttered noodles aren't very healthy, but they're cheap.

I went one time to a church where they were having a food bank, to get a little bit of food. I did that one time. It was so humiliating! I was so angry when I was there. My mom basically talked me into going because she wanted to see me get some food for me and my kids. I was very angry that I was there, at my ex-husband and his new wife. I felt like there was no reason I should be there. I listened to the people talking in line, and there were a lot of recovering addicts, there were children, and there were homeless people. The stuff that they give you is bags of flour, day-old donuts, expired bread, stuff like that. Things that you could tell were from a bakery but had expired a while ago. But you're just happy to get whatever. The flour wasn't even in flour bags, it was in like plastics bags and tied up because they had to divvy it out. It was kinda strange. But, I made biscuits out of that flour.

When I think about people I know, it's really true that the more educated people are, the more likely they are to be healthy and have healthier habits. I don't know why that's true, but it really is true. And it's really sad because people who are overweight just get harassed. Like one time, my mom – who was overweight – was waiting for a bus, and some teenagers in a car came by and threw a Big Mac at her. It went all down her shirt and they called her names and stuff, and my sisters all get called names. The sister I live with now was at K-mart one day. As she was walking past a couple, and right where she could hear it – because she was right there – the guy said, 'if you ever look like that I'll leave you', and pointed at my sister. It all goes back to, if you don't feel good about yourself, what kind of motivation are you going to have to take care of yourself?

## **Barriers to “Eat Better and Exercise”**

What keeps me from eating better and exercising is that I eat what’s there, I eat what’s convenient. And convenience food is never good. But that’s what I eat, because I don’t have my own place, and I live with my sister. I eat what she eats, and she doesn’t have the best eating habits, by any degree. I still walk and everything, but my job is pretty physically demanding, so I don’t always feel like walking as much as I used to, because my job is basically manual labor. But it’s not sustained cardio – It doesn’t really help me lose weight. And my job is stressful: Stress adds weight, it doesn’t help you take it off. It’s mostly convenience eating. If I had my own home, and I had a sufficient amount of money, I would fill my fridge with things like yogurt, bran cereals, even shredded wheat. But I don’t have that option right now. A lot of time when people are poor they don’t have that option, just like when I get these \$10 gift cards at the dollar store. They don’t have shredded wheat, and if they did, I’d have to take half that \$10 to get that shredded wheat. At the dollar store I can get 10 bags of noodles with the same gift card. When you don’t have money for food, and you have kids, you’re just thinking about how to fill their bellies and keep them comfortable. You’re more concerned with that than nutrition. Even though I would rather see them get the right nutrition, you don’t want them to be hungry, and sometimes cheap stuff is cheap for your body, too.

Two years into working as a nanny, my daughter’s employer started to teach her how to cook. My daughter was buying all this organic stuff and cooking it at home. But I remember it cost a fortune. It cost her half her babysitting paycheck to make a couple meals. It was nice that she was doing it, but it was expensive. Even if you just want to get spices – good ones. I went with my daughter to Metro Market and I remember when we were going through the line they

had this tiny little box of caramels. This thing was about the size of a 6-inch ruler, and it was \$12. I picked it up and I was like, “Oh, I want some caramels. Oh, I don’t want some caramels!”

## **Choice**

I would never choose to be overweight. I chose to eat chips, and to eat what I ate. But a lot of times – not with the chips – but with the other things, I really didn’t have a choice. It was either eat some crap out of a box or go hungry.

Maybe I shouldn’t even say that it’s not choice: I want to say that because of me. But when I look at the sister I live with and the way she eats... But she certainly doesn’t have the means to cook like my daughter’s employer cooks, for example. I feel like it’s not a choice, for me. And, I think it’s illustrated by the fact that before I got divorced, and I was middle income, I was always thin and healthy. And then after I got divorced and I was poor, and I had to make not-so-great choices at the grocery store, I gained 60 lbs.

I choose to eat potato chips. I could’ve said no. But I don’t know, there’s something about convenience food, I guess. When you’re always taxed out, you just go for what’s convenient. And usually what’s convenient isn’t what’s good. You’re not necessarily willfully being a slob, you’re just going for what’s easy. Because everything else is hard. I don’t know that it’s a choice that I freely made so much as a choice I had to make.

I’m fortunate to live where I do, but I bet that if I lived in the east end or south Tacoma or something it might be different. That’s one thing my sister and I talked about too: joining a gym. They’re expensive! There are tracks at places like the Y MCA, but you have to have money for that! I know the Y does offer financial aid and things, but sometimes even just \$10 is too much; it would be too much in my case. Maybe there needs to be something more accessible for people

who have no money instead of there being an assumption that ‘you can pay something’, because a lot of people can pay nothing. And here, it can be tough to walk outside in the rainy season.

But, because I don’t have money to join a gym or anything – I walk, even if it’s raining.

### **Fixing the Problem**

I think it’s like a catch 22, because the poorer you are, the more stressed out you are, the worse you eat. It’s like a cycle, like a never-ending cycle. So I think – in my opinion – the highest priority should be to find a way to relieve your stress level. Once you can relieve your stress level, your mind is clearer for making better choices. It’s hard to make good choices when you’re always stressed out. If you come home, and you have some crappy minimum-wage job, and you’re tired out, you can either cook something, or grab some chips and some nacho cheese, you’re probably gonna grab the nacho cheese because you’re stressed out and tired. But if you can somehow figure out a way to manage your stress, and make yourself take walks and what-not, then you have a better chance at least.

I think the thing that gets overlooked is the stress that comes with poverty, because you’re constantly worried and stressed out. If you’re poor, the job you have is likely to be more stressful – physically stressful. If a doctor, in my opinion, really wanted to help a poor person who was overweight, they might actually start with some type of ‘how do we give you relaxation exercises? How do we lower your stress level?’ Also, people stress-eat – I know this from personal experience. If I can manage my stress, I’ll sit down and have a cup of tea instead of sitting down and having a bowl of chips. So I think there needs to be some kind of connection to stress and relaxation tips and a focus on lowering your stress level to help you manage your weight. I’m not a medical student, but I do know that stress is so hard on your body, and they say

women gain weight around their mid-section from stress, you know. People stress eat, let's be honest. Soda is the sum of all evils and I try not to drink it. But I used to eat a lot more chips and stuff than I do now.

I have a niece who's severely obese. Her mom took her to Disneyland and had to push her around in a wheelchair because she couldn't walk. But, she just got Obamacare too, and she's seeing a doctor who's working diligently with her about her weight. He weighs her like once every couple weeks and stuff, and she's lost 70 pounds since she got Obamacare! She's in school now, and she's just shedding pounds. You can see she makes better choices. We'll get together to watch the Seahawks, and everybody will have Doritos or candy, and she doesn't eat them now. He told her just to walk to school: If it's raining, just take an umbrella. She does that, just walks to and from school. Just small things like that, and I think also the accountability because he sees her frequently. She's accountable. When she goes in there and she's lost 2lbs here or 7lbs there, she feels good about it. He's taking the time, and that's something you don't see much of anymore. When I think about all that she's been through and how many times she's been to doctors and stuff, this doctor weighs her like every 2 weeks. I think that's the key thing; she's being held accountable for the weight loss, and being rewarded by seeing it go down. So it's both. I suppose if you had a group you walked with or if a health care provider wanted to organize something like that for low-income patients, you'd get the same thing, the accountability and the reward of figuring out that it's ok to go for a walk.

We have to find a way to balance not blaming the poor with holding the poor accountable. How do you do that? I think my niece is a good example; she's happy with the reward of losing weight. She's 26 and this is the first time that she's ever lost weight. And she's

been terribly obese since she was about 5. I think it's just because this doctor holds her accountable but makes it an exciting thing, too. So I guess it's just important to find that balance.

I also think that you have to be careful with the way you talk about accountability. I'm sure that, if the doctor who's seeing my niece emphasizes more the reward of seeing the weight go down, rather than "we're gonna hold you accountable for this" because that would rub her the wrong way and she'd be like "screw you, I'm leaving". It's accountability, but you need to be careful how you talk about it because poor people, like myself, are very sensitive about how people view them. We know people view it as our fault, even though a lot of times, it's not.

Not every poor person is on drugs or making terrible choices. A lot of poor people, like my mom, struggle their whole life trying to get out of it. My mom had the highest standards of anybody I've ever seen. She went to a tech school. And she died poor. She died without anything. And, certainly, she would never choose that. Who would choose that?

## APPENDIX F: LANDON

### **Early Experiences with Weight**

I was about ten when I first realized that the concept of weight existed. My mother was struggling with weight and I didn't quite understand that. Coming into my own, I was an overweight kid: I wasn't really taught how to eat properly. Not overweight necessarily by appearance, but by common medical standards. Whatever was on the table, it was there for a reason; because it tasted good. It didn't really matter if there was a lot of salt or fat or whatever. Or if it was made with genetically modified stuff, preservatives, whatever. It was just on the table; you ate it. I remember actually sitting down one time and having a pork chop in front of me - I still to this day don't like pork chops – and my dad forced me to eat that pork chop and I was just having a fit.

As far as realizing that weight was a thing, I was in the bathroom and I was looking at myself - at this time I looked female-bodied, because I am a transsexual - and I remember looking at myself and seeing my stomach in particular and being really, really upset. I had just come into my understanding that weight was a thing and then here I'm overweight and I'm having that consciousness in a negative way, not the self-loving type way: 'You love your body because your body allows you to exist', right? But more like: 'I need to change; I need to fix myself'. That was really devastating.

As a child, I remember my mom was taking - I don't remember what they're called, they're a certain diet pill - but Pamela Anderson I think was the one that was pushing them. My mom's an alcoholic, so she was taking the diet pill, she wasn't dieting, like eating better food, and she was drinking on top of it, so I remember being really scared and terrified that my mom did that.

I also got to see my older sister grow up and struggle with weight. She used to be really, really small, like kind of terrifying for as small as she was. But then she got bigger, and to this day she's pretty big in comparison. But she's super active, and I don't wanna say she eats right, but she eats better than probably what I've ate in the recent past couple months.

### **Nutrition and Physical Activity**

I actually had kind of like a running joke with the group of lesbian friends that I had, that I was kind of like a human garbage can. They would feed me any leftover crap that they had. They went to McDonald's, bought food, I ate it, because I wasn't gaining any weight while I was eating it. That really messed me up after a while; I'm sure that would mess up anybody. But it was either I ate that food, or I couldn't go out hanging out with my friends, because I didn't have the money to buy the food that I would rather have bought. Then, my group of friends changed, my high school experience changed, and so my body changed. I gained more weight. I didn't have any consciousness of 'I should probably go for a run today'. My last experience with the gym or activity was a 9<sup>th</sup> grade speed walking course. I really enjoyed that.

Outside of that, between ages 15 and 21, I didn't really do much scheduled activity in my lifetime, mainly because I never really thought I could. I didn't think that I could run, and I never played team sports. A lot of that came down to my experience in the gym, as somebody that was really uncomfortable with my body, as well as struggling with my sexuality and gender identity: Being in a gym atmosphere is just not something that I ever thought I could get over because sexuality and gender identity is a big component of gym spaces. In addition to gaining weight, I was also transitioning from female to male, and there's a lot of safety concerns that come in when you play any type of team sport or participate in gym culture. Especially in the locker room, which is why I never really got into that type of activity. And I wasn't just going to rush

into a team sport without actually having some type of, I don't know, confidence in what my body could do, because I didn't really think that I could do much of anything.

During this time, I did ride bikes a lot. In high school, I had to bike from home to school and back, which was quite a ways. So I was still active in some small ways, but they're all individual-based. What that meant for me is that there was really no accountability in me doing it; it was just something I did to survive at the time, because my parents wouldn't take me anywhere. They wouldn't take me anywhere.

Later, as an adult, I was living with a roommate, and we had terrible eating habits; I still wasn't getting the fact that maybe I should treat myself well as far as the food I was putting into my body. It was really like a bro apartment atmosphere, and so we really ate what bros ate, especially when I started going back to school and I started taking out loans. I had a lot less loan coverage than what I do now, and I was living off of pretty well nothing. So that also meant that I didn't have the money to buy the food that I, for example, buy today, because I had no money period.

### **Appearance, Identity, and Stigma**

While transitioning, my relationship to my body changed; it wasn't always the weight that was my contention, it also began to be the way in which I viewed myself in general relative to masculinity and femininity: My ideal self didn't match the way my body looked. So I still really didn't have a relationship with my body in a way that was healthy at all. The majority of the folks that I ran into on a daily basis were a constant reminder that "You don't look like a man, you don't act like a man" or anything like that, so I was constantly being shamed. What that meant for me was that I wanted to detach from my body completely.

After high school, I went to Pierce College for a year and then took a year off, and through those 2 years, I went through this process of always negotiating how people viewed me for my gender. I was never really comfortable with my body at all, in that sense. I think I was always critiquing my body. I broke up with my ex-girlfriend at 21, and I haven't dated since. And a lot of it goes down to that, and a sense of worthlessness. And just combining all that crap together - having to do with defining my body as weight, as well as the gender transition, meant that I really wasn't desirable in my own eyes. My identification with health is always attached to how my body looks, it's attached to my appearance; it's not attached to how good I feel, the energy that I've had, or what not. I know the difference now, but when I was younger I didn't know the difference.

I saw my auntie for the first time in a long time this weekend, and she asked me if I lost weight. Even though she's seen me throughout my whole life, she couldn't tell the difference between me three or four months ago to me now. If I would've gained weight as a woman, I guarantee you, even if I gained 10lbs. people would see that, and would remark on it. I think there's a freedom or an ability for a lot of folks to remark about women's weight. In a social situation when it comes to a man's weight, it's either they don't consciously care about it, or they don't feel as though they can comment on it. I actually gained about 20lbs over the last four or six months and she actually thought I lost weight. Something I had been overtly conscious about and she had no idea.

What motivated me to start working out was just the shame. It was shame, and the worst type of anxiety, from knowing that I could go out in public and I'm being read a certain way that makes it so my personality just doesn't mean anything. It's not something that is even in people's minds when they see somebody that is overweight or obese - they just don't care. My auntie is

overweight, and she has a disability from previous injuries – she’s been in two full body casts in her life from two different car accidents. She parked in a disabled spot (she has a disabled license plate) and went in to Safeway recently and somebody wrote her a nasty note saying that she's not disabled, she's just fat: She should die. It's the second one she's got in the last 5 years.

### **Experiences with Health Care and BMI**

My most frustrating experiences with health and weight came when I was 22 or 23. After working at some really labor-intensive jobs, I started to realize that I had a back issue. I was binding my breasts, which had to do with trying to fit within that gender mold. The binder that I had cut off at the midsection in my back, and really messed up one of my vertebrae, which I still struggle with to this day.

I also struggle with anxiety, which got worse while I was in school, and I started struggling with depression. A lot of that came from what I was learning in my particular program at school that was really making me sad and depressed. Especially the sense of helplessness, like 'I can't change it'. I think a lot of that had to do with my transition from female to male; it's like there's a sense of helplessness when the world doesn't really care how you identify. Whether that's as your gender, or as maybe the way in which you view yourself and want to be viewed from your body in general. I started taking antidepressants. I also took a tranquilizer. I didn't know the side effects of those drugs at all. The doctor I saw prescribed Celexa and Xanax together, which is a terrible combination to start at the same time.

Taking those medications - I think particularly the tranquilizer - just made it so I didn't give a crap about anything. What that also meant was that I started eating even worse. At that time I think I was 180 pounds, but when I stopped taking the medications 6 months later, I weighed 230

lbs. I remember that I bought a pair of cargo shorts – they were tan – and my roommate said: “Those are fat shorts”. The worst part was that I was actually active – I saw almost every day of the summer I stopped taking those meds, and was constantly walking my dog about the city despite considerable pain from my back issue.

When I had stopped taking the medication, I realized how big I was finally. I didn't really have a consciousness, while I was on the medication, that I had gained weight. I had hardly any idea, which was pretty devastating.

I think the reason why I was heavily medicated from my doctor to begin with was that I had weighed so much at the time, from my back issue, that I wasn't doing any activity. And then also that I was Trans, and he's a very religious man. And I don't think that my identity was something that the practitioner, in this case - and I'm not saying that it was a conscious decision on his part - but I think, subconsciously, he was like, 'Oh, this person's really messed up, so I'm going to over medicate him'. Not like, purposefully over-medicating, but, I mean you don't ever start people off with that level of medication. Ever. And you especially don't not follow up with them, you know? He never saw me again.

I've been on testosterone now for about 5 years, and the whole process of being on testosterone and watching my weight fluctuate from being more of a female body structure to more of a male body structure means that I've had to have intimate relationships with my practitioners. If they don't understand where I'm coming from as far as my identity goes, they're not going to treat me with respect or understand that my body's weight distribution is not just a standard number of pounds. And the doctor that I have up in Seattle is more respectful to me. The odd thing, though, is that the doctor still uses BMI as the standard, despite having this discussion about identity and me being Trans. When I started losing the weight, she was still calculating weight with the BMI,

which completely sidesteps the fact that identity, weight, and health in general are all part of your individual identity as a person. And you can't calculate it using the BMI: If you're gonna say 'This person's overweight', and here I'm going through my transition from female-bodied to male-bodied, how are you gonna tell me that I'm overweight at this point, when a month later I'm not gonna look the same, my body shape isn't gonna be the same? My body's going through a lot of changes - that universal standard is so fallible.

### **Barriers to Physical Activity and Nutrition**

I remember watching T.V. one day and really saying, 'You know, I don't know anything about food. I know that I can't eat salty noodles anymore'. By that time I hadn't even realized how much salt was in packaged noodles. I had no idea: It never really crossed my mind. I had to start eating differently because I was having an allergic reaction to something, but we didn't know what it was – my practitioner at the time had no idea what it was, but was just giving me antibiotics at the time for a sinus infection. I stopped relying on the doctor after I had a weird experience with an NP that looked at my rashes from the allergy, and even exposed part of my genitals to “see” the range of effects on my body. I was humiliated. I wasn't really sure exactly how to do a food elimination diet – but I knew I could never go through that again. So, I just started eating raw foods. Particularly, learning how to enjoy lettuce and vegetables and stuff, which was a learning curve for me!

Around that time also I started using the elliptical at my apartment. In addition to the back pain I already had, I was in a really bad car accident when I was 22, which made my back pain worse. I was in a really small car, and I was hit from behind by an SUV. I don't want to exaggerate, so I think I had about \$7,000 worth of medical bills in between chiropractic therapy, massage

therapy, and a trip to the hospital. So, there was a different relationship that I had with my body as well; one that really is centered around pain, and how to manage that pain. I don't think I managed that pain really well for a while.

Part of that process I think of me using anti-depressants, was because I also really had a shitty quality of life, because I couldn't get up and go about my day without feeling a lot of pain. I still can't, but the difference is that I'm a lot more active. Being active, for me, really means that I'm exhausted to a point sometimes, and I forget about the pain, or I just go to sleep because I'm exhausted. I don't have enough education about how all that stuff works to really know what's bad pain and what's good pain, in working out or weight-lifting. And then, what's bad pain and good pain, in that sense too. Honestly, throughout my whole life, I think the moral of the story is I didn't have the education; I still can't buy the education from weight-lifting professionals even though I am employed at a workout facility.

I developed a relationship with the elliptical at my apartment instead of starting dating, that's what I did. The elliptical changed my life for sure. And cut out really bad food, as much as I could. I also still eat things that I can cook, like tacos. I still like to make spaghetti - I make a really good spaghetti!

After I finished my Bachelor degree, I moved out of my apartment and started living with my sister. I got a full-time job that was physically demanding: I was super active. I lost a lot of weight from that, but I don't know if my quality of life got better; I was in a really bad mood all the time because I worked so much. I also stopped using the elliptical because I had been using the one at my apartment and I lost access to it after I moved out.

Before I moved out, I inherited a bike when a close friend of mine passed away. I rode it constantly for no reason. It gave me the space I needed in my head. I was able to go out; I had a reason to be out. Unfortunately, it got stole right before I moved out.

## **Dealing with Stress**

I had to move out of my sister's place when she started dealing with a domestic violence situation. I lived on my parents' couch for a while, and it was terrible; I wasn't taking care of myself at all by that point. The process of coming back to trying to feel healthy, which I've been dealing with since I came back to school for my Master's degree, has been pretty awful.

I don't think that I'm still at the place that I was at the end of my BA. It's the little things like that that've been affecting how I view the future, which means that if I don't have a good outlook for the future, I'm not gonna necessarily want to take care of myself physically. Which has been a constant struggle throughout my life. Because I have student loans, I have this sense of dread when it comes to long-term finance stuff. I'm about ready to graduate and I can't imagine how I'm going to handle that.

Now, I work part-time for an athletic club, and I like to be in that atmosphere. It's a really good gym for me, a really good gym. Working out makes it so my depression is less; particularly, my anxiety goes down. My triggers aren't being triggered if I work out. For whatever reason, the exhaustion that I feel from working out makes it so I calm the hell down. And that's something that I'm very thankful for, that I didn't know was an option until I started running. So imagine all those years that I had anxiety and I didn't know that there was a quick fix out there. But I mean, it's something that has to be constant. I like structure; I like a schedule. So,

I have to have scheduled workout times throughout the week, and if I don't then that relief isn't there, because it won't be a habit for me.

When I first started trying to just free run, I went down to the gym in my apartment complex for what I thought would be a ten minute run. There was a military guy in there who worked as a trainer I guess, and he told me, 'You're just exhausting yourself. You don't need to do that; just use an elliptical, that's what a lot of folks in the military use.' I started 10 minutes at a time. I couldn't do anything more. Ten minutes at a time and then I went up incrementally, at maybe every other day. Now I run about 25 to 30 minutes a day, maybe 3-5 times a week.

Running is an outlet. It allows me to get all my frustrations out, especially while I was living with my mother - me and my mother do not have the best relationship at all. So, it's not like it made the problems go away, but it helped me out a lot.

## APPENDIX G: LEE

### **Struggling with Weight Gain and Weight Stigma**

I never had a weight issue growing up. In fact, when I graduated from high school, I weighed 98lbs. I could eat anything I want. On the way home from school, we would stop and have fries and shakes. Never had a problem with weight. I had my kids, and I gained more than I was supposed to, but I lost it. It would take me a little while. Everything was going well until 1992. I was put on Lithium for bipolar [disorder]. I gained 5lbs a month for 12 months. It was very difficult. Towards the end of gaining that 60 lbs., I was with my husband at a business event in Arizona. He was at a meeting, so I put on my suit and went to the pool. While I was in the pool, these two ladies looked at me and one looked right at me and said, 'Boy, if I looked like her I wouldn't leave the house in a bathing suit!' and the other one looked at her and said 'I wouldn't even leave my closet!' You can imagine how that felt; I kinda ran/walked back to the hotel room and just did a little bit of crying for a while. And of course never went back to the pool. It took me a couple years before I could go again.

It's hard to experience the stigma for the first time when you've really not had that problem before. I have to admit, I was one of those who looked at people, and I didn't put myself in their shoes, I didn't, you know, say, 'Gosh, this can't be easy for them'. So when the shoe's on the other foot, boy. That was something. I think I'm a better person for it now. In all aspects now. I don't judge people.

It's still hard for me if I don't have somebody with me. It's very difficult for me still, so my self-esteem went down. And when your self-esteem goes down, what do you do? When I grew up, it was 'Don't complain, have a cookie', so it was the old have a cookie or have a piece of pie or have 12 cookies, or... You know, that kind of thing.

They finally took me off the lithium, 'cause I said 'I can't do this anymore', and put me on something else. It wasn't quite as effective, but at least I wasn't doing the 5lbs a month thing. But it was still inching up and inching up. From about '95 on I kept trying Weight Watchers. I'd go for 5 or 6 months, I'd lose 5 or 10lbs, maybe, and I just couldn't stick with the Weight Watchers regimen. It didn't include what I have later found to be the major thing for me, and that's movement - exercise. So I would go, and then I'd go away for a year, and then I'd try it again. It never did anything.

Finally, in 2007, 2008, I said, 'ok, that's enough'. I decided to try hypnotherapy, and worked on the self-esteem and all that stuff. And yeah, the weight started coming down a bit: I went from 230 to about 225 with that, and then my life kinda collapsed for a while: In 2011, my husband lost his job. He was unemployed for a while. Things were tough, but I was doing okay. He got a job in West Virginia, so we picked up and moved all the way across the country and then that didn't work out, so in 2012 we moved to Puyallup because he got a job out here. That was just a rental and that went under foreclosure, so in 2013 we bought our current house.

A little less than a year ago, I found another hypnotherapist who specialized in weight loss. I started doing that, and that one emphasized the exercise a little bit more. I was doing a little better, but there was still a missing piece. And so I went in, that was in a small group session, so I asked her for a private session, and she said 'Ok, let's figure this out, figure out why it's still so hard for you'. And so we went back, and through some searching, I realized that I didn't feel like I should have to work hard at it because I didn't feel like it was my fault. I felt like it was the medicine's fault, and why should I have to struggle so hard to get it off, when this medicine put it all on? I had a really hard time working through that one. 'Yeah,' she says, 'It wasn't your fault, but you have to get past that'. That really started the whole process. Every once

in a while I gain one pound back in a week, but then I lose it. It's really been a downward progression.

## **Medications**

The doctor, even though I went to see him every 2-3 weeks, he never said anything. He had to have noticed I was gaining weight. For God's sake, 5 pounds a month! It wasn't pretty! And he never said anything. I don't know why he didn't. I think he saw that the lithium was working, and... He was older, he was probably 70 when I was seeing him. He was only doing this part-time, towards the end of his career. So I don't think maybe he kept up on what new options were out there, because once I said I'd rather be without it and suffer those consequences than do this anymore, he said 'Well, let me do some research', and then he found something.

Since then there have been better and better drugs all along. Most of them still have the weight gain possibility, but I'm on one now that I've been on since 2009 I think, and [I've had] no problems with the urge to eat, [or] the weight gain: I'm not changing. When I first got on it, it was new, so it wasn't... there was no generic yet. \$275 a month. But luckily, we could afford it, even with our very high deductible. We very lucky that way; other people could not do that.

Not even a year ago, maybe 6 months, [the medication] went to where you could get the generic. But before then, because my husband's now self-employed, we have a \$10,000 deductible. Not pretty. Last year, we were only \$275 from reaching that, where they would actually start paying for something. That adds up, and there are people that don't have the resources we have to do that, and I feel bad about that. So it's nice to know that this one is now a generic.

## **Finding Motivation for Physical Activity**

I know that exercise CDs, they work for some people. They didn't work for hardly anyone that I know. I got frustrated with them, because I was in such bad shape I couldn't even come close to doing what they did. Many weight loss programs claim that exercise is a part of their program but it's really not. I think exercise is what really ramps up to the next level. And I think a lot of people don't because we are overweight. Some gyms you go in and people look at you like 'Why are you here?' Well, don't I need to be here more than you need to be here? Come on man! My husband was shocked. He said, 'You'd think those people would be real excited for you and really amazed and thrilled for you that you're doing this'. He found it really odd that people would be de-motivating instead of motivating. But exercise is one of those components, just like the eating, that a lot of people don't focus on.

In July, I got a Fitbit. I'm telling you, that Fitbit is motivation. That is unbelievable motivation for me, because you can only - \*I\* can only - cut back so much on food. And so, I eat 12-1300 calories a day. I cannot do under a thousand. I just feel like I'm being deprived and I can't stay with that, which is probably why I couldn't deal with Weight Watchers. But with the Fitbit, I am able to see, 'Oh, look how much I've got done today! I can do a little bit more!' When I started in July, 3500 steps was pushing it. Now, my goal is 7500 and most days I make 10,000. The weight's coming off, a pound and a half to two pounds a week. And I've lost 27 and a half pounds of my goal of 75.

I really feel, for the first time since this whole process started, that I'm able to do it. I know that I can do it now, because I've made so much progress. And it's easy. I mean, I shouldn't say easy. It's easier than it was in the past. It's something I know I can do now. For me it was

getting past 'It wasn't my fault, so why should I have to work so hard?' Once I got past that, and started experiencing a little success, and then I got a Fitbit, that was the final piece of my puzzle.

I go to the YMCA and I try three days a week to do the weight work to keep my arm strength up, and to get muscles, because when you get muscles you burn more fat. I just started doing water aerobics. I'm trying to do that two days a week on Tuesdays and Thursdays, because I'm going to have to have a hip replacement. Right now, there are some days where walking is just really hard, so I do some water stuff.

## **Support**

I think you can help support yourself. My husband, for the most part, is my support. Every once in a while he tries to be a little too supportive, but he's just thrilled with me, we celebrate when I lose a pound. We may go out for dinner, but we don't go out for \*dinner\* dinner; we go someplace where we can get like a nice fish dish, with a little bit of rice and a salad. Or if we do go out for like Mexican, we share a dish and take some home still.

Things are different, but you know, we'll go to the park for a day, take the doggy for a walk, just things like that. He'll bring me flowers so that's nice. My daughter is fantastic, she's so supportive. We text every day, which is really cool. I give her my weekly weigh in, and every day, my Fitbit. She uses the one on her iPhone, but she lives in NY where you walk everywhere so it's really not fair! But yeah, she's real supportive. I tried my mom, but not so much.

## **Learning about Nutrition and Cooking**

I did a lot of learning on the internet. That's how I got to where I am. I knew [a lot of the information online] wasn't healthy but a lot of people don't know. If you're going to go on [a

diet], lose 40 pounds in two weeks, those starvation-type diets, I know those won't work. I know I have to find a website that has a healthy way, with healthy recipes to try. I'm very comfortable with doing that.

Right after I started the first hypnotherapy in Colorado, I was diagnosed as gluten-intolerant. Not the whole Celiac, but gluten-intolerant. My health issues that I had just totally went away within 6 months of going off of gluten. That cut out a whole bunch of stuff right there. It was far enough back that they didn't have gluten free bread or gluten free cookies; they didn't have any of that, so I had to cook healthy. So I started then. I guess I'm self-taught because I certainly didn't learn that growing up. I enjoy cooking so it wasn't a problem. My husband does very well, so I don't have issues with the cost. We can buy the fresh fish; we can buy the fresh veggies. I go to the grocery store every 2-3 days for fruit and veggies.

Just recently in the last few months, my husband says, 'I like eating healthy, but I'm kinda missing some things that you used to make.' So we sat down together and he came up with three things that he really missed. So we sat down together and said, 'ok, how can we fix these so that they fit in with what I can eat, as far as the gluten free, and you know, what can I eat? Gluten-free was fairly easy, because there are products. One of his was lasagna, and we used to have lasagna with a ton of French bread soaking in butter and garlic, and a teeny little salad. And so, gluten-free noodles, that was ok. I use less cheese in the lasagna than I used to, told him to add more cheese on top of his if he wanted to. I cut it into small single-serving pieces, and he would have two servings and I would have one. Whereas it used to be just 'Here you go!' If I cut him a big one and me a small one, that would make me feel bad for some reason; it's psychological, I know. But if all the pieces were the same size, I didn't care if he had two. As long as they're the same size. And then, instead of the whole loaf of French bread soaking in garlic butter, I used the

end - the heels - of my gluten-free bread, which is pretty dry, a little tiny bit of butter and some garlic on it. I had two pieces of that with my lasagna and a really big salad. That worked.

It's about portion control, and also the plate thing: Making your vegetable the biggest thing on the plate, instead of the lasagna being the biggest thing. It is sometimes difficult. I'm not gonna say every day is easy. It's sometimes difficult: 'Do I have to have a salad again?' But I sometimes throw a bunch of frozen vegetables in, maybe a few chunks of ham. But I have to admit I do get tired of salad: I have to have variety. That's another reason Weight Watchers didn't work for me: It didn't give me the variety. And I think that's probably a lot of people, too, because when you do overeat, you don't overeat the one thing, you overeat a little bit of everything.

### **Talking to Healthcare Providers about Weight**

The doctor that I had in Colorado was overweight herself, so she never brought it up. I find it kind of shocking, that most of the nurses are incredibly overweight. I was kinda surprised with that. I would say probably half if not more. And the providers I've been to, the nurses are way more overweight than I am. When I say, 'Yay I've lost however many pounds since the last visit!' they do celebrate with me. But it wasn't something that was brought up until I moved and saw my new doctor there. Then she says, 'Look, we need to work on that. And you're at an age where it's not going to be easy', which I don't think you should say. That's the worst thing you could say: 'This isn't going to be easy but here's what you do'.

Sometimes providers say, 'Well, we have to wait till they're ready'; you know, most of us are ready. Most of us want to get past that hurdle. I think that's one place probably where healthcare can help, is don't just say, 'you've gotta lose weight', or say 'Well, until you get over

the hurdle you can't lose the weight', or whatever: 'What's your hurdle? Here are some ways that have worked for other people.' You know, try this, try that. You can work through your hurdle, but it's not gonna just disappear'.

Digging in is not always easy. It really isn't always easy. But you know, it wasn't easy, there were tears involved. Many, many tears involved, but it was so worth it for me. It was so worth it, because I've really turned a corner, and now I don't just think that I can make it, I know. I mean, I'm over a third of the way there. I know I can do it. I'm not gonna, you know lose 20lbs by Christmas or whatever, that's not realistic, but I know it's gonna come off.

## APPENDIX H: RICHARD

### **Making Time for Walking**

I've had asthma since I was 2. So, I've had a little bit of an issue with exercise. I didn't really have a weight issue until college. I put on the freshman 15, and it's been a struggle ever since to try and keep it off. It's a little harder right now; I don't have a lot of free time to do the exercise that I like, which is walking. I'm in the process of moving from one residence to another, and [I'm] doing a bunch of work like remodeling and cutting trim and all that kind of stuff so I'm lifting heavy things all the time. I think it's kind of taken the place of walking, but I'd really rather be able to spend a couple hours a day walking.

On Monday I dropped my father-in-law's truck that we've been using off at Ziggy's Auto Shop, and I walked from there to my house. That's kind of the walking that I like to do. I used to walk 9 miles a day to work and back from work when I was in Olympia. I lived downtown and I worked at St. Peter Hospital. You get time to think on the way. I usually didn't listen to music – sometimes I did – and on the way home you get to reflect on what happened during the day, kind of like shed all the work stuff off, so by the time you get home, it's not clinging to you anymore. It's a huge stress relief.

I lost 65lb that year. So I was all confident and everything. Since then, I've put 50 of that back on but now I'm down to losing about 35. So I've got just a little bit more to go. I started because my car got broken into and it stopped working for a while. I didn't have the money to fix it, so I just decided to walk to work. The buses aren't that reliable and I've had a problem with time management in the past. So, two hours before I had to be at work, I'd start walking. It only took about an hour and 5 minutes to get there, so I had plenty of time to get there, and I could stop and take pictures – I'm a photographer.

## **Self-Confidence and Safety**

I tend to skirt those [construction sites], because I don't feel safe with all that machinery and stuff going on. And drivers suck, when you're a pedestrian. I don't trust any cars. I like walking through non-busy neighborhoods rather than a main street. A lot of walks I did in Olympia were on Sundays, they don't have any trains running, so you can walk miles and miles of tracks all through downtown, from the west side to the east side. So, that was pretty cool.

I feel less safe when I'm walking with my wife: I feel like I need to help protect her. And, since we live in South Tacoma now, that's kind of a higher crime rate area than North Tacoma, so it's a little bit of a concern for me when we go walking. By myself I don't feel it. I'm not worried about it.

I feel like when I'm heavier, my confidence is lower, and my self-image is worse. That kind of affects the type of interactions I have with people. I tend to be shyer, not so outgoing. When I lost that 65lb, 4 years ago, by walking to work, my confidence level shot up. I was also doing some performance poetry at that point and I've had stage fright my whole life. At that point I was able to work through that a little bit. I still have some insecurities around being in public and stuff, and when I'm heavier that reaction kind of skyrockets.

## **Healthcare and the Weight Loss Industry**

I was diagnosed with ADD when I was 26. One of the medications they give for ADD is dextroamphetamine. I've found that when I'm taking that regularly, I lose weight, because I have a lot of energy and I'm running around doing a lot of things, but I can focus on stuff. So

that's like a beneficial side effect, but I don't like being on it because it's something that can be habit-forming and addictive, and I don't like to deal with that kind of stuff.

I saw a naturalist for a while, and she gave us some nutrition stuff. I didn't find a lot of the naturopath stuff effective. I don't really see any effect from homeopathy; I think that's more a placebo effect than actual treatment. They would give us these little tincture things and say 'if you get hungry, try this' and it didn't work for hunger. They also gave us these little tiny pills, like little balls. They're sublingual, you're supposed to put them under your tongue and they would dissolve and give you a sense of well-being. That didn't really work for me. They gave me sulfur for some reason. She said 'well, you're missing sulfur out of your diet'. That was nasty.

My wife is also overweight, so we both kind of are struggling with that together. We started doing smoothies and adjusting our diet to whole foods, macro-type stuff. We tried Atkins for a little while. That was fun, but it didn't really work; we got tired of it. I love bacon, so I was really happy with that one. I've tried being vegan and vegetarian a couple times. I was happy with the macro food stuff, you know, eating more natural stuff, less cooked. Less protein, getting protein from like beans and legumes, stuff like that. Kind of just substituting healthier stuff for all the unhealthy stuff we were eating. Cutting out most of the carbohydrates and trying to cut out sugar and caffeine, all those things that can exacerbate conditions. That was helpful. The homeopathy stuff was not that helpful.

## **Nutrition**

My grandmother was a heavy-set woman and she fed me butter. She'd make me a peanut butter and jelly sandwich and I'd be like 'don't put butter on it – it's already got peanut

butter!’ and she’d put it on anyway. So, from an early age, you learn those type of eating habits and it takes a lot to try and change things.

In freshman year, I came home from school, and I was hungry, and no one else was home. I looked at this box of instant mashed potatoes and I was like, ‘hmm, that looks really good. I think I want that right now’ and I cooked it. It turned out lumpy and grey. I was looking in the pan, like ‘what did I do?’ and my mom walks in. She’s like ‘what’s the matter?’ and I said ‘I tried to make this and it just looks gross.’ She said, ‘I’ll show you how to make it from scratch.’ From then on, every day she’d teach me to make something else. I took a European cooking class in high school and I’m an experimenter, so I take recipes and adjust them.

You can get really healthy stuff from small farmers and not have to go to the store as often. A lot of the stores do have some awesome sales on vegetables – I try to buy all organic if I can. I’m the cook in the house, so I’m planning all the meals and making lunches for my wife. She’s a schoolteacher. So, the nutrition in the house is pretty much my responsibility. I do give in, we are both pretty dependent over chocolate; it’s a comfort food. And, sometimes popcorn with actual butter on it. But we do pretty good.

## **Health Literacy**

I worked in a radiology office, and we did a lot of Lap Band readings, gastrointestinal operations, stuff like that. The people we did that for were all about the operations. They’re doctors who promote that because that’s their business; that’s what they do. I would hope that people would be able to get more varied input before going to that extreme. I know a couple people who got the – one person got the lap band, the other person got the gastrointestinal bypass, and their lives are a lot harder now. They did lose weight, but managing their diet now is

very difficult. One of them actually had to have a colostomy because of complications from the operation. Consider that a last-ditch effort, you know, if nothing else works. I would hope that healthcare providers have a bunch of different options to offer, and realize that it's not a cookie-cutter thing; everybody is different. Everybody has different requirements and different methods that will help them.

I've had probably the equivalent of 3 years of college. I don't have any degrees, never graduated college. I went to community colleges, trade schools, stuff like that. Basically, I just like learning about stuff, but I can't settle on one thing. I'm an artist, photographer, musician, performance poet. I kind of skip around to different things, I'm always looking for something new to learn. I like to read about scientific stuff, biology and physics and all that stuff. I'm pretty well read and I think that there's not a lot of literature out there concerning diet and how to manage that that people who maybe are not as educated can find, or discern from the fad diet type things. You'd rather read the fad diet things, what the celebrities are doing, rather than go through a book that gives you data, and how to manage things.

## **Choice**

I come from a family of really heavy people, and I think it's a balancing act between genetics, diet, and exercise. If your diet is more calorie-rich, then you need to increase the exercise, especially if your genetics lean toward, you know, being a heavy-set person. It's kinda like a balancing act. I think you need to balance diet and exercise and what your genetics are predisposed to. And I don't think there's a wonder pill out there or anything like that. Everybody's different, everybody has different requirements as far as their caloric intake and how they need to balance that out.

I think that economic status has a lot to do with it. It makes no sense to me that foods that are heavily processed, require big huge factories and canning and stuff, are cheaper than natural foods. They're better for you, have more nutrition, more vitamins and minerals – those are really expensive! The processed stuff is really cheap, so if you're in an economic situation – and I've been there before – where you can't afford really good food, you have to eat crap. There's also a lot of misinformation out there, put out by the dairy council, the meat council, all this kind of stuff. You don't have to have meat every day. You don't have to have 3 square meals every day. Everybody's different, everybody has different requirements. I think what's most important is getting in tune with what your requirements are. So, weeding through misinformation, and economic status, can have a huge effect on you, and I don't think that's always your choice. Advertising is pretty strong; they know how to manipulate you. Economic status isn't always easy to get out of.

## APPENDIX I: RYAN

### **Dealing with Weight Gain**

I never had a problem with being overweight until after my pregnancies. I had two kids pretty close together: There's only 15 months between them. I had some health issues - preeclampsia - during my first pregnancy, which caused an abnormal weight gain during pregnancy, almost to an unhealthy level: I gained 100 pounds. Then I became pregnant 6 months later with my daughter. It was a normal pregnancy but still I hadn't lost any of the weight from the first baby.

I was in the military, and there are certain height and weight requirements you have to meet, so I was trying to push toward weight loss and wasn't seeing any results. In the military, they send you for height and weight counseling. You see a counselor, they talk to you about your food choices, they talk to you about what you're doing, and then also order labs to make sure there isn't anything going on physiologically to cause the weight. It was discovered that I had hypothyroidism, so they put me on the lowest dose of medication that they could, which was 50mcg of Synthroid, which was designed to correct the hypothyroidism. There wasn't any structured follow up with that; they'd order some labs but that was about it.

I still wasn't seeing any progress with weight loss. I was told that it was due to the hormone change in my pregnancy, and it would resolve itself. So, I sat there, waiting for it to resolve itself, and ultimately ended up waiting 2 years before I became frustrated with the fact that no matter what I was doing, there was no progress. I was watching what I ate, primarily vegetables, fruits, started going through, you know, the fad diets, like the HCG diet. I stopped the HCG diet after a doctor advised against it due to my thyroid problems. I tried a lemonade-vinegar cleansing diet, but after I started thinking about it and kinda rationalizing things... Being

in healthcare I know that theoretically, weight loss is supposed to be simple math; you burn more calories than you consume. So, it became more of a game of counting calories the best I could.

During this time, I had three oral surgeries, and after the third oral surgery my mouth was wired shut for 6 months. So, physically I am unable to eat, because I can't open my mouth. I'm drinking Ensure, you know, low-fat, low- you know, somewhat high-calorie but nowhere near the 2,000 calorie recommended diet you're supposed to have. It's like, 'Ok, well there should be some significant weight loss now, because I physically cannot eat'. Still nothing.

By this time, I was being threatened with being chaptered out of the military for failure to lose weight. I saw the nutrition counselor again, and I was like, 'Look, something is not right, because I'm physically not able to eat anything. I'm exercising, nothing is happening. What's going on?' And again they were just like, 'Well, you're just going to have to try something. Change it up'. There wasn't any better advice, 'cause, you know, over the course of 2 years, they start thinking, 'You're not doing what you're supposed to be doing; you're lying about whatever information you're presenting'.

I was almost in tears after this, and while I was working with a surgeon I've known since before the frustration and the weight gain, he had asked me why my thyroid was off. I told him, 'The only advice I've ever been given is that it's because it was related to the hormone changes in my pregnancy and things will resolve itself'. And he was like, 'So nobody ever found out why your TSH is off?' He ordered a lab for me, and I went down, had the lab drawn, and found out I have Hashimoto's thyroiditis. It is an autoimmune disease; it's not going away, and the only thing you can do is take Synthroid to regulate your TSH levels. I went and saw the Endocrinologist; they drew labs and strictly monitored my Synthroid dose and my labs. They played around with my Synthroid dose until they found me to be taking 262mcg of Synthroid - my body just

absorbed it and discarded it. They still don't know why, because that's a very high dose; usually people who've had their thyroids out are only at 75mcg of Synthroid daily. But it doesn't affect me.

### **Nutrition and Physical Activity**

The other aspect of things is that your metabolism has a lot to do with weight gain/weight loss, and I happen to be in a job that doesn't allow me the opportunity to eat whenever I want to, even if it's small meals or snacks; I'm scrubbed into surgery. You get a 15 minute break, a 30 minute lunch, and another 15 minute break. Typically, you are running to grab your meal if you haven't already pre-planned it. Even if you do pre-plan your meals, so that you can, you know, keep things the way that you've always been told you're supposed to, you're still scarfing it down within 30 minutes, trying to eat it real fast, and that's about it.

I'm still in the military, and I still have to take physical fitness tests; I perform and I pass no problem - I'm physically fit, I'm just overweight. It was recommended to me to try juicing, just, you know 'Drink your juice instead of water and you'll get all your nutrients and your vitamins, but it'll be easier for your body to break down stuff'. It's like 'Ok, but, what if the problem is that my metabolism is slow and I'm just not burning very many calories? Plus the fact that as you get older your body's just naturally slowing down anyway?' So, you start to hit those cross roads where you're like, 'What do I do?' and then everybody's got their own little advice as to what things that you should try and what you should do, and it becomes frustrating.

I exercise; I exercise every day. I will get on the treadmill for 30 minutes as a walker - I have knee injury so I can't run. But, enough to get your heart rate up, get your body sweating, get your muscles going. You know, a standard walk versus an actual workout where you're

increasing your heart rate, and forcing your body to burn calories. And the row machine which works different muscle groups as far as toning goes. And then strength training and resistance, just so I can still do my pushups and my sit-ups.

I don't walk outside because it's dangerous! I'm afraid Meth America is gonna hit me up and get me on a drug kick! I do have the luxury of access to post, where it culturally is acceptable to be walking down the street, and to be out exercising, because other people are gonna be on the installation doing it as well.

After I had my kids, I thought it would be a great idea if I could just jump on the treadmill at home and actively be walking while I'm watching T.V. - multitask, you know? I have certain shows that I love to watch, and I just become a couch potato: I could be active in doing it. I did, for a little while... until my son started crawling and he crawled to the back of the treadmill and face planted while I was on it one day. Yeah, that was the last time I even attempted that.

I love to hike, so I go on nature walks. I just discovered Trampoline Nation, which has indoor trampolines. The only problem is I can't jump forever cause then my knee starts to hurt because of my injury. I need to find more vigorous indoor activities, because anybody can go out and go hiking, but if you don't like the rain you're not gonna go walking in Washington weather in the rain. Or if you don't feel safe in your neighborhood you're not gonna go out walking around. Riding your bike is dangerous in this state, too - I found that out!

### **Dealing with External Standards**

When you look in the mirror, you're like, 'Ok, I know I'm not a size 4 or 5, but I'm not a size 30 either, you know. I can look nice in clothes, and I just have a figure but it's not optimal'.

You know, you deal with society and what's acceptable, and now of course society has the term 'thick', and 'thick' is good because people want girls with a figure, but it's not acceptable on the military standards side.

Some people don't try as hard as they could try, physically. But mentally they might be giving it all they have. Especially with weight and your image, it's so much of a personal struggle that you really have to get past your own mindset on things in order to overcome things. I have a friend who wanted to lose weight, and she would ask me to go to the gym with her. So I would take her to the gym with me; we'd go, we'd work out. But then when she gets home, she wants to throw down a 40 of beer, because she has a problem with alcohol. It's like, 'Well, you're just negating everything that you've done', and then she would get frustrated because she wasn't seeing any results, and here she is going to the gym. People want quick results. Period. If you're not getting the results visibly that you think you should be getting, or it's not happening fast enough, you're not keeping in mind the fact that, 'Ok, muscle weighs more than fat'. Some people don't even know this - not everybody's medical. But muscle weighs more than fat, so while you're going to the gym and you're working out, you want to see weight loss, but you're not accounting for the fact that you're getting toned and losing inches while you're gaining weight. So, you know, it's not so much frustrating, it's just hard to know what actual progress is, instead of what it's defined as, for yourself.

### **Struggling with Weight Loss**

I think desperation plays a big part in it, too. If you've been doing things and you've been trying new things and you're not seeing any results, you start to get to the point where you want to try anything. Where you've tried the simple life changes - lifestyle changes. This year, I

stopped drinking soda. I haven't noticed a drastic loss in weight, but I've actually noticed a change in how my body is not as lethargic as it used to be. But that's not things that people would necessarily pick up on based on one little thing. And it was hard. It was really hard to quit soda; soda's everywhere, it's in everything. The fast food meals that you order comes with soda. The fact is that a bottle of soda is cheaper than a bottle of water, so your finances play a part in that, too.

It's debatable whether healthier food is affordable. If you're organized enough, and have the time and culinary skill, maybe. People go the easier route. And if it's easier for people to buy a chicken salad versus preparing their own... You can get a loaf of bread, and a pound of hamburger and a head of lettuce and some tomatoes that can feed you for 4 or 5 days, for the price of what it cost to buy a Big Mac meal. When you start thinking about it that way, you factor in value with price, and it tends to balance out.

Time is a big thing, too, especially when it comes to working out. Now you want to stop eating fast food all the time and you want to go to the gym. So you're spending an hour working out at the gym, and you have to get home and get your stuff out in order to cook, but it might be quicker just to grab a meal on the way, and not have to worry about cooking when you walk in the door. In order to make something a habit, you know, it's gotta be 28 consecutive days. So that's why at first things are so hard and people just stop because they'll bargain: 'Oh, if I just do this one time, then you know, I'll be good'. But you're still tweaking that bad habit; it's still there, so you can't actually kill it and get past it.

If you're always telling yourself you can't, and you've been defeated by a goal, then you're not going to give any more. Or, in my case, where you know, you start to try all these different things, and still aren't getting any results. It's not so much that you can't, but it's no

matter what I try, it's not working right now. So, you either hit the 'Ok, well, switch it up, try something else', or in acts of desperation you try things that normally you wouldn't try at all, where you get suckered into the marketing.

### **Experiencing Bias and Stigma**

When I tell the medical providers, who are supposed to be providing treatment to me, what's going on with me, they assume that I'm lying as opposed to, maybe there's an underlying issue, since there aren't any results that they can see. It literally took me telling a physician, 'Look, my mouth is wired shut. Physically I cannot eat, and I'm working out, so what is the problem?' It becomes frustrating because, as the person who's dealing with it and going through it, you want results, more so than the person that's trying to help you. And you're not getting it, because everybody has this idea of what is supposed to work, and they forget the fact that not everybody is the same, and not everybody's going to have all the same results from certain things. So it becomes very frustrating.

There's also the factor where people look at you and are so quick to judge, and that's a natural response, everybody does it. It's unfortunate because you don't know the story behind it; you don't know what people are going through with their own struggles. You don't know what had happened, what transpired for them to get to that point. It's even more hard when you haven't had this problem all your life and it's something that's relatively new; it doesn't seem to get any easier as you go along because of age progression and things like that, your body just naturally starts to slow down anyway. So when you've been a small and petite little size 4 up until the age of 25 when you had your first kid, and now you're having to deal with your new body, it's hard.

Everybody's story ultimately is probably gonna be very different, which is also important for health providers; you can't treat all your patients like they're the same. Because they're not.

## APPENDIX J: VIOLET

### **Weight and Health**

I have PCOS, which is a hormonal imbalance that affects a lot of different aspects of physiology, one of which is weight. I was diagnosed when I was 18, but I've been symptomatic with it since I was 15. Women who have PCOS tend to have male fat patterns versus female fat patterns, which is peculiar. It also makes it very hard to lose weight, and very easy to gain weight. It can also cause you to crave certain things - like sugar and carbs - all the time. As a young kid, I was fine; I was normal weight. By the time I was 18, as I got into adulthood, I was about 180lbs. That's still overweight: I'm 5'3". I'm 25 now, so I think my weight hit its max when I was about 21 or 22. I tipped the scales at about 230, which is when I started paying attention to it. That's when I was like, 'Oh, crap, maybe I should do something about this! This is terrible!'

From the ages of 15-16 and 17-18, I was living in a homeless shelter. I was a homeless teenager, and that's a whole different ballgame as far as nutrition goes. But, my doctor would do cholesterol tests on me, and say 'you really need to watch your weight,' and [hand me a pamphlet and say] 'here's a healthy lifestyle'. I guess maybe he was trying to be helpful by giving me these pamphlets, but for me, it wasn't that easy, because I was living in a homeless shelter. The access to the food I have is donations and what's made at dinner every night. It's oftentimes cheaper and easier to feed people by doing lots of bleached-white flour products and like low protein, because protein is expensive. Fresh fruits and vegetables are also very expensive, and so when you're trying to feed 20 homeless teenagers... Do you know how much food teenagers eat? It's the same in the prison systems, too.

I had tried to lose weight in between that time and now, like 'eat chicken, brown rice, and vegetables' you know. Lose 5 pounds, put 20 back on - terrible! It was three years ago when I

finally sat down and did it and committed and have been able to keep it off. I've never really hit my 'goal weight' per se, but I've gotten very close to it, and I've always thought that's it's not necessarily how much I weigh, but how I look and feel in my clothing, and I've been in a close range, so it's one of those 'Meh, I'm good enough! This'll do for now.' It took me about 2 years to get down to that point, so I went from 230 lbs. to about 150, and I've been maintaining within a 10 lb. range around there. Last year, I hit 150, and I was like 'ok, this is good', and I've been trying to maintain around that weight. I've had to kind of re-diet a few times to get it back under control. It's something that I'm always going to struggle with and I do know that.

When I had my IUD put in a couple years ago, I was going over the options at Planned Parenthood, because birth control and PCOS can be a whole debacle. And she says, 'you know, for somebody with PCOS, the amount of weight that you've lost is quite an achievement'. And she tells me, 'If you gain the weight back, it's probably no fault of your own. Your body wants to be fat; it's just part of having PCOS'. BMI is such a skewed system: What I've learned [is that] there's a huge difference between, like a chubby 135 pounds and a lean, muscular 135 pounds. In my former career as a vet tech, we'd have the conversation with people about their fat dog: 'Hey, so it says here that you're letting your dog free-feed, and your dog is 20lbs overweight. For a 20lb dog, that's really bad. Let's have a conversation about how much food you should be feeding your dog.' Even just that conversation about their dog, for some people, is wildly upsetting. So I can't imagine being in the doctor's shoes and having to have that conversation with your morbidly obese patient. For some people, there's definitely health issues, for some people it's lifestyle choices, for some people it's economic choices. I think for a doctor it can be really difficult to have to broach that conversation and not come off as 'Hey, you're fat, shame on you'.

## **Choice and Accountability**

I lost all this weight because I wanted to, because I was miserable, because I didn't like the way that I felt or looked. At the end of the day, the only person I'm accountable to is myself, because I'm the only person who has to live with me and the choices that I make. I'm lucky that my economic circumstances have allowed me to make healthier choices and spend more on healthier foods.

I'm not shy about the fact that I've lost a lot of weight. When I'm actively trying to watch what I eat and I go out with friends, I'm like, 'Oh, I'll have the burger, but can you leave off the cheese and the mayo, and can you do like a lettuce wrap instead of a bun. Or can you just give me the fucking burger patty?' My friends are like, 'What? What are you doing?' As they're drinking the extra-super-large regular Coke with a giant serving of fries and the burger with all the extra fixings, they're like, 'Oh, I'm so fat and I'm so miserable, if only I could lose weight'. And I'm like, 'you do realize what you're eating, right?' And so there's that conversation, where it's like 'you could make better choices'.

Then there are people [for whom] economics are a huge factor and it is expensive to eat healthy. It is expensive to change your kitchen around completely and get rid of all the cheap easy stuff. I remember my mom was watching a documentary once, and it was about an immigrant family, a non-English-speaking immigrant family. It was cheaper for their entire family to eat a Burger King every day, for every meal, than it was for them to buy groceries. What else are they supposed to do? They're trying to do the best that they can do, and that's the best that they can do. Which is awful.

Sometimes health plays a huge factor and there's not a whole lot you can do with it. My mom was diagnosed with Addison's disease 10 years ago, so she is on replacement steroids for the rest of her life. And steroids cause weight gain! So, she can't go off of steroids 'cause she'll die. She really struggles with her weight. She's put on about 100lbs and she hates it because she was always really skinny for a long time. She's also on disability and SSI and lives in a group home setting, where it's cheaper and easier to feed them bleached white flour products. They've got leftover bread and leftover donuts from the bakery, and less of a focus on brown rice, and healthy fruits and vegetables, and protein, stuff like that. So she's in a corner where she does not have the option to do much about it. It's a whole different ball game as far as having healthy options for public assistance and group home settings, and jails and things like that. Prisons have been primarily privatized and have now become a cash-making operation: How can you make the most money? The biggest thing is feeding the inmates, so 'We're going to feed them absolute crap'. You get a nugget of awful protein and then all the bread that you want. You're just teaching people bad eating habits.

### **The Impact of Diet and Physical Activity**

My weight loss has been largely [about] diet. Last year I was doing a lot of roller derby, and that is when I hit my lowest weight so I know that definitely contributed towards my weight loss. The idea of joining a gym sounds nice, and I have a lot of friends who've lost weight and they maintained by going to the gym every night and working out. For me, it's just - don't know what it is, exactly, I just don't want to go to the gym. When I was a teenager, PE was not a thing that I participated in, like that was not happening. So, like, my experience with being physically active was fairly limited. Roller derby was the one exception to the rule. Derby actually attracts a

fair amount of women who are like 'yeah, I've never done anything physical in my life, but this looks like something I could totally get into', and it can oftentimes be a game-changer for them.

I've done diet systems and programs: The first 20 lbs. I lost, I used the HCG injections, which is the pregnancy hormone. Basically, their premise is that you either take the oral drops or an injection on a daily basis, and it triggers your body to burn its fat stores. You take in less than 500 calories a day, you're on a very limited diet; you eat 2.5 or 3 oz. of lean meat, and a certain amount of vegetables. Fruit was fairly limited, and absolutely no carbs at all. Usually there's a cycle and then you add foods back in, and you can re-cycle until you hit your goal weight. I did lose 20 lbs. in a month with it; it came off really fast. I definitely don't think it was the healthiest way to lose weight. I decided not to continue with it, but it did give me a good-enough kick start that I was like 'ok, losing weight is something that is doable'.

I've also lost 20 lbs. on Weight Watchers. I have a problem with Weight Watchers because they appeal to the masses by being like, 'oh you can still eat your favorite foods', which is probably what got you to that problem in the first place. What I've found is it's a lifestyle change, so if you're like, 'oh I can still eat Jell-O and potato chips, and whatever, but just in smaller portions,' you're not changing the problem that got you there in the first place.

I've been maintaining on a program called AdvoCare, which is really big on lifestyle changes versus very drastic short-term stuff. And so, there's a huge Facebook group for, I think it's almost like 800 people in the Pacific Northwest, with some people kind of outliers in the rest of the United States. They're all people who have lost weight, are losing weight, and they're there to kind of like support each other. So they're like 'I had a really shitty day, I had pizza', and everybody's like 'yeah, that sucks. It's ok, tomorrow will be better.' There's a lot of support, and that's what I really, really like about it.

## **The Weight Loss Industry and Knowledge about Weight and Health**

There's a huge market for weight loss. I think people are capitalizing on people's desperation to fit a certain standard and not be miserable. I have a huge issue with gastric surgery: I feel that when you get to a certain point in your life, when you're 300lbs, 400lbs, 500lbs, there's a huge underlying cause, likely psychological, that you are addicted to the food or you're eating your feelings or something like that. And so, yes, you can go have surgery, you can lose 500lbs and get to a "normal" weight, but it doesn't solve the problem that got you there in the first place. I see a lot of people who are like, 'yeah, I got gastric bypass a couple years ago', or 'I had the lap band', or something, and they put all the weight back on, or they've learned to cheat the system and eat the foods they're not supposed to eat. So I have a bit of a problem with that. I think for some people it's necessary, but it's also not something I necessarily agree with.

I think the biggest thing really is not necessarily what a doctor can do for their patient, it's capitalism, and convenience, and the fact that all of these super-awful foods are being crammed down our throats - in a figurative sense - in terms of advertising and convenience. I don't think we really talk about true nutrition, and like 'This is what a healthy portion for you is'. When I talk to people I'm like, 'Oh, I get to eat carbs today', they're like, 'Oh, so you can have bread?' and I'm like, 'No, like a complex carb,' and they're like 'What's that?' and I'm like, 'Seriously? Come on now!'

I think a lot of people don't realize that when you get down to whatever your desired weight is, chances are you're going to have leftover skin and you're not going to look, you know: You are going to be 145lbs with a body of someone who used to be a lot bigger, and not the body of someone who's 145lbs and has always been 145 lbs. I think that can also be a factor why

people end up regaining the weight, because they don't have the body they imagined they would, because it's different. It's totally different. I have a little belly pooch from leftover skin. I talked to my plastic surgeon about it, and he goes, 'you can lose 30 more pounds if you wanted to but that leftover skin is always going to be there. There's nowhere for it to go, you can deplete all the fat cells in your body and you're still going to have leftover skin. People are really shameful about it. Honestly when I started losing weight, I did not expect to lose my boobs; it was not something that I'd ever really had in the forefront of my mind.

### **The Struggle to Lose Weight**

I think a lot of people get defeated when they're trying to lose weight, because they're like, 'Ok, I'm exercising, and I'm eating differently, why isn't this weight coming off fast?' They tend to forget that it takes your body a while to put that weight on; it's gonna take a while to take it back off. Weight loss has been something that I want to be able to maintain. I heard a statistic that a large percentage, like over 70-80% of people who have drastic amounts of weight loss, end up regaining all that weight, and usually then a little bit more in a 5 year period. I don't want to be a statistic!

It's a marathon, it's not a sprint. I think people make a lot of drastic changes. The person who inspired me to start losing weight because she's over 300 lbs. did the HCG diet and she dropped like 100lbs in 6 months, which is super-drastic and really unhealthy. And you know what? I got to see her a few months ago; she's put all the weight back on and then some. She saw me, she's like, 'You've kept the weight off?' and I'm like, 'Yeah, but I lost 20 lbs., and then I waited a few months, and then I lost a little bit more, and I lost a little bit more'. I've tried to

make it as maintainable as possible, and I think that's where a lot of people get caught up. They want it all right now.

Weight loss in the short term can be fairly easy. The bitch of it is trying to keep your lifestyle up and keep it maintained. Society doesn't make it easy. When I go grocery shopping, I go to the vegetable section and I circle back and hit the meat department. I maybe have to go into the aisles for like, a couple of things, but I skip 80% of the aisles in the store because it's all pre-packaged crap. We're a society that is based in convenience. And I think that has a major part to play in why there are so many people overweight.

I can justify the cost of eating healthy because I would normally be eating out otherwise. I have to put a lot of thought into, 'ok, so I'm going to be gone from the house today for 18 hours'. That means that all of my meals need to be transportable, easy to heat, or cold so that I don't have to deal with heat. They have to be pre-measured, and things like that. And so I've learned to adapt. And so I'm in school for 12 hours a day, which means that I eat my breakfast at school, I eat my snack, I eat my lunch, I eat my snack, and then I go home and I have my dinner. I sit down once a week and I pre-plan all of my meals, and then I go grocery shopping. I cook all of my meals and then I portion them out and freeze them. And that's how I've made this a maintainable lifestyle for me. But as much as I talk about not having free time, I don't have kids, and I'm not a full-time worker. So I do have that luxury of having a day off where I can plan and can cook, and all that.

I'm definitely happier for the weight loss. I feel more confident. Trying on clothes is a lot nicer, and finding clothes is easier, too. It's hard, sometimes I have definitely been like, 'should I just say 'fuck it' and eat what I want and just be fat again?' because it's hard. And I try to tell people that. It's hard, and sometimes it's the hardest thing you'll ever do. But, you know, when I -

I've got this red pencil skirt that I love - when I put on that red pencil skirt, I look in the mirror, and I look fucking amazing. I'm like, 'Yes, it was worth everything!'"