

**Weight Matters: an investigation of women's narratives
about their experiences of weight management and the
implications for health education**

Submitted by Lisa Caroline Browne, to the University of Exeter as a
thesis for the degree of Doctor of Education in Education,

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A handwritten signature in black ink, appearing to read 'Lisa Browne', is written over a solid horizontal line.

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Abstract

This thesis is an investigation into women's experiences of repeatedly attempting to lose weight and maintain a weight they find acceptable, and the implications of this for health education.

This was an interpretivist inquiry which generated data through narrative interviews. The data was analysed using three different strategies to enable deeper understanding of the participants' experiences. To set the context health education resources relating to body weight, healthy eating and activity were collected from local community and health settings. A former local practice nurse was also interviewed about her role in assisting women with weight loss. A literature review revealed an emphasis on research and policy that focuses on the dangers of overweight and obesity, prioritising individual behaviour and energy-deficit approaches to losing weight.

A qualitative method was used to collect data from a convenience sample of five women. Data from interviews and autobiographical writing were recorded, transcribed and analysed within a narrative analysis framework.

Analysis of the findings using three interpretive lenses are presented first as re-storied accounts of the women's narratives, and secondly thematic analysis addressing issues of control, pleasure and pain, and embodiment and alienation. Finally a relational analysis reveals the ways in which participants position themselves in relation to themselves, other characters and the interviewer in order to build their desired identities.

The data shows that the participants had followed a wide and diverse range of diets, eating and exercise plans, none of which had been successful in both reducing their weight and maintaining it at a level they were happy with, even after repeated attempts. Whilst biomedical literature suggests a dividing line between pathological eating disorders such as anorexia nervosa/bulimia and normality, the disordered eating and emotional difficulties described by the participants supports the view that a broad range of eating and body-image

problems may be more culturally normative than is generally recognised. Dieting and weight cycling were common experiences.

The findings of the thesis suggest that contrary to current public policy, the views of these women who are unhappy with their body weight are complex, idiosyncratic and demonstrate resistance to health messages that target individual responsibility for weight management. Their views are developed from personal experiences - the findings suggest that these women are stigmatised. However, one response to this can be to stigmatise other people whom they see as more overweight than themselves. Normative femininity is increasingly centred on appearance and women who do not comply with the requirements risk alienation and pain.

The identities that the women construct are relevant for health education but not taken into account when national policy and strategies are developed to address overweight and obesity. The risks to health of weight cycling are also not addressed by policy. The implications of the thesis are discussed in relation to the embodied experiences and gendered roles of women, the role of health education and its relationship with biomedicine.

Chapter 1

Introduction

Within the UK, in every setting where people live, work and study, images of slender, attractive women are not far away. From posters in the shopping centres and on public transport buses, trains and taxis, to advertisements in newspapers, magazines and even food product wrappers, women are idealized as slim and youthful in a limited and weary aesthetic like that of Bordo's 'Empire of Images' in which celebrity images are digitally modified and in which those images teach us how to see, and what we should see and how we should expect women to look (Bordo, 2003 xii).

I see these images in my own community and they contrast oddly with the women I see around me. The women I see are real flesh and blood in different shapes, sizes and ages. Does it matter if advertisements show women with their real body size reduced, their waist to chest length increased, hair volumized and extended, skin tone evened, wrinkles removed and dimpled skin smoothed? Is it reasonable to assume that women are well aware of airbrushing and digital enhancing techniques used by advertisers so they are not deceived by the images? Alexandra Shulman, editor of British *Vogue*, when asked if the fashion industry felt responsible for creating the images that girls could never achieve but measure themselves against, replied 'Not many people have actually said to me that they have looked at my magazine and decided to become anorexic' (Bordo, 2003 p xiv).

A multi-million pound beauty, diet and fitness industry uses images to sell its products and services. The financial success of that industry would suggest that its advertising strategy works very well. The rewards gained by diet, beauty, fitness and pharmaceutical industries can be huge when they pressure women by promoting unattainable expectations. Wolf (1991) expressed what she described as 'The Beauty Myth' as the final and most dangerous lie relating to the rules of femininity and the ways in which women are expected to look and behave because it sets an impossible standard which they nevertheless try to achieve. Conversely, to be fat is to be stigmatised (Goffman, 1963; Rand and

MacGregor, 1990; Brochu and Morrisson, 2007), even by the health professionals who could be expected to be non-judgemental in the best interests of their patients (Teachman and Brownell, 2001). The Telegraph reported a quote from Dr Hamish Meldrum, Chair of the British Medical Association Council. Dr Meldrum said an obsession with labels may be stopping overweight people from tackling their problems. He said: "We are saying 'This patient has a hyper-appetite problem' rather than 'They are just greedy'" (Smith, 2007).

In this chapter I will present the rationale for this research study and introduce the current issues that most immediately affect women in relation to their weight and body image. The role and position of health education and my own position and background is also outlined. The local context of the research study is important, both in terms of how it reflects the national picture and any differences seen, therefore my investigation of local resources available for women seeking to lose and maintain weight is reported in a context section of this chapter.

My own journey

I trained and worked initially as a state registered nurse and midwife, with further study including a MA in Public & Social Administration (Health) and a post-graduate certificate in education. I developed an interest in health education, holding posts in the (former) national Health Education Authority, local authority health education services, and managing the health promotion unit of a NHS community health trust before teaching health studies, health promotion and teacher training in higher education.

Much of my work involved managing programmes of health education/health promotion, including the development of training and education resources for the general public and professionals, in topics which included healthy eating and weight management. However, since nursing training I have also been preoccupied with my own weight. At the age of twenty I would swap diets and share exercise programmes with friends. There were always rumours about colleagues who would lose large amounts of weight quickly and become ill.

Despite our concern for our colleagues we were always keen to know which diet they had followed. In general I would 'weight-cycle', that is regularly losing and regaining weight over a period of several months.

Diets usually focused on one or two foods – steak and grapefruit, hard-boiled eggs, or pineapple – or exclusions of whole food groups, such as the Atkins diet which eliminated most carbohydrates. I tried many and the results were similar – an initial, satisfying weight loss, soon followed by compulsive eating and rapid weight gain. Eventually I stopped dieting and settled at a weight that felt healthy for me. However, I gained a stone following the birth of my daughters and, over the years, would occasionally think I should do something about losing the extra stone. Whilst working as a health education/health promotion professional I felt that losing weight was a low priority and, as I began teaching, I became too busy to worry about anything beyond my family and my job.

A few years ago my sister asked me to support her in her attempt to lose 8 stone in weight as she was concerned about the effect of her weight on her health. With some misgivings I enrolled with her in a local commercial slimming group. Attending the group raised issues that were unresolved from my early dieting experiences and which I had noticed others struggling with. This coincided with the writing of my initial research proposal on the EdD programme. Although the slimming group does not feature in the research study, my experiences of the group helped to provide a context and shape its direction.

The following is an account of my first visit to the slimming group:

The group was held in a purpose-built community centre, in a large room with I felt a fraud. The other women, including the consultant, were clearly bigger than me. However, I felt I had to go through with it as I had promised my sister, who would be joining me the following week. The meeting began with a talk by the consultant about new food products and recipes that would be permitted on the slimming group eating plans, and the exercise award certificates that were named to indicate the duration and regularity of exercise that had been undertaken. A brief conversation with each attendee followed, in which details of their weight loss or gain over the previous week were discussed, although individuals' actual weight was not revealed. Women (there were no men in the group) applauded each others' weight losses and commiserated over gains, offering advice on ways to avoid lapsing from the eating-plan. The plan, which comprised a choice of three programmes, was not referred to as dieting.

I noted that all of the programmes contained food I did not allow myself to eat (for instance, bread, potatoes and bananas) as I felt they would promote weight gain. I decided that the eating-plan would be unlikely to work for me but that I would continue to attend in order to help my sister. At the end of the meeting I paid the new member fee, stated my target – the weight I was before I had my children – and my current weight was taken and recorded in the member's log book. I was dismayed to see the extra stone I had gained over the years, that I was hoping to lose with the group, had somehow crept up to 2 stone 10 pounds.

(Extract from Research Journal)

Reflecting on this account two years later I remember that on the following week, whilst my sister attended the talk for new members I went into the cloakroom and was startled to see a woman around my mother's age, wearing just a sweater and underwear. She brushed off my apologies, saying that she was just changing the light slacks she wore for the weekly weigh-in, for a warmer pair that she had brought with her. This was my first experience of the weekly 'weigh-in' in which many women wear their lightest-weight clothes to the

meetings, whatever the weather, changing to warmer, more comfortable clothes once their weight has been recorded. One woman always weighed-in wearing Lycra gym clothes, in all seasons. Others told me they avoided eating or drinking at all on group meeting days, until they had been weighed. I noticed that the kitchen which contains tea and coffee-making facilities for members was often used by members to eat their breakfast between weigh-in and the start of the meeting. I was quickly absorbed into that culture. Although I have since reached and maintained the weight that was set as my 'target' I still remove many layers of clothing, including scarves, gloves, cardigans and other lightweight items before being weighed, and never eat just before being weighed-in at slimming group meetings, thus 'modelling obedience to cultural norms' (Bordo, 2003).

In other aspects of my life, for instance at work and social meetings, I often meet women who refuse biscuits or cakes at coffee and tea breaks, making reference to their body size and their attempts to lose weight. Some of these women are young, some middle-aged or older and their body sizes range from slender to large. They often introduce the topics of diets that have helped them or their friends to lose weight, and lead lengthy and complex discussions about these.

The culture of weight-loss and weight-management which is such an important issue in the lives of many women and which disproportionately affects women (Orbach, 2006) is interesting, particularly in terms of why women feel it is so important to lose weight, and why they need to repeat the attempts throughout their lives. The support available from national and community health services and commercial weight management services seems to be unable to help them lose weight and maintain that weight loss in the long-term. The aims of my research study were to gain an in-depth understanding of the experience of women who have repeated unsuccessful attempts to lose weight and to maintain a weight they are happy with, and to explore the implications of their experience for health education.

As a health educator I have planned programmes around national campaigns and events, for instance National No Smoking Day. The outcomes of these programmes have been enhanced by legislation that works in tandem with

health education field workers' aims – for instance, legal restrictions on the advertising of cigarettes and tobacco products. Cigarette smoking is now banned in public places, many addictive substances are illegal; alcohol is also regulated – anyone supplying alcohol must be authorised by a licensing authority approved by the Home Office, and its sale is restricted to those over the age of eighteen (gov.uk, 2013) – and further regulation is the subject of increasing debate. This is not the case in the issue of healthy eating where much work remains to be done. Indeed, in the promotion of healthy nutrition and physical activity, and women's health and self-esteem, the aims of health education practitioners appear to be directly opposed by huge corporate interests, in the same way that tobacco smoking used to be when it was advertised through television, posters, shop fronts and sporting events. Images of unhealthy, thin, sometimes underage girls continue to be idealised and promoted as glamorous and desirable in television, magazines, posters and even posed on cars and boats at shows, whilst the converse – images of very large people, are used for audience engagement and shock entertainment value in television programmes such as *Honey*, *We're Killing the Kids*, *Super-Size Super-Skinny*, and *Super-Size Me* (Rich, 2011; Seale, 2003).

In reviewing the evidence and strategies used to reduce tobacco smoking Yach *et al* (2005) suggested some lessons that health educators tackling the problem of unhealthy diets and inactivity could learn. The first was to address the issue of individual responsibility against that of collective action, recognising that individuals are unlikely to be successful in making healthy choices where they are not supported by governments and other sectors, including private interests. Also included in the lessons was the importance of leadership by 'media savvy and politically astute leaders' (Yach *et al* p899). It was noted that the global breakthrough in tobacco control occurred when a director general of the World Health Organisation was willing to speak out against smoking, supported by medical scientists, thus empowering others in their efforts. It was also noted that this has not yet happened in terms of healthy diet and physical activity promotion (Yach *et al*, 2005 p899).

Regulation of food quality, supply and marketing is currently carried out through voluntary partnership deals between the food industry and the Department of

Health. National events such as the recent London 2012 Olympics could have been an opportunity to promote healthy lifestyles for public health education. Instead, images of the event were dominated by those of its food industry sponsors – Heineken, Cadburys, Coca Cola and McDonalds. Indeed it was boasted that the Olympic village was home to the largest McDonalds in the world (Barford, 2012). Health education clearly missed this national opportunity. It would be useful to look at the background of health education further before setting the context for this study.

Health education

The World Health Organisation (1991) defined health education as an intervention to help people to be in control of their own health and the factors, including their own behaviour, which influence it. They also stressed the role of community action, equity, advocacy and empowerment as being part of health education. Health education and health promotion are terms that are often used synonymously in practice, although in many definitions health promotion is broader, including health education and healthy public policy (Tones & Green, 2004) or health education, health protection and the prevention of disease (Downie *et al*, 1990). Tones & Tilford (1994) included the equitable distribution of resources and the influence of ideology on health in their revised definition of health promotion. Definition will again come to the fore, with the increasing movement of all health promotion, education and preventive services into the public health sector where they are subsumed within the domain of health improvement.

The move within the UK towards a pathology-based understanding of weight and its place in women's health occurred with the move of health education and health promotion over the last decade into the Public Health Directorates of National Health Service provision. Scott-Samuels & Springett (2007) have noted that health promotion in England has largely disappeared and been replaced by public health, which does not share the same values. Public health is rooted in epidemiology and the planning and provision of services to prevent and treat disease. The public health message, drawing from discourse rooted in the medical model of health is that overweight and obesity in Western societies has

increased rapidly in recent years and is set to increase further, with consequent increase in ill-health, disability and impaired quality of life (British Nutrition Foundation, 1999, Zaninotto & Head *et al*, 2009). Within public health discourse, the problem is addressed by promoting weight loss and increasing physical activity. However this seemingly straightforward solution masks complex issues. The promotion of weight loss 'fails to integrate people's lived experience as gendered, situated bodies in an inequitable world' (Aphramor 2005 p315) and the consequences of ignoring this can be serious. The nature of and rise in prevalence of eating disorders in young women is well-documented (Evans *et al*, 2008; Orbach, 2006, 1993; Levine & Piran *et al*, 1999, Chernin, 1981). Less well documented is the experience of women who define themselves as overweight and who try, repeatedly and unsuccessfully throughout their lives, to lose weight and to maintain a body weight they are happy with. However, they are subject to the same images and pressures. In this study I planned to investigate the meaning women attach to their weight and their attempts to control it, and to explore the implications for health education/health promotion.

Narrative Inquiry

This study takes an interpretivist approach as I am exploring the perceptions and lived experience of individuals. I therefore needed a research design that would enable participants to address the topic freely and with minimum constraint. Narrative inquiry is a framework in which life development and personal identity can be explored by interpreting written or orally narrated stories or accounts which are shaped in an order that is meaningful to the narrators (Riessman, 2008; Polkinghorne, 1988).

I intended to explore human experience, for which subjectivity (the ability to consider one's relationship to the focus of the study) and my own relationship to truth, are important. My view is that understanding human behaviour within the social reality that individuals experience requires the researcher to recognise the role of self in research and to acknowledge the values, culture, and beliefs that they bring to it. I share Denzin and Lincoln's (2005) view of the importance of the relationship between investigator and participant. I wanted to explore the perspectives of individuals and to acknowledge my position and role as

researcher in interpreting participants' meanings about their experiences and in shaping that interpretation. Researcher reflexivity is therefore important. As Bruner wrote 'The qualitative researcher is not an objective, authoritative, politically neutral observer standing outside and above the text (Bruner, 1993 in Lincoln & Denzin, 2000 p 1049). As a woman who shares concerns about weight management, I wanted to acknowledge my own experience and make transparent my own role in the research process, by including my own story and by making explicit the decisions made in gathering, analysing and representing data.

It became clear that researching this group would benefit from a methodological approach that focused on their experiences. Narrative inquiry was chosen because it would enable me to gather stories the women constructed in order to make meaning of their experiences. People are natural storytellers and stories have been traditionally used to communicate across generations. They give coherence and continuity to experiences, shaping and constructing the narrator's identity (Lieblich *et al* 1998). This approach was therefore useful for my study in exploring women's experiences and the ways in which they construct their identities through their stories. Mishler (1986b) argues that people make sense of their lives through stories and that their audience participates in their creation. They can also show how people position themselves in the midst of conflicting ideologies and power relations (Wells, 2011). This is particularly relevant to the investigation of sensitive topics such as women's weight and body size, which may be influenced by dominant narratives and societal discourses.

Narratives are created and heard in contexts – social, historical and interactional (Riessman, 2008). This involves the framing of human behaviour and belief within a social-political context. I recognised that it would be important to look at the context of the women's lives – their history, social circumstances and economic situation, and relationships, which may be shown by their stories – and to acknowledge my own role in the construction of the stories. Narrative inquiry refers to not only the gathering of stories but includes their purpose, significance and meaning, determined through systematic analysis of data and its re-presentation. My own approach is explained further in chapter 3.

Context of the study

Health education has undergone many changes over the past five decades and these will be examined in chapter two. At the time of this study health education, part of the broader health promotion field, was placed within the setting of National Health Service public health. From April 2013 public health within England moved to be part of a new body – Public Health England. This is an umbrella organisation, with local management devolved to local authorities, who will provide public health against indicators that include the indicator of people weighing less (DOH, 2012).

In examining the local context in which the research study would be set I carried out a small data gathering exercise, looking at two local areas: First I collected samples of health education literature that would be available to the participants from community-based facilities and local media. Next, a former practice nurse from a local health centre was interviewed. The interview is reported here rather than with other study data because the purpose was to learn about the role of the practice nurse as a resource in providing support and information for women in her locality who are seeking to lose weight, rather than generating the narrative data that would be used in the main study. Most resources are available nationally, with some adapted by local health and community services to suit communities in their areas. However I wanted an insight into the background, culture and resources in which the stories of the participants were set. I planned to recruit five women from the South West of England.

Health education resources

In April and May, 2012 I collected samples of health education resources that would be available to the participants if they wished to access support for weight loss or maintenance. They comprised advertisements, leaflets and posters aimed at weight-loss or maintenance of a healthy weight, or healthy eating and activity. These were collected from two libraries and the 'Health Education corner' at the largest health centre on the border of Dorset and Hampshire, where four of the five participants live. The fifth participant self-reported information on resources in her area. Resources do vary from area to area across England. For instance, weight loss, healthy eating or exercise groups may be offered within primary care settings. However my aim was to

see what was available to participants locally to understand the context for healthcare in this region.

General Medical Practitioners (GPs) can refer patients who meet specified weight criteria to local gyms on an 'exercise prescription' scheme and/or to local commercial slimming groups for a period of twelve weeks free of charge. In addition, participants who are able to pay can use local authority and private gyms and swimming baths. They can also join commercial slimming groups. Advertisements in local newspapers for all of these facilities and additional ones (beauty and toning centre, kickboxing, dance classes to 'keep fit the fun way', and hypnotherapy – the 'virtual gastric band') were also gathered.

In the libraries a few books relevant to weight management were available for reference and loan. These included a Family Health Encyclopaedia, and other books relating to health and nutrition. One self-help book for weight loss was seen. There were no relevant posters, leaflets or booklets in the public information section of either library, although there were computers available which could be booked for a limited time by members of the public. There were also basic computer training and support sessions available within the libraries for people wishing to learn how to use computers and search for weight-loss information and resources online.

The health centre yielded more direct information. A large section of the waiting room was arranged as a health education/patient information corner, with posters, leaflets and booklets displayed. It was set up and is maintained by volunteers from the Patient Participation Group. The PPG comprises lay volunteers and membership is by invitation (decided by other members of the group). There were few resources specifically for weight loss. One was a large poster titled 'Managing Your Weight' with an image of weight and balance scales and bullet points advising on fruit, vegetable and water intake, reduction of fat and alcohol, and increasing physical activity.

Some resources advised on weight loss in relation to the prevention of disease:

One pamphlet, titled 'Keep a Healthy Weight, cut your cancer risk' published by a cancer charity, explained across eight sections with full-colour photographs, how being overweight causes cancer; how to

measure one's risk; the role of body shape in affecting health; suggested changes to food intake and physical activity, and concluding information on useful websites for weight loss. It advised readers to ask their doctor to refer them to specialised weight loss services.

A fact sheet titled 'Diet & Stroke' was published by the Stroke Association who claimed to have independent editorial control, but was funded by a pharmaceutical company named Merck, Sharp & Dohme. The fact sheet addressed antioxidants, the role of salt, cholesterol and vitamins. There were also three paragraphs about watching your weight, one of which advised increasing exercise.

'Choosing the right fats for a healthy heart' was an A4 double-sided full-colour leaflet published by Flora Pro-activ. It had healthy eating and healthy lifestyle tips, advising readers to switch from butter to Flora (a spread which is claimed to be high in polyunsaturated fats)

Other resources were aimed at groups defined by age, gender or community:

The Age UK healthy living book targets retired people. It contained sections on healthy eating and exercise and gave information about the Food Standards Agency, with contact details and download information for their healthy eating guide for the over-50s, 'The Good Life'.

'Healthy Women' was a full-colour pamphlet published by the NHS. It folded into sixteen sections, illustrated with photographs of women of different ages, ethnicities and shapes. It contained sections on alcohol, screening, physical activity, healthy eating, self-esteem and body image. There was an information section, listing contact details for NHS Direct, Sport England and Sport Scotland, MIND, Smoking Helplines, Cancerbackup, and Alcohol help organisations.

Health and Community guide: a 28-page full-colour booklet, supported by advertising, is published annually, providing details of health and social care issues, services and treatments within named areas. One page in the 2011/2012 issue addressed healthy lifestyles, weight control and healthy eating. Contact details of the NHS Change4Life website had been listed.

In summary, the health education literature available was limited and it was not clear whether publishers were independent or how they were funded. Sources for the information given were also missing or unclear so that readers could not be sure whether the advice given was authoritative or current. The literature did not seem to be an important source of information for those seeking help with weight management so I looked at support within the health centre. I discovered that another form of guidance was within primary care clinical services, based in general practice. Women could seek consultations with GPs or nurses, free at the point of delivery.

Interview with a health professional

I therefore interviewed a former Practice Nurse (Sister Smith) who had retired that year from a nursing role within primary care, to discover whether further weight-management support might be available to women through clinical consultations. General practice has an important health education role in primary care. My aim was to discover the extent of the support and guidance in weight management that could be expected from a large general practice in the region in which four of my five study participants live. This interview was not conducted as part of the main study. However, the same ethical and practical protocols applied, as explained in chapter three. Sister Smith came to my house for an interview and answered the following questions:

- 1) Where did you work, and for how long?
- 2) What was your job function?
- 3) Were patients referred to you for weight management, or did they self-refer?
- 4) What forms of support did you offer those patients within the practice?
- 5) Were there limitations on the support that could be provided? What were these?

The interview was relaxed and informal. Once I had asked the first three questions the conversation led naturally into the areas that I wanted to cover in questions four and five. I prompted or questioned further when interesting points

were raised that I felt it would be useful to expand on. Sister Smith provided a great deal of data, which can be summarised as follows:

Role

She was an experienced nurse whose clinical duties within the practice were mostly around women's health issues, asthma, family planning and assisting with disease management clinics. In terms of weight loss management, patients would sometimes self-refer, asking for advice because they had got to know her from other clinics, especially as part of the 'whole-person' check in the well-woman clinic. Sometimes Sister Smith would opportunistically target patients during clinics if she felt they would benefit from weight loss advice and information; for example those with hip problems whose mobility would be improved if they weighed less.

Clients

Weight-loss patients were mainly women – she could only remember seeing two men who wanted to lose weight. Sister Smith distinguished between older and younger women. For younger patients she developed a system of referral to a local slimming club that she attended herself. The club waived the joining fee for patients who were referred by her. This appears to have been an informal arrangement as, when the club leader left, the person who replaced her was not prepared to continue the system.

Older women were found to be more challenging because either they were 'in denial about the extra calories they ate' or because they had given up and were not prepared to try further. She also noted that the lifestyle and social life of older people was based very much around food, but luxury convenience food, and that older women said their husbands would not be prepared to eat different meals. Older women also created reasons for not losing weight, for instance, their legs hurt so they couldn't exercise, rather than focusing on the amount and type of food they ate. It was suggested that many older women had undiagnosed depression, often through resentment of their husbands – some women were quite frightened of their husbands but were isolated in their marriage, living a long way from other family, not having friends to talk to and not wanting to worry their children. She found that those women would treat

themselves to luxury food when they went shopping because it was the one thing they could have control over.

Reasons noted for overweight

Sister Smith said that the commonest reason for people being overweight is that they like food; they were given sweet treats as children, and continued to use food as rewards, treats and compensation. She noted that differences in food production nowadays means that manufactured food tends to make us fat. She also believed that increased socialising and its link to increased alcohol consumption is a factor. Patients also denied having a problem with their size, referring to themselves as big-boned and saying their mother was also big-boned and the same size as they are now.

Sister Smith and I also discussed and compared diets we and our friends had used, and how dieting need not be expensive as usual meals can be modified to make them lower in fat and sugar. She said how few foods contained the 'traffic lights' symbols on packaging that show which foods are high and low in fat, salt and sugar, noting that the war years were simpler as there was less choice of food available.

Support offered

In terms of the support offered, this was mainly advice, publications such as leaflets and posters, and exercise prescription. Sister Smith felt that more support should have been given to patients by the health visitor, as their role is so broad. Referral to the NHS dietetic service was only possible if patients had co-morbidity, such as diabetes or severe heart disease. It was explained that dieticians were so overworked they were unable to offer a service to someone who was overweight and just wanted to lose weight.

Limitations on support offered

'Using up appointments' on patients who wanted to lose weight was also noted to be a problem as the primary care trust did not fund the practice to carry out these activities, particularly as these appointments would need at least twenty minutes. Sister Smith said this was a reason why doctors would often not refer to the patient's weight – they were afraid it would extend the appointment time

to twenty minutes and doctors did not have this time available. Because appointment time was limited, nurses would only be able to give general advice about cutting-back, avoiding cakes and sweets, increasing fruit and vegetables and checking packets for information. She remembered one of the nursing auxiliaries at the practice having success with a patient who was attending regularly for weight loss. She speculated that the auxiliary was probably fitting the patient into a 'double blood-pressure appointment'. Support on weight-loss was generally inconsistent as another nurse at the practice disliked the slimming group that Sister Smith attended, so would bring different sheets that focused on calorie-counting rather than the slimming club 'healthy eating' approach.

A surprising aspect of this interview was in an aside, when Sister Smith talked about a game she played in which *'you give people points and whoever spots the fattest person pays for, oh doesn't have to pay for the coffee so you go around and (laughs) I've seen an eighter, that's an eighter over there and the fattest person is ten and if you get a tenner you don't have to pay coffee all day. The best place to do it is America ... you see people who are a twelve over there, I'm telling you.'*

I returned to this conversation during interpretation of the narrative data.

Conclusion

From looking at these resources it was apparent that a variety of weight loss resources in terms of commercial slimming clubs, gyms and exercise groups are available nationally. However, investigation of the local context revealed that there are limited resources available free of charge for weight-loss support and these are largely uncoordinated. Online resources are limited to those who have access to and are able to use computers. Although computer access and training is offered through local libraries, this is restricted as the libraries investigated have been subject to local authority reductions in funding so opening hours have been reduced.

Access to literature in the health centre visited currently depends on the choice of unqualified volunteers rather than healthcare professionals. Some of the literature seen has been produced and/or funded by commercial firms who have

a financial interest in readers following their advice. This could be viewed as local National Health Service organisations promoting specific commercial firms.

Access to a course of free approved commercial exercise or slimming club membership is currently available through local general practitioners but only for those who meet specific body mass index measurement criteria. This would exclude women who are in the overweight but not obese category. It is also clear from the interview that consultations in Sister Smith's practice were not generally available for weight loss support except where this was necessary for the treatment of diseases such as cardiovascular disease or diabetes.

It was established from the initial investigation that weight-loss resources available to women in this locality comprised services from private slimming and exercise clubs that were available to all who could afford them, and primary care consultations restricted mainly to those suffering from chronic medical conditions associated with obesity. Those with a BMI of 30 and over would qualify for a 12 week membership of an approved slimming club, funded nationally. Health care literature available was uncoordinated and its sources were unclear. A woman seeking support and guidance on weight-loss and management would not have a clear route through the resources examined.

The following chapter reviews the literature on health and medical aspects of obesity and overweight, national policy and programmes and health education, and social/cultural factors. I then move on to the chapters which explain the methodology of the study and presentation and discussion of the findings.

Chapter Two

Review of Literature

Literature relevant to the study will be reviewed in this chapter. This covers several disciplines although the research studies within each discipline complement each other. For instance, some studies focus on a population approach to health, gathering data through surveys, whilst others use qualitative interviews with individuals to address a personal, social dimension of health. Much of the published research is in biomedicine and public health/public policy but broader health education literature is also relevant and I found a rich source of literature within sociology. Feminist scholars have addressed the topic of women's bodies from different perspectives, including narrative inquiry (Riessman, 2000; Langellier & Peterson, 1992) ethnography (Luttrell, 2003) and studies relating to embodiment (Bartky, 1990; LeBesco, 2010; Bordo, 2003) – although these do not address weight management specifically.

Prevalence

Studies of prevalence are firmly based within the positivist paradigm, with evidence obtained from quantitative studies, particularly large-scale surveys. This evidence has been used to suggest that overweight and obesity in western societies has increased rapidly in recent years, despite measures taken to reduce the levels (Swinburn *et al*, 2011, Lobstein & Leach, 2007, WHO, 2005). For instance in 1996 prevalence in the UK was calculated as more than double that of 1980, having increased to 16% in men and 18% in women (British Nutrition Foundation, 1999).

Zaninotto & Head *et al* (2009) extrapolated prevalence trends in the UK, using 1993 to 2004 figures to project the prevalence of adult obesity to 2012. They reported that approximately one third of all adults would be obese by 2012 if trends continued. They also warned that public health action to halt or reverse current trends and narrow social class inequalities in health was required. A study of trends in body-mass index in 199 high, middle and low income countries and territories showed an increase in mean BMI from 1980 to 2008, with the USA having the highest mean BMI within high income countries. It also

found that more than 1 in 10 of the world's adult population was obese - 1.4 billion adults, 20 and older, were overweight; of these, over 200 million men and nearly 300 million women were obese (Finucane *et al* 2011).

In 2011 the National Health Service Information centre reported that 60% of women, 50% of men and 25% of children could be obese by 2050 and from a 2010 Health Survey for England:

More than a quarter of adults were obese (26 per cent of both sexes) in 2010. In total, 68 per cent of men and 58 per cent of women were overweight or obese in the year.

The prevalence of obesity increased from 13 per cent in 1993 to 26 per cent in 2010 among men, and from 16 per cent to 26 per cent among women. While the rate of increase in obesity was slower in the second half of the period, in 2010 obesity was at its highest level since the time series began in 1993, and in men the 2010 level was also significantly higher than in the period between 2000 and 2005.

(NHSIC, 2011p15)

Swinburn *et al* (2011) identifies this as a global obesity pandemic which, he says, began in high-income countries in the 1970s and 1980s before spreading to middle-income then low-income countries.

These epidemiological studies are appropriate to measure prevalence. However, the value attached to findings can be challenged. An example is in the BMI (body mass index) which is the measure used to establish underweight, healthy weight, overweight and obesity. This is expressed as a number which is calculated from the weight and height of an individual – their weight in kilograms divided by the square of their height in metres. It was developed by Keys *et al* (1972) who found that the ratio of weight to height squared is better than the simple weight to height ratio in measuring relative weight, for use as a research tool. However, Keys warned against using this as a measure of ideal or healthy body-weight, noting that individual variations such as age, socioeconomic

factors, gender and ethnicity, even fat distribution and muscle mass affect health and are not taken into account in a BMI measurement.

The BMI ranges are:

Underweight	under 18.5
Healthy weight	18.5 - 24.9
Overweight	25 - 29.9
Obese	30 - 39.9
Morbidly obese	40 and over

National Obesity Observatory 2012

Table 1: Body mass index

Closer examination of the Body Mass Index as a measure of, and proxy for, healthy body weight, reveals that, in 1998, BMI classifications were revised, creating overweight and obese people overnight (Campos *et al*, 2005). The value of the BMI as a measure of body weight is in any case contentious. Measuring obesity is not straightforward. Seid (1994) is sceptical of the assumption that weight, in relation to height, can determine an ideal weight for health. BMI does not measure body fat or determine health, nor does it take account of the way in which fat is distributed. For instance, a waist circumference greater than 34 inches in a woman, not her BMI measurement, it is suggested, is associated with conditions such as heart disease and diabetes. Campos *et al* (2005) argues that a normal weight-range has been pathologised, whilst there is convincing evidence to suggest that the overweight category is associated with longevity.

The BMI measurement is clearly not value-free. However, despite the warnings of Keys *et al* (1972) and later challenges of Gard & Wright (2001), Orbach (2006) and Evans *et al* (2008), BMI has become the standard expression for weight and is widely used. For example the National Institute of Health (2011) explains that 'overweight' and 'obesity' are terms used to describe body weight

greater than the weight considered healthy for a particular height and that body mass index is the most useful measure of overweight and obesity.

Next the proposed links between overweight/obesity and poor health are examined and challenged.

Links to morbidity and mortality

Overweight and obesity are considered to be public health problems as evidence suggests they are linked to chronic ill-health, disabilities and impaired quality of life. Greater morbidity and mortality are reported in those who are obese, particularly from diabetes, hypertension and cardiovascular disease (Olshanky *et al* 2005, Popkin and Kim, 2006). A British Medical Journal press release warned that in middle-aged women obesity reduces the chance of a long and healthy life by almost 80% (BMJ, 2009). Further, Olshansky *et al* (2005) suggest that the current trends of obesity in the US will halt the steady rise in life expectancy that has been noted over the past two centuries. High blood pressure is just one of the problems, as warned in this NHS report:

Although current signs are that obesity rates may be levelling off, the existing health burden remains a cause for concern. In 2009, in England, 51% of obese men and 46% of obese women had high blood pressures, compared to 20% of men and 15% of women who were not overweight (ie had a BMI less than 25). In 2010/11 there were 11,574 admissions with a primary diagnosis of obesity (ie a BMI more than 30) to NHS hospitals, more than ten times the number in 2000/01 (1,054). In 2010/11 almost three times as many women as men were admitted with a primary diagnosis of obesity (NHS IC (2012)).

However, high blood pressure is not the only health problem associated with overweight and obesity. Links with other medical conditions have also been reported. Links between obesity and increased morbidity and mortality are well-documented (WHO, 2007, Lopez *et al* 2006, Olshanky *et al*, 2005). Raised body mass index (BMI), that is BMI over 25 is noted as a risk factor for type 2 diabetes, cancers and cardiovascular diseases (Swinburn *et al*, 2011). Health complications include increased risk of diabetes, coronary heart disease, gallstones, some cancers, reproductive disorders and strain on joints, causing osteoarthritis (British Nutrition Foundation, 1999). The World Health

Organisation included obesity and high cholesterol as well as malnutrition in a list of risk factors to health addressed in a report on reducing risks and promoting healthy lives (WHO, 2002). Swinburn *et al* (2011) refer to a global obesity epidemic in which, since the 1980s, middle-income and low-income countries have increased rates of obesity although the highest rates continue to be in high-income countries. Non-communicable diseases have now become the main cause of disease that could be prevented, even in low-income countries.

Overweight and obesity are linked to more deaths world wide than underweight. For example, 65% of the world's population live in countries where overweight and obesity now kill more people than underweight (WHO, 2012). The World Health Organisation (2004) provided a global strategy for action on diet, physical activity and health but governments and policy leaders are moving slowly on implementing it. Gortmaker *et al* (2011) argued that governments should be leading the efforts to prevent obesity but few have shown leadership in this area.

In the Department of Health report 'Healthy Lives, Healthy People' the health risks associated with higher BMI were further stressed, with the information that, compared to a 'healthy weight' woman, an obese woman is more than three times more likely to have a heart attack, more than four times more likely to suffer from high blood pressure, and almost thirteen times more likely to develop type 2 diabetes. Raised risks for other conditions included gall bladder and liver disease, ovarian cancer, osteoarthritis and stroke (DoH, 2011).

However, links between overweight/obesity and poor health may not be as straightforward as these research findings suggest. A spurious credibility may be attached to findings simply because the medical model is powerful and authoritative. Also, as Lupton (1995) and Illich (1976) note, the language of medicine may be used to disguise moral judgements. Dominant discourse may rarely be called upon to defend its position and there are challenges to the evidence linking overweight and obesity to poor health which are examined in the following section.

Challenges

Not everyone concurs with the problem-based approach to overweight and obesity. The cross-party parliamentary inquiry (APPG & YMCA, 2012) heard evidence that the risks to health from overweight may be overstated, due to the BMI measure used being an inaccurate way to classify large groups of individuals and their health risks, reflecting a concern of Orbach, who claims that 'the new rise in obesity is not simple growth, it is largely also due to the Body Mass Index being revised downwards over the past six years' (Orbach, 2006 p xii). It heard that poor health may not necessarily be a consequence of overweight. Factors that are independent of weight loss, such as regular exercise and maintaining cardiovascular fitness, can reduce the risks that are associated with overweight, with regular exercise more likely to improve health than losing weight. It is also possible that in some cases excess fat may be the symptom of an existing, underlying condition rather than the cause of it. For instance there is evidence to suggest that insulin resistance is due to a metabolic syndrome that also predisposes people to excess fat. This occurs because of the fat storage effects of the extra insulin that the body produces to compensate for the insulin resistance (Neel *et al*, 1998).

It is also important to look at the plans that are suggested by health professionals to enable people to lower their BMI. People are advised to follow weight reduction eating plans which reduce calories, and to increase their activity levels in order to lose weight. The assumption is that following this medical advice will enable weight loss and improve the person's health. However, assumptions often go unchallenged due to the authority given to medical and scientific opinions. Gard and Wright (2005) note that obesity researchers will often speculate about the causes and solutions of obesity, whilst presenting their views as certainty.

Ernsberger and Koletsky (1999) assert that weight cycling, in which weight is lost then regained before being lost again, may account for the health problems associated with overweight, and is more dangerous than maintaining a high, steady weight. This is supported by findings from the Framingham study in which it was found that excess mortality associated with obesity could be

accounted for by the impact of weight cycling as those people who were obese but with stable body weights were not at increased risk (Campos *et al*, 2005). Campos points out further that epidemiological studies of the relationship between body weight and mortality fail to control for variables such as fitness, exercise, diet quality, weight cycling, and diet drug use. It may be that body weight is a proxy for these unmeasured variables. It may also be easier to modify these, for example by increasing exercise, than it is to lose weight. Exercise training in obese women has been shown to improve blood lipids and insulin sensitivity without body fat loss and even in those who gained body fat during the period of training (Lamarche *et al* 1992, Bjorntorp *et al* 1970). Also, reduction in blood pressure has been shown in women who have made lifestyle changes but whose body weight has remained the same (Bacon *et al*, (2005).

The stigmatization of overweight people may prevent them from taking up healthy behaviours such as exercising (APPG & YMCA, 2012). The Health At Every Size Group (HAES) has tried to address this by setting up groups of people who meet to support each other in becoming healthy and maintaining good health, irrespective of body size, and with no aim of losing weight. Within such a group people can exercise together without feeling targeted for disapproval by others. Aphramor reviewed weight management research, concluding that there is not only lack of evidence to show that energy-deficit approaches to weight loss work, but also that the missing evidence is replaced by speculative claims. In conclusion she recommends the alternative health at every size (HAES) approach (Aphramor, 2010).

Studies do not provide consistent evidence that dieting results in significant health improvements, regardless of weight change. Rather, weight loss is often followed by weight gain (Mann *et al*, 2007, Aphramor, 2010). In a study to investigate the most effective obesity treatments, following the inclusion of these in Medicare plans, the conclusion was that diets do not lead to lasting weight loss or health benefits (Mann *et al* 2007).

A challenge to the accepted wisdom that overweight equals poor health outcomes occurred in 2005 when a curious finding from a research study was reported. In a cohort of 7,767 heart failure patients, those with higher BMIs were found to have lower mortality risks (Curtis *et al* 2005). A limitation of the study

was that there was no data on pharmacological treatment of participants. However, researchers adjusted for age, smoking status and history of previous disease. The study concluded that overweight and obese patients had a lower risk of death compared with those at a 'healthy' weight, for reasons that were not understood. However, more recently the obesity paradox has been supported by findings from a study of 65,000 patients with acute coronary syndrome, in the Swedish Coronary Angiography and Angioplasty Registry (SCAAR). It was reported that those with a BMI that classed them as overweight or obese had a lower risk of death after PCI (percutaneous intervention) than normal weight or underweight study participants, even up to three years afterwards. The underweight group had the greatest risk for mortality (Angeras *et al*, 2012). In an editorial accompanying the report, von Haeling *et al* concluded that weight loss in patients with chronic illness and a BMI of less than 40 'is always bad, and in fact not a single study exists to suggest that weight loss in chronic illness makes patients live longer'(von Haeling *et al*, 2012 p331).

Flegel (2005) found, when studying the mortality and morbidity statistics of those in the different BMI groups, that only the upper and lower categories of BMI were associated with increased mortality. The healthiest group was the BMI category of 25 - <30, which has the classification of overweight. People in this group do not even enter the range of statistical significance for harm – this occurs at BMI of 35 and over, which involves much smaller numbers of people. Another study found that one in four people within the healthy BMI range had cardiac risk factors that are usually associated with obesity; whilst half of the people in the overweight category and a third of those in the obese category had healthy metabolic profiles (Wildman *et al*, 2008). Flegel has recently repeated her study with similar results and a systematic review, comprising 2.88 million people over 97 studies showed that all-cause mortality was lowest in people in the overweight BMI category of 25 - <30. Severe obesity was associated with an increased risk of death from all causes, but lesser amounts of excess weight either did not increase the risk or were protective. Grades 2 and 3 obesity (BMI>35) were both associated with significantly higher all-cause mortality but Grade 1 obesity (BMI 30 - <35) was not associated with higher mortality. Overweight was associated with significantly lower all-cause mortality.

Flegal and colleagues noted that their findings are consistent with previous studies, which have also shown lower mortality among overweight and moderately obese individuals (Flegal, 2013).

Aphramor (2010) reviewed articles from the *Journal of Human Nutrition and Dietetics* in order to evaluate the claims made by weight-loss researchers, and concluded that, despite the failure of the energy-deficit approach to weight loss it continues to dominate research, with controversies and complexities in the evidence base inadequately discussed, and available evidence misrepresented. 'It could be said that weight loss enjoys special immunity from accepted standards in clinical practice and publishing ethics' (Aphramor, 2010 p1).

There are also challenges to the notion of an obesity epidemic. Gard and Wright explore the characterisation of the so-called 'obesity epidemic', pointing out the ways in which '... scientific uncertainties which exist tend to be papered over by unsubstantiated assumptions' (Gard & Wright, 2005 p5). It is hard to imagine why individuals or groups would want to replace evidence with assumptions. However, there may be benefits associated with constructing obesity as an epidemic. Moynihan has reported significant drug industry funding to the World Health Organisation's International Obesity Task Force (Moynihan, 2006) and financial benefits through the weight-loss industry are considerable. They may include research grants, royalties from books and publications, and commercial profits from slimming clubs and weight-loss products (Saguy & Riley, 2005).

Lebesco (2010) used the concept of Cohen's 'moral panic' (Cohen, 2002) to examine fatness through the lens of the current preoccupation with the obesity epidemic. She noted the components of moral panics – concern, outpourings of hostility, consensus that the threat must be tackled, disproportionality in the warnings or threats of harm, and volatility in the way the panic finds expression. She linked these to development of the argument that an obesity epidemic is associated with the poor, working classes and people of colour. Lebesco also examined moral panic expressed by antiobesity researchers, pointing to the 'fat-hating author, Michael Fumento' (Lebesco, 2010, p 75) who expresses outrage against fat activists, saying they have 'turned what had been two of the deadly sins – sloth and gluttony – into a right and a badge of honour'. Lebesco remarks that 'our culture has less of an issue with slothful people who happen to be thin

(and there are plenty) and gluttons who don't wear the visual evidence of their appetites on their bodies (because of high metabolisms or bulimia or a host of other reasons' (Lebesco, 2010, p75).

Others have looked at the ways in which discourse around body weight is incorporated into contemporary research. Saguy and Riley (2005) examined four main groups – antiobesity researchers, antiobesity activists, fat-acceptance researchers, and fat-acceptance activists, arguing that these groups frame contests over excess body weight and its consequences. Those in the antiobesity camp tend to be clinical and scientific researchers and medical practitioners, framing medical arguments about weight as high risk behaviour like smoking, which individuals can and should control. Those in the fat acceptance groups meanwhile frame fatness as a body diversity issue. Both groups have sometimes framed obesity as a disease. Whilst this limits individual blame it further stigmatizes fat people as diseased. In addition, it is argued that the 'obesity epidemic' is misleading, concluding that notions of morality are central to the controversy over obesity, with medical arguments about body weight used to justify fears that are based more on morality than health (Saguy & Riley, 2005, Gard & Wright, 2005).

Stigma

There are emotional and psychological costs associated with overweight and obesity as there is stigma attached to both, and the prevailing culture idealises slim figures (Bordo, 2003, Brownell, 1991, Wolf, 1991, Chernin, 1981). This can cause low self-esteem in overweight people, who may experience discrimination as a result. Stigma is a powerful consequence of weight discrimination, which can have psychological and physical consequences. It may be based on stereotypes of overweight people as lazy, unsuccessful and lacking in willpower. In a systematic review of weight bias and stigmatization toward adults, Puhl & Heuer (2010) found that weight stigma is a form of bias that is socially acceptable. They noted that overweight and obese people are often victims of detrimental weight-related stigmatization across many domains, including employment and educational attainment, and that this undermines public health.

Discriminating against people who are overweight is commonly perceived as justifiable as a way of motivating them to lose weight (Crister, 2004, Hebl, 1998) although the converse may be true – with morbidity and mortality increased by stigmatisation (Bayer, 2008). An iatrogenic effect (that is, harm caused by medical intervention) of stigmatization and discrimination has been reported (Guttman & Salmon, 2004; Puhl & Heuer, 2010; Puhl *et al* 2007). Puhl & Brownell (2001) and Puhl & Heur (2010) found weight stigma experienced across a range of contexts, with the worst stigma encountered from close relationship partners such as parents, spouses and friends. Weight bias of health professionals has also been reported, even in those specialising in the treatment of obesity (Schwartz *et al*, 2003). Teachman & Brownell (2001) also found implicit anti-fat bias among health professionals who specialize in obesity treatment; however this was lower than implicit anti-fat bias in the general population.

Another study compared participants' perceptions, attitudes, behavioural intentions, and implicit associations towards normal-weight and overweight men and women. Explicit and implicit anti-fat prejudice was demonstrated, with men showing greater negativity towards overweight people of either gender (Brochu & Morrison, 2007). Weiner *et al* (1988) found that people with stigmatizing conditions rated high on personal responsibility, such as drug addiction and obesity, were disliked and received fewer helping behaviours than those who had conditions rated low for personal responsibility, such as Alzheimers Disease.

Anti-fat prejudice can also influence attitudes of those charged with protection and care, such as health professionals and those who contribute towards policy development. For instance a Mississippi State House Bill was put forward to prevent restaurants from serving food to obese people. The Personal Responsibility in Food Consumption Act was supported by one Congressman who pointed out that people get fat if they eat too much and that it is their own responsibility not to do so (Pomeranz, 2008). Evans *et al* (2008) demonstrate how media reporting of obesity portrays overweight people in ways that would be seen as unacceptable if it was addressing any other form of ill-health issue. In a study of 79 obese women who were trying to lose weight, adult teasing,

self-esteem and internalization of socio-cultural appearance standards were found to be predictors of body image dissatisfaction (Matz *et al* 2002). Authors noted that self-esteem in adulthood and interpersonal-cultural context, rather than childhood experiences, were important in predicting body image dissatisfaction in adulthood. The depth of this dissatisfaction can be profound. In a study of obese adult patients' perceptions of social discrimination before and after obesity surgery, individuals said they would prefer to be blind or deaf or have another disability rather than be obese (Rand & MacGregor, 1990). Nor is this a modern phenomenon. Stunkard *et al* (1998) showed stigmatization of obesity in Japan and Europe in medieval times, based on theories of the time as to the cause of obesity. In Japan it was thought to be the karmic consequence of moral failing, and in Europe it was associated with the deadly sin of gluttony. Puhl & Heur (2010) found that weight stigma generates health disparities and interferes with obesity intervention efforts, compromising their effectiveness. They see this issue as a priority for the field of public health.

National Policies and Programmes

The linking of overweight and obesity to poor health outcomes means that legislation that succeeds in reducing prevalence of the problem could potentially lead to significant savings in health expenditure. The National Audit Office (2001) estimated the cost of treating disease that could be attributed to obesity as £469.9 million with over 80% of this attributed to coronary heart disease, hypertension and Type 2 diabetes, followed by osteoarthritis, stroke, gall-bladder disease and colon cancer. It recommended that GPs and their teams should be carrying out health promotion as well as consistently giving individuals advice. The Quality Outcomes Framework, an annual reward and incentive programme for GP surgeries, was introduced into primary care in 2004 as part of the new General Medical Services contract. It captures data from individual practices and details their achievement against indicators. The data is potentially a rich source but does have limitations. An example is the prevalence rate reported on obesity, which was 10.5% - lower than the 26.1% reported by the Health Survey England (DoH, 2010) as only patients over 16 who have a record of a BMI of 30 or higher in the previous 15 months will be

included in the QOF obesity register. A proportion of the QOF will be ring-fenced in 2013 for public health indicators, including that of obesity.

The Foresight programme (Foresight, 2007) was commissioned by the Government Office for Science to examine the possibilities for the delivery of a sustainable response to the issue of obesity in the UK over the next 40 years. The resulting report challenged the traditional research paradigm used in clinical medicine, by pointing out that the collection of diverse data over time which would be the usual approach, would not meet the need for urgent action. It pointed out that, in particular, as the prevalence of obesity rises it will be normalised so the calls to action may reduce. The report was clear that 'Scientists ... must, where necessary, make do with the best evidence available. This means placing greater priority on 'practice-based evidence'. Likewise, 'policy makers must accept that some well-intentioned interventions may fail' (Foresight, 2007 p137). An expert group on obesity was set up to advise on the evidence that had emerged. An initial role was concerned with the following strategies and programmes:

'Healthy Weight, Healthy Lives' (2008) was developed as a cross-government strategy for England, supported by the Change4Life social marketing programme which worked with civic and commercial partners to target populations considered to be at risk of obesity. The strategy set out the Government's plans for addressing obesity, aiming particularly at the target set by the 2007 Comprehensive Spending Review:

'to reverse the rising tide of obesity and overweight in the population, by ensuring that all individuals are able to maintain a healthy weight. The initial focus is on children: by 2020 the proportion of overweight and obese children will have reduced to 2000 levels' (DoH, 2008).

The strategy called for monitoring of adult obesity levels through the Health Survey for England. The use of 'early indicators of success' was suggested, including:

- Daily consumption of fruit and vegetables
- Reduced consumption (and/or sales) of foods high in fat, salt and sugar
- Nutrient intake

Measuring and monitoring patterns and trends in health-related eating behaviours and dietary intakes was seen as vital, both for national policy development and for planning services at local and regional levels. This was carried out through The National Diet and Nutrition Survey which was previously a series of cross-sectional surveys, collecting nutritional information on specific age groups. In April 2008 it changed to a rolling programme with data collected annually. Findings from the first two years showed no changes, with the overall diet and nutrition of the UK population being broadly similar to previous surveys, and no new nutritional problems identified. A Low-Income Diet and Nutrition Survey of over three and a half thousand people examined diet, physical measurements and nutritional status from analysis of blood samples between 2003-2005. One conclusion was that men and women with a lower level of educational achievement tended to have a 'less healthy' diet than men and women with more education. The expert advisory group on obesity supported the development and delivery of the strategy and consequent public health programmes.

In order to support health strategies and programmes Puhl & Heuer (2010) suggest education as the most promising way to combat the stigma that undermines obesity interventions. They see this issue as a priority for the field of public health. Attempts within the UK to reduce overweight and obesity have included public health information on healthy eating and exercise, incentive schemes, the development of an exercise prescription scheme, and more recently, referral to commercial weight management services. The Cabinet Office's behavioural insights team proposed financial incentives to reward people who reach a healthy target (Cabinet Office, 2010). However, incentives have not proved effective in encouraging sustained weight loss (Paul-Ebhohimhen & Avenell, 2007). Although guidelines recommend that general practitioners should identify and treat people with obesity (NICE, 2006) there are few treatment options in primary care. In a meta-analysis of the effectiveness of obesity prevention and interventions, Summerbell *et al* (2003) found very little research evidence of effectiveness in intervention programmes. Blaxter notes that the public has learned the lessons of health education (Blaxter, 1990) and the British Nutrition Foundation have pointed out that people have received the health education messages and understand what they should

be doing to reduce and prevent obesity. However, despite this, the prevalence of obesity continues to rise (DoH, 2011; British Nutrition Foundation, 1999).

Jolly et al (2010) evaluated a range of weight management services, finding that commercially provided weight management services are more effective and cheaper than primary care based services. They concluded that primary care based services led by specially trained staff are ineffective. Jebb *et al* (2011) also found that commercial weight loss programmes offering regular weighing, advice about diet and physical activity, motivation, and group support, can offer an early intervention that is clinically useful for weight management and can be delivered at large scale. However this does not address the issue of maintaining weight loss. Evidence suggests that weight loss does not lead to long-term weight reduction and that it can be harmful (Neumark-Sztainer *et al*, 2006; Mann, 2007; Bacon *et al*, 2005).

‘Healthy Weight, Healthy People: A call to action on obesity in England’ (DoH, 2011) heralded the effects of forthcoming health and local authority changes on obesity prevention and services. It focused on environment change to help individuals address behaviour that leads to overweight. Although aiming to empower individuals through measures such as physical activity guidance, the Change4Life programme and tailored support driven by local authorities – who it is intended will have a lead role in health improvement – the strategy clearly pointed to individual responsibility in changing behaviour, supported through the public health responsibility deal by partners who include the food and drink industry. Crucially, the report announced the intention to ‘reward progress against outcomes, and not process (DoH, 2011 p6).

From April 2013 the National Obesity Observatories which provide information on data, research and evaluation related to weight become The Public Health England Obesity Knowledge and Intelligence team, whilst the responsibility for driving weight management programmes will be with local authorities. General practitioners in primary care will identify, give brief advice and any clinical services such as medication, and then refer on to further specialist services. Health and Wellbeing Boards comprise health and social care membership and

other key local partners working together to improve the health and wellbeing of local populations and reducing any health inequalities (DoH, 2011).

Explanations and responsibility

The causes and responsibility for overweight and obesity are contested, with some groups blaming individuals for their excess weight whilst others point to social, economic, environmental and psychological factors. The Foresight programme report (2007) explored and mapped societal and other factors that have increasingly led to an obesogenic environment, opening up the possibility that overweight is more than simply the result of unhealthy lifestyle choices by individuals.

‘... for an increasing number of people, weight gain is the inevitable – and largely involuntary – consequence of exposure to a modern lifestyle. This is not to dismiss personal responsibility altogether, but to highlight a reality: that the forces that drive obesity are, for many people, overwhelming’ (Foresight, 2007 p10).

Nevertheless the former Prime Minister, Gordon Brown, when introducing the ‘Healthy Weight, Healthy Lives’ strategy the following year, stressed the responsibility of the individual in controlling their body weight ‘... maintaining a healthy weight must be the responsibility of individuals first - it is not the role of Government to tell people how to live their lives ...’ (DoH, 2008 piii).

The Secretary of State for Health, Andrew Lansley, when introducing the next strategy - ‘Healthy Lives, Healthy People: A call to action on obesity in England’ (DoH, 2011) focused even more firmly on personal responsibility.

‘Overweight and obesity are a direct consequence of eating and drinking more calories and using up too few. We need to be honest with ourselves and recognise that we need to make some changes to control our weight. Increasing physical activity is important but, for most of us who are overweight and obese, eating and drinking less is key to weight loss. Each of us is ultimately responsible for our health’
(DoH, 2011 p 4)

Not everyone shares this view. When interviewed by the BBC on publication of the obesity strategy, Professor Phillip James, Director of the Association for the

Study of Obesity, described the obesity strategy as a 'pathetic' and 'stupid' response to the problem, saying that legislation was needed because the junk food industry 'manipulated' people into consuming those products (Triggle, 2011). The Campaigns Director of the Children's Food Campaign, Charlie Price, said of the strategy, 'This is a deeply disappointing and utterly inadequate response which represents a squandered opportunity to address the obesity crisis', and 'High in rhetoric and lacking in substance, it is nothing less than an abdication of the government's responsibility to protect public health' (Triggle, 2011). Although the strategy talks about creating the 'right' environment for individuals to make healthy choices, it relies on voluntary agreements from industry, and the promotion of physical activity from local authorities, rather than using regulation. Lansley, when asked why the government did not use legislation, replied that 'by working in partnership, more could be achieved faster' (Triggle, 2011).

James went on to accuse the health secretary of 'handing public health over to the food and alcohol industries', by handing the nutrition element of the Food Standards Agency to the Department of Health, with its food and drink industry advisers, suggesting that an independent approach was particularly needed as obesity is an important risk factor for health.

James's scepticism with simplistic explanations for obesity is shared by others and the certainty surrounding explanations of individual responsibility for obesity is increasingly challenged. There is a trend towards exploration of factors outside the individual's control to explain increasing obesity rates, with suggestions that the physical, social and political environment is a contributory factor to obesity (Smith & Cummins, 2009). Li *et al* (2009) showed that the density of fast-food outlets in the neighbourhoods they studied was associated with increases in weight and waist circumference of adults. The ease of walking in neighbourhoods was also associated with decreases in weight and waist circumference in adults (Li *et al*, 2009).

'Obesity is the result of people responding normally to the obesogenic environments they find themselves in. Support for individuals to counteract obesogenic environments will continue to be important, but the priority should be for policies to reverse the obesogenic nature of these environments.' Swinburn *et al* (2011 p804).

In the USA, Parker & Keim (2004) found in a study of limited-income, overweight and obese white women that disordered eating habits were common due to social, economic and familial pressures, with weight loss a low priority because of social and economic barriers. They found that food was used by the women to cope with the stress and pressures of life and concluded that multidisciplinary programmes were needed to target these social and economic factors as well as addressing nutrition.

However, the World Health Organisation (WHO) and medical literature (WHO 2004, 2007, 2012; Olshanky *et al*, 2005; Kim & Popkin, 2006; Swinburn *et al*, 2011) continue to see overweight and obesity as a public health problem. It would be useful to look at the development of health education in addressing public health issues relating to overweight and obesity.

Health Education and Public Health

Health education and promotion developed against a backdrop of social and political change that informed what Kickbusch (2003, p386) has called 'the third public health revolution', focusing on health as an important dimension of quality of life. According to Kickbusch health policies need to address both the collective lifestyles and social environments of modern societies as they affect the health and quality of life of populations.

Baric (1985) recognised the importance of the social, political and economic environment to healthy lifestyles, noting that health education is concerned with raising individual competence and knowledge rather than the health promotion aim of creating an environment that is conducive to healthy lifestyles (Baric, 1985). Health education was once seen as a system of education for healthy living and disease prevention (Breslow, 1999) but is now seen broadly as one of the components and key areas of health promotion (WHO, 2010). In Britain this was reflected in the establishment of the Health Education Authority, a special health authority founded in 1987 to advise the government on health promotion strategy through research and work with health professionals. It was replaced by the Health Development Agency and subsumed into the National Institute for Health and Clinical Excellence in 2006. Changing philosophies saw the

development of health education to health promotion by including the addressing of structural levels. The term 'health promotion' was introduced by the *Ottawa Charter for Health Promotion* (WHO, 1986). The charter was developed from the first international health promotion conference which was held in Ottawa, Canada, in 1986 as a means of achieving the 'Health for all by the Year 2000' goal that the WHO launched in 1981. The charter introduced the concept of the 'new public health,' with the following *Adelaide Recommendations on Health Public Policy* (WHO, 1988) reflecting the increasing awareness that deprivation and social inequity link with poor health outcomes. Without an explicit focus on structural change health education that targets individuals has little chance of improving health for all. Within the charter, health was seen as a tool or resource to allow people to live their lives well, rather than being seen as the objective of living. It defined health promotion as a process which allows people control over improving their health. Giddens coined the phrase 'life politics' to refer to this type of integrated approach, commenting that politics cannot be divided into vertical streams of action so that, for instance social policy, health policy, and economic policy are separated. If the question faced in 21st-century politics is how people want to live their lives (Giddens, 1991), then positive welfare mobilising life-political measures to connect personal and collective responsibilities are important. They reflect the World Health Organisation's goal to highlight indicators that address member nations' responsibility for health, rather than just health services, through integration of health, economic and social welfare. In Europe this integrated approach became a new public health (Kickbusch, 2003). Twenty five years later an integrated international approach is called for in order to tackle the obesity epidemic.

'Many parties (such as governments, international organisations, the private sector, and civil society) need to contribute complementary actions in a coordinated approach. Priority actions include policies to improve the food and built environments, cross-cutting actions (such as leadership, healthy public policies, and monitoring ... integration of actions within existing systems into both health and non-health sectors (trade, agriculture, transport, urban planning, and development) can greatly increase the influence and sustainability of policies. We call for a sustained worldwide effort to monitor, prevent, and control obesity.'
(Gortmaker *et al* 2011)

Further WHO papers addressed the need for supportive environments, (WHO, 1991b) the impact of urbanisation and sedentary behaviour on health promotion in the twenty-first century, together with a discussion of the evidence for health promotion effectiveness, (WHO, 1997) and then two papers which focused on related areas. These included the need for governments to accept a core responsibility for funding health promotion and for improving the multi-agency networks to ensure that social, economic, and environmental factors are addressed. The accountability of UN agencies for the health-related impact of their developments was also included (WHO, 2000, WHO, 2005). The WHO Global Strategy on Diet, Physical Activity and Health was adopted by the World Health Assembly in 2004. All stakeholders were charged to take action at global, regional and local levels to improve their population's diets and physical activity levels (WHO, 2004).

The WHO's Health for All policy update (WHO, 2005) noted that addressing health determinants effectively is not straightforward and that education rather than legal prohibitions may be more effective. Swinburn & Egger (2008) however argue that policy-led solutions that apply to whole environments have more chance of success than health education programmes as they work across whole populations, including hard to reach groups, and are sustainable. However, this is merely theoretical if lobbying by powerful groups with vested interests prevents policies from being adopted (Triggle, 2011, Corporate Europe Observatory, 2010, Brownell & Warner, 2009).

Models of health education followed the WHO's lead, with Tannahill's (1985) spheres of health promotion: health protection, health education, and preventative services hinting at a more holistic approach to health then later revised, together with Downie (Downie *et al* 1990, 1996). Ewles & Simnett's framework comprises the activities which are carried out to improve health - these include overlapping spheres of ill-health/disability based services, and positive health activities such as health education programmes that focus on lifestyles and behaviour change, as well as health-focused public policies (Ewles & Simnett, 1999). Beattie also pointed out that increasingly health professionals claim health promotion as the basis of their work (Beattie, 1991). Tones, Tilford & Robinson (1990) focused on policy development, including fiscal, economic and environmental aspects at both local and national levels in

their model to promote health, but they included health education with the individual as well as interventions at a structural level. Health education increasingly became incorporated into a broader health promotion approach which recognised the importance of a wide range of health determinants.

A later approach was social marketing, outlined in the framework of Winett (1995) who proposed that models of behaviour change should be integrated with development at community and institutional levels. His framework has six categories, beginning with epidemiology, moving through national priorities for health, then mortality, morbidity and health behaviour, before outlining the marketing plan in categories five and six. Marketing terminology such as product, price and product promotion is used. This fits well with the increasing public health base of health promotion (Scott-Samuels & Springett, 2007) which uses epidemiological information for its foundation, and with government health policy increasingly favouring commercial involvement in the NHS in the form of partnerships such as the Private Finance Initiative (PFI) and the LIFT project which provides purpose-built primary and community care premises for lease by public authorities (Department of Health, 2012).

Social marketing theory has been criticised when applied to settings in which there is unequal distribution of power, which influences behaviour and choice. According to Rayner & Lang (2012) its supporters believe that public health should emulate commercial firms, on very small budgets. Demonstrating why this is unrealistic, they point to a study they carried out for the World Health Organisation, in which they showed that Coca-Cola spent more on its marketing of soft drinks than the whole of the WHO's biannual budget (Lang *et al*, 2006).

The newer nudge theory (Thaler *et al*, 2008) has been taken up by the Cabinet Office's behavioural insights team – the so-called 'nudge unit' (Oliver, 2011). In nudge theory behavioural economic insights are used to change the environment and social norms, to encourage healthier individual choices. This is also addressed by Rayner & Lang in a British Medical Journal 'Head to Head' article in which they point out that 'nudge pitches government action at the soft end of policy interventions rather than the hard end where taxes, regulations, or bans feature'. They call for public health to 'regain the capacity and will to address complexity and dare to confront power' (Lang & Rayner, 2012 p899).

Following this, the government expert advisory group on obesity that Rayner and Lang were members of was disbanded quietly. Rayner later told the BMJ that he thought the Department of Health had been upset about the article. He said: 'They don't want to hear critical independent advice. They only want advisers who agree with their way of thinking' (Wise, 2011).

A House of Lords Select committee inquiry into the use of behaviour change interventions concluded that the use of nudge theory was unlikely to achieve behaviour change and advised the use of a broader range of measures, including regulation (Cabinet Office, 2011). A recent British Medical Association report has also highlighted concerns about public health policy for England, noting the government's heavy reliance on voluntary partnerships with business and its support of nudge theory rather than regulation and legislation (BMA, 2012).

Health education models and their increasing recognition that there are collective and environmental or policy-dependent elements of positive health intervention are relevant for issues that impact on large groups of people, such as obesity. The discourse on obesity includes theories of broader causes of overweight, such as the effect of the social /political environment and use of space which would address the obesiogenic environment.

If overweight can be attributed even in part to factors outside personal individual control, the health education mainstay of providing health information, either generic or customised materials (Kreuter & Holt, 2001) will be limited in effectiveness. The critical health literacy model described by Nutbeam (2000), which stresses broader health promotion outcomes, empowering individuals and communities by improving actions and control of social groups over the determinants of health and structural issues, in addition to improved access to good quality resources, is a long way from being translated into practice within the UK, although areas which have benefitted from a multi-faceted approach have been more successful in reducing harmful behaviour. The reduction of tobacco smoking is an example of a health promotion success (Jha *et al* 2006). It is perhaps a reflection of the complexity of overweight, obesity and resourcing issues that the same model is not being used to successfully address weight reduction and management. Lang and Rayner note the 'policy cacophony' in

obesity, caused by the number of interventions and the disputes over their value (Lang & Rayner, 2007).

Despite the 'policy cacophony', the British Medical Association's director of professional activities, Vivienne Nathanson, reports that calls by the British Medical Association for food and marketing regulation have not been heeded (Newton, 2012). Six years ago doctors at the BMA annual representative meeting asked for mandatory traffic-light labelling to inform consumers about the quantities of fat, sugar and salt in food. A year later it was agreed at the BMA Annual Representatives Meeting that relying on the industry to voluntarily take measures to address the problem was unlikely to work. The Food Standards Agency developed a front-of-pack traffic light colour-coded system which includes an icon and text to indicate whether food or drink is high, medium or low in salt, fat and sugar, and the percentage of the product's percentage contribution to the guideline daily amount (GDA) in each category. Traffic-light labelling has been reported as effective (NICE, 2010) but the European Union has refused to endorse traffic lights as a statutory food labelling system, instead opting for daily guideline amounts to be displayed on food packaging.

Within Britain, ministers have rejected legislation, opting instead for voluntary responsibility deals with the food industry to improve public health. The BMA have asked 'repeatedly' to join the responsibility deal set up by the Department of Health to cover diet and obesity but have been refused. The BMA joined the deal that covered alcohol but resigned from it because of 'the rather pathetic nature of the pledges made' (Newton, 2012, p11). Rayner and Lang (2011) accused the British government of 'quietly breaking with' the consensus that they claimed had been reached between scientific advisers and politicians on the complex and multi-factorial nature of obesity. They point to food supply, pricing and marketing, domestic culture, consumer choice and genetic factors, asserting that obesity is the result of all of these and that frameworks for action should now be developed. They also point to the experience of the alcohol responsibility deal between government and industry to show that 'questions of pricing or irresponsible marketing' are not included in the areas that are discussed (Rayner and Lang, 2011, p898). The powerful food and allied industries' lobbying role against government regulation appears to be effective,

despite the potential of policy-led solutions to reach whole populations and to be adopted as default behaviours.

Health education and health promotion have been largely subsumed into public health departments, where health issues such as obesity and overweight are addressed through a biomedical model. Scott-Samuels & Springett note that, since 1997, health promotion has been disappearing. They looked for evidence that it had been mainstreamed into the health-promoting policies and programmes that have developed during this period but concluded that this was not the case. Instead, health promotion in England has been subject to a hegemonic absorption by an increasingly individualistic public health discourse (Scott-Samuels & Springett, 2007). Public health in England has been transferred to a new body – Public Health England – with an outcomes framework that includes health protection, health improvement, public health of healthcare with the prevention of premature mortality, and improving the wider determinants of health. Local authorities rather than health authorities will manage a ring-fenced budget to provide public health against indicators, including the indicator of people weighing less. Improvements in public health will be rewarded with cash incentives (DOH 2012).

Mindell *et al* argue that corporate interests have subverted the state's regulatory role by shifting responsibility to the individual in matters such as obesity and smoking, seeking to gain control over the health promotion agenda and to determine government policy. They point out that the food industry spent £836m lobbying the European Union against traffic light labelling on food packaging, which would have given consumers easy to understand information about the nutritional value of the food. They accuse the government of 'appointing the fox to guard the henhouse' (Mindell *et al*, 2012 p55).

Social, cultural and other factors affecting body weight and women's perceptions of their weight

Body image

The British Medical Association (BMA) targeted the role of the media when they published a report 'Body Image, Eating Disorders and the Role of the Media'

(Morant, 2000) in response to a motion at their annual representative meeting two years previously. The report called upon the media to use more realistic body images and avoid portraying very thin women as role models. The report suggested that the Independent Television Commission review its policy on the use of thin women in advertisements and called for schools to have media literacy programmes to help young people develop skills in critical viewing. Proposing the need for critical viewing skills reflects the belief that disordered eating as a response to disturbed body image is culturally normative. Studies which control for attractiveness indicate that body-image concerns are caused by exposure to the thinness of models, rather than their attractiveness (Dittmar & Howard, 2004; Halliwell & Dittmar, 2004). In addition, Dittmar and Howard (2004) found that average-size models had a relief effect, in which some women reported less body-focused anxiety after exposure to attractive, average-size models than after exposure to no models. Bordo asserts that women and especially young girls see airbrushed, digitally enhanced women with bodies that cannot realistically be achieved and find themselves falling short of that perfection. This is suggested as a reason for the development of disordered eating – an attempt to shape one’s own body to achieve that perfection (Bordo, 2003). Such attempts can be less than satisfactory; Brownell points out that weight and body shape are influenced by biological variables – possibilities for change are not infinite. To avoid conflict between culture and physiology, he calls for education to help people set realistic goals (Brownell, 1991).

Bordo also proposes that women are not always passive recipients, duped by artificial images. Rather, they understand that the people they see as important, lovers and potential lovers, employers and potential employers, have ideal images of women that are shaped by the media norms (Bordo, 2003). Women have to compete for the things they want, whether employment, success, or love, on the terms that the market sets. In addition, images may carry more than a model of perfection to be emulated. They may suggest acceptance by peers, popularity within a social group, security or even righteous reward for hard work.

The BMA report (BMJ, 2000) was published at the same time as the government women’s unit ran a summit on body image, with representatives of

modelling agencies, designers and magazine editors as well as young women attending, together with experts on eating disorders. This publicly acknowledged official concern about women's bodies and their health. Tessa Jowell, the minister for women at the time, made clear the government's view that eating disorders are a cultural phenomenon, mostly associated with industrialised Western society. Welbourne, of the Eating Disorders Association, welcomed the report but warned against using the media as 'scape-goats' instead of addressing societal change. However, she remarked that 'a cloud of blame does lie over television, which chooses men of all sizes to be presenters, but only thin women' (Morant, 2000). Evans *et al* also warn against single-solution remedies such as media literacy programmes, whilst ignoring issues such as class and culture. They suggest that gender, class and ethnicity are appropriate entry points when looking at obesiogenic environments (Evans *et al*, 2008).

A cross-party parliamentary group was set up in 2011 to address body image dissatisfaction and the promotion of positive body image. This resulted in an inquiry in November, 2011 to look at the causes and outcomes of body image dissatisfaction, with its findings published in a report 'Reflections on Body Image' (APPG & YMCA, 2012). The inquiry found evidence that dissatisfaction with body image is high and increasing, affecting all of society but with some groups such as children and adolescents being more vulnerable than others. The damaging consequences were noted as including a disordered relationship with food. The report identified positive body image as particularly important to emotional wellbeing. It reported over-reliance on digitally enhanced images to persuade people to use products and services, including cosmetic surgery, which would help them to achieve that appearance, noting that health was being sacrificed for appearance (APPG & YMCA, 2012).

The targeting of individuals

The risky behaviour frame that antiobesity researchers use, Saguy and Riley (2005) argue, serves many purposes. It is a bridge between obesity and unhealthy behaviours such as smoking and excessive alcohol consumption. It is also a way of targeting individuals, which is cheaper than changing the obesiogenic environment. In addition it avoids the need to upset the powerful

food industry by addressing issues such as food packaging and marketing. If the idea can be sold that no food or drink is inherently bad – individuals simply need to control their consumption and take sufficient exercise – then the marketing of processed foods high in fat, sugar and salt to encourage consumption is non-contentious. In addition food producers can ensure continuing markets by targeting children and associating their products, however dubious, with brightly coloured, jolly characters who promise fun and happiness. It can be seen that UK policy clearly favours this commercial approach. In addition to Ministers' comments about the responsibility of individuals, quoted earlier, there is a partnership between the government and the food industry which is financially beneficial to the food industry. For instance, the 2012 London Olympic Games were sponsored by Cadburys, Coca-Cola, McDonalds and Heineken (Barford, 2012). This appears to have ignited the interest of the media, who reported on BBC News Health 9.7.12 that a local general practitioner had criticised the sponsorship deals which allowed the association of junk food and alcohol with the Olympics and with sporting role models. He said:

'It is naive and ignorant of sports men and women to blame obesity on lack of physical activity. I encourage the health benefits of regular exercise, but this is not the solution in tackling obesity. One would have to run for five hours to burn the calories of consuming a chocolate bar, a packet of crisps and a burger and chips washed down with a fizzy drink' (BBC News Health, 2012).

Furthermore the BBC reported that the Labour shadow minister for public health, Diane Abbott also criticised the deals, saying that Olympic sponsorship is allowing companies to 'promote their brand and insinuate themselves into people's daily diet' (BBC News Health, 2012).

For those who are unwilling or unable to regulate their appetites or to make healthy food and activity choices there may be a more insidious form of social control than government regulation. This is bound up in notions of wellness and individuals' responsibility to maintain good health in order to contribute to productivity and, increasingly to compete with others. In 1951 Talcott Parsons introduced the concept of the 'sick role', outlining the responsibilities of those entering this temporary state, chief of which is to follow medical advice and

treatment in order to return to wellness as soon as possible (Parsons, 1951). It could be argued that, even now, individuals are required to use the means provided to prevent illness, for instance by refraining from smoking and not becoming fat, so that they do not become a burden on society (Rose, 1999). Foucault (1973) noted that the medical surveillance of populations is carried out in order to intervene if there is a threat of illness, and consequent loss of productivity. Health and wellbeing has become expected of individuals, who have a personal responsibility to use all means possible to remain in optimum health. They are assisted in this role to some extent by national policy which provides regulation in areas such as food safety, health and safety at work, and banning or restricting harmful substances such as drugs and tobacco.

It can be seen that the reductionist approach of much of the medical and scientific research in this area is reflected in national public policy on weight loss, which moves the responsibility for health away from institutions and towards individuals. However, this ignores the pressures on individuals who are expected to conform to a lifestyle, appearance and personal regulation that, it is argued, is even more tightly regulated in the case of women and girls (Gard & Wright, 2005; Bordo, 2003; Bartky, 1990). The formal and informal ways in which individuals can be subdued and controlled within contemporary western society, and the potential outcomes of this on women's perceptions of their bodies and identities are examined in the next two sections.

Theoretical understandings of perfection and control

Pressure to conform to an ideal body shape and size may say more about fashions of the time and current value systems than about health. Gard & Wright (2001) point out that obesity is a visual representation of failure to control one's appetites. Contemporary ideals require the regulation of food intake, exercise and every aspect of appearance, including deportment (Bordo, 2003). Furthermore, current health policy stresses the responsibility of individuals to control their weight (DofH, 2008; 2011). This responsabilisation is supported by pedagogy, both informal – for instance community-based exercise classes and instructional literature such as low-fat recipes in magazines aimed at women – and formal, as in educational institutions.

Evans *et al* (2008) note the effects of focusing on weight and health as elements of the health role in schools. They explore performance codes and perfection codes that are used to monitor areas of children and young people's lives, and point out the potentially devastating effects of this attention. In a school environment which already has a performance culture in which young people compete for achievement in academic and sporting tests, their bodies become another area in which they should strive for perfection. Compliance with these practices can normalise disordered behaviour on the part of young people. When coupled with the pressures on girls 'in a performative culture which reduces them to a commodity while meeting the expectations heaped on them by families and schools' this was seen as being a particularly serious difficulty for middle-class girls' (Evans *et al* 2008).

Disciplinary power on girls and women currently takes many forms. Whilst theories of discipline upon the body may be bound up with specific institutions, for example schools (Foucault, 1979). Bartky (1990) looks at the consequences of unbound disciplinary power on the subordination of women. She points out that the lack of a formal institutional structure creates an erroneous impression that the production of femininity occurs naturally or is voluntary. Foucault argued that the transition from traditional to modern society involved a significant change in the way power is structured. Previously ultimate physical authorities such as monarchs would have power vested in them and that power would be devolved to others directly. Although the exercise of power would be brutal for some individuals in those traditional societies, many would escape notice. Conversely, modern power structures are subtle and pervasive, reaching all individuals through multiple mechanisms, encouraging them to monitor themselves and others. The mechanisms are ever-increasing, with reality media now added. Mass media is an important source of knowledge about health and medicine (Lupton, 1999), with Rich (2011) suggesting that reality media is an aspect of public pedagogy that serves to form social identity, thus encouraging people to carry out surveillance of their own bodies – self-policing – and those of others, in the interests of addressing a so-called obesity epidemic. Even the WHO's global strategy on diet, physical activity and health includes in its

recommendations 'instruction, surveillance and evaluation' (Groskopf, 2005 p 41, quoted in Evans, *et al*, 2008). In today's society, few escape notice.

Following Goffman's notion of 'total institution' (Goffman, 1961) Scott suggests that a new form of total institution has evolved, exercising a more benign form of social control – performative regulation - a mix of coercive and voluntaristic (Scott, 2010). She argues that this has led to new ways in which individuals reinvent themselves, coinciding with a growth in what she calls Reinventive Institutions: Coser's 'greedy institutions' are invoked to show how self-improvement institutions demand not only commitment and loyalty from their members, but their social identities also (Coser, 1974). The voluntary nature of these institutions can blind members to their similarity to the social control exercised by the old total institutions. The discipline of performative regulation can be as strictly controlling in its way as asylums were in the containing and punishing of inmates. The generic new identities that replace the broken-down old ones are referred to by Scott as McSelves (Scott, 2010 p219) – a reference to the pre-existing template that, far from being the authentic result of a journey of self-discovery, is rather closer to a one-size-fits-all model. The discipline involved in the supposedly voluntary reinventive institution may be welcomed as the means to self-improvement, with members monitoring each other and validating each other. Evans *et al* (2008) note how this happens in schools, with broad health concerns influencing the development of health and education policies which are then included in pedagogical practice, requiring young people to undergo surveillance and to regulate themselves in the interests of health.

Groups such as slimming clubs also work on this principle, with mutual surveillance and sharing of personal transformations in the light of collective, participatory therapeutic support. Group leaders are exemplars, showing how they transformed their own bodies, rather than experts passing on knowledge. Commercial slimming clubs can be successful, at least in the short-term, at achieving initial weight loss, comparing well with primary care services when effectiveness is measured (Jolly *et al* 2010). Radner suggested that instructors such as Jane Fonda appeal to people because they act as an example to their students rather than as an authority. Radner argues that Jane Fonda's 'authority is generated by her membership within the group to whom she

speaks' (Radner, 1997, p 116). For Radner, Fonda took aerobics away from fitness and good health and re-sited it within feminine culture, with an emphasis on power not through strength but through having the perfect body. Hribar (2001) further points out that Fonda feminized aerobics by linking health and beauty in her videos. Bodies were disciplined in the 1980s according to feminine norms (Ellison, 2007). With the disappearance in late modernity of belief in, and reliance on the expert authority, problems both political and personal, are increasingly expressed through the body – what Turner (1996) calls the somatic society, in which life's problems and desires become linked with body projects.

As Bartky notes, 'The disciplinary techniques through which the 'docile bodies' of women are constructed aim at a regulation which is perpetual and exhaustive – a regulation of the body's size and contours, its appetite, posture, gestures, and general comportment in space and the appearance of each of its visible parts' (Bartky, 1990 p80). Women may regulate their behaviour and appearance in order to avoid offending social norms, or to simply fit in to their social setting. People ask why women who know well that they are being positioned in this way, continue to comply, but as Gard and Wright point out:

'the answer should be obvious. It is not only that the meanings about feminine heterosexual attractiveness and how to attain it are pervasive, but also that the risks of not paying heed to these messages are high. These risks include being socially marginalised, undesired and undesirable' (Gard and Wright, 2005 p158).

This can take many forms. Bordo remembers being passed over for a senior academic post for which she had been interviewed. A member of the interviewing committee later told her that she was not chosen because of the way she moved around during her presentation (Bordo, 2003). Her comportment was clearly deemed to be unacceptable, whether because it did not meet the requirements of expected feminine behaviour or those of senior academics, is unclear. Many people report experiencing discrimination from those who feel it is justifiable when directed at someone who is obese (Puhl & Heuer, 2010) Even doctors and nurses feel it is acceptable to discriminate against fat patients (Brownell *et al*, 2005). It is particularly problematic because of the lack of counter-discourse to exhortations to be healthy. As Lyn McAfee,

Director of Medical Advocacy for the Council on Size and Weight Discrimination pointed out, 'People get to discriminate against us because they're just trying to help us with our health'(Saguy & Riley, 2005 p878).

Constructions of the self

In contrast to much of the medical literature reviewed, the literature which focuses on social and cultural constructions of weight, suggests that individuals are not always responsible for their overweight. An issue that lacks clarity is the extent to which individuals choose to construct themselves in a particular way. Goffman (1959) argued that people are social actors rather than victims of systems; they construct and interpret their visual self. Moreover, they cannot choose not to do this – they must engage with the social process which is necessary for identity formation; appearance and identity are as one. He focused on the presentation of the self as a performance, reflecting the relationship between the self and the society in which it is presented, as a continuous interactive process.

Giddens also argues that, whilst appearance is a signalling device to show class and occupational position, the body does interact with society in order to construct the self. 'The tightly-controlled body is an emblem of a safe existence in an open social environment' (Giddens, 1991, p107). However, if the new appearances and identities people are constructing are based on their society's notion of perfection, as Giddens suggests or as close to perfection as they are able to achieve, it can be seen that replacing the desired female body – for instance, the slim, toned, Fonda of the 1980s, with the digitally altered images Bordo points out are unachievable (Bordo, 2003) may interfere with reflexive self-construction in a way that causes anxiety. Responses to failure may include increasingly desperate attempts to achieve the desired shape through diet, exercise, cosmetic surgery, or the increasingly popular bariatric surgery which forces a reduction in food intake, even where this is uncomfortable or painful.

However it has been suggested that Giddens neglects to consider how failure to achieve the identity that is not only desired but is imperative may harm individuals at a personal and identity-damaging level (Frost, 2005). Disordered

eating may be one consequence and there is increasing recognition that the development of eating disorders may represent one extreme in a broad spectrum of bodyweight-related problems. The integration of the prevention of eating disorders with the prevention of obesity has been proposed, with the recognition that there are shared risk factors and that eating disorders, obesity and unhealthy weight-loss practices are cultivated within the same cultural context but treated differently (Irving and Neumark-Sztainer, 2002; Haines and Neumark-Sztainer, 2006). Evans *et al* (2008) note that their research with young women suffering from disordered eating exposed issues relating to obesity discourse in education, culture and society that also caused difficulties for other young people. Brownell examines the psychological and physiological consequences of seeking perfection and falling short, in a modern culture in which slenderness as well as physical fitness is expected. The rewards of success in achieving an attractive body are less than could be expected, but the consequences of failure can be serious (Brownell, 1991).

Further, Bordo (2003) has explored the issue of disturbance in size awareness, labelled Body Image Distortion Syndrome (BIDS) as a marker for eating disorders such as anorexia nervosa. Those suffering from this condition supposedly have problems in seeing their bodies realistically. She cites Thompson (1986) who showed that the majority of women overestimate their body size and do not feel good about their bodies even when free from eating-disorders, questioning the notion that this overestimation of body size represents an underlying psychopathology. Rather, she proposes that women's unhappiness with their bodies, whether or not in the context of eating disorders, does not represent flawed processing of an external reality; rather it is a response to social attitudes towards women's size. Moreover, 'eating disorders, far from being bizarre and anomalous, are utterly continuous with a dominant element of the experience of being female in this culture' (Bordo, 2003 p57).

Conclusion

The literature review shows that the medical and scientific research available on overweight and obesity and about eating disorders such as anorexia nervosa

and bulimia is mostly the quantitative, positivist research which dominates biomedicine.

Much of the literature within this field is concerned with finding evidence to demonstrate that overweight and obesity is a problem and measuring the extent of the current problem, together with predicting the extent of the future problem, (Wang *et al*, 2011; Finkelstein *et al*, 2005; WHO 2007; Lobstein & Leach, 2007) and evaluating health education projects within specific groups or communities (Graffagnino *et al*, 2006; Greenberg *et al*, 2009; Prochaska *et al*, 1992). There is some research with children and their perceptions of body size, and family nutrition projects; also analyses of specific elements of women's difficulties with food and with their body image, with theories including low self-esteem, mother/daughter separation difficulties, and the replacement of repressed sexuality with eating disorders (Orbach, 2006; Brown, 1985; Chernin, 1985; Meadow & Weiss, 1992; Johnston, 1996). There are fewer studies asking women directly about their experience of obesity or overweight.

In the reviewed literature I have shown that positivist, quantitative approaches have been used to explore the public health problem of increasing obesity prevalence, although their relevance is contested. McKinlay (1995) has noted that in public health qualitative methods have more relevance than quantitative methods for socio-political topics and relations because of their potential for complexity. Anti-positivists have criticised 'science's mechanistic and reductionist view of nature which, by definition, excludes notions of choice, freedom, individuality and moral responsibility' (Cohen & Manion, 2000 p17). Biomedical discourse dominates the field of weight management and has the effect of reducing complex gendered societal issues to a condition that affects individuals and for which those individuals are deemed to have responsibility. Furthermore, the condition is identified by numerical measurement (the BMI) and the solutions put forward reduce the issue to a calorie-in, calorie-out equation which ignores other factors that have been examined in this chapter, such as the construction of self, gender, and broad societal, educational and economic issues that affect human experience.

In contrast to some of the medical literature (Olshanky *et al*, 2005; Lobstein & Leach, 2007; Zaninotto & Head, 2009; Swinburn *et al*, 2011) the literature which focuses on the social and cultural construction of weight-related issues suggests that individuals cannot be held wholly responsible for their overweight and that the issues are far more complex. Within this, research on young women's eating disorders and the associated obesity discourse (Evans *et al* 2008; Orbach, 2006; Gard & Wright, 2005) and studies of body image (Frost, 2001; Bordo, 2003) has been seen. However there is a lack of qualitative research on the experiences of women who have not been diagnosed with an eating disorder but who are nevertheless unable to maintain an acceptable body weight.

As a health educator I have been interested in, and challenged by, the difficulties women seemed to have, not only in losing weight, but in maintaining a weight they were happy with. The difficulty was not explained by medical understandings of weight management and I was keen to explore the possibilities of using alternative methods to further my knowledge and improve practice.

The research diary that I had started writing from the earliest stages contained an outline of the topic that interested me and rather than being confined to short notes, it was written in the form of storied prose. I have always found this form of writing useful for reflection on professional practice, particularly when making sense of challenging situations in practice. Riessman (1993 p3) recognised the tendency to narrativize experiences, particularly when there is 'a breach between ideal and real, self and society.' She thus notes the value of a narrative approach to studies of identity and to those which explore individuals as active subjects, especially as narratives can reveal aspects of social life such as gender relations and power practices which tend to remain hidden. Individuals' representations of themselves come from social and historical locations which add to the context of the narrative.

The embryonic writings from my research diary, which eventually became my own story to be included alongside those of my participants in chapter 4, resonated with my reflections from professional practice and with some of the feminist readings to give shape to the following research questions:

When women repeatedly attempt throughout their lives to lose weight and maintain a body weight they are happy with,

- i) What is the meaning of their experience?*
- ii) What are the implications of their experience for health education?*

The positivist, quantitative research that dominates medicine, science and public health is inadequate for exploring complex human experiences and the meanings of these. It was notable from my literature review that research using an interpretivist approach was mainly confined to educational and sociological studies. The gap therefore appeared to be in the borders between medicine, science, education and sociology. I needed an approach that recognised what each research discipline offered and where its value ceased.

It seemed clear that medical and scientific research was confined mainly to studies of overweight and obesity prevalence and links with poor health, because positivist, quantitative methods such as large scale surveys which generate statistics and can test hypotheses are well-suited to producing this form of evidence. Health education has become aligned with public health medicine so shares its theoretical base.

The interpretivist methodology used in many sociological and educational research studies, however, offered ways of exploring the meanings of human experience, producing evidence rooted in the reality of worlds constructed by individuals within their own social culture. I could see this as a useful way to address what seemed to me to be an unexplored area – a gap in knowledge. As Gard & Wright (2005) observe, it is when scientists are forced to think about the causes of the situations their raw data show that they have to leave their expertise behind and step into an area of uncertainty. It is in this uncertainty that scientists are accused of allowing ‘unsubstantiated assumptions’ and ‘rampant speculation’ (Gard & Wright, 2005 p5) to replace evidence. When raw data shows an increase in prevalence of overweight and obesity, and associated ill-effects on individuals, but no evidence is offered to suggest why this is so, there is scope to look at the issue in a very different way.

This literature review has looked at the work of feminist writers and their studies of the ways in which women's identities are constructed (Lebesco, 2010; Bordo, 2003; Bartky, 1990) and studies of women with eating disorders (Orbach, 2006; Chernin, 1985). However, there remains a gap in the place where education, public health, sociology, science and medicine meet. In this place the issue of overweight and obesity in women could be viewed through various lenses – biological, social, moral and ideological. I wanted my research to address this, adding a different perspective to the study of an issue which is increasingly located within biomedicine.

The following chapter outlines my own approach to this research, using a rather different qualitative methodology that adds to existing knowledge by examining individual experience through the generation of personal narrative, using analytical methods which give a fuller picture of women's experiences grounded within a social, cultural context.

Chapter Three

Methodology

This chapter addresses the research design of the study and the principles that informed my choice. The methodology and ethical issues are discussed and details of the participants and data collection tools outlined.

The aim of my research was to gain an in-depth understanding of the experience of women who have made repeated and unsuccessful attempts to lose weight or maintain a weight they are happy with, and to explore the implications of their experiences for health education. I wanted to open up the stories of ordinary women who have not been diagnosed with eating disorders but are nevertheless unhappy with their weight. The appropriate research design had to allow for exploration and the investigation of embodied experiences of women from their own perspective and to acknowledge my own experiences within the research.

Theoretical Framework

Research design is informed by theoretical perspectives and the theoretical framework for this study was rooted in social constructivism, interpretivism, and feminism. I worked within a relativist ontology which recognises multiple constructed realities (Guba & Lincoln, 1994) framing the research in a way that recognises reality as subjective and multiple. Knowledge may be seen as something that can be acquired, whilst others would argue that knowledge has to be personally experienced. The former view lends itself to a more positivist stance in which the world is objective and independent of knowers, universal laws exist and can be discovered and used to investigate, explain and predict empirically, typically using methods such as observation and experiment (Williams, 2006) and in which the researcher is independent of the subject of the inquiry. This positivist approach is dominant in medical and scientific research, as seen in the epidemiological studies focusing on obesity, in the literature review. Conversely, social constructivism rejects the notion of a reality independent of the inquirer, arguing that all knowledge is gained from social interactions, all forms of understanding are historically and culturally relative,

and realities are multiple (Berger & Luckman, 1966). Social constructivism thus focuses on the ways in which individuals and groups create their perceived reality. Phenomena which arise from personal, subjective experience unique to the individual are investigated by examining the ways in which individuals interpret, create and modify the social world – the interpretive paradigm. Interpretivist forms of inquiry have developed to meet the need for research that makes sense of the social world and can investigate human behaviour. To an interpretivist, the social world is not a true reality that is out there, waiting to be discovered. It is created by people, who are actively constructing social reality in a constantly changing world that is directly affected by context (Denzin & Lincoln, 2005; Guba & Lincoln, 2000; Gergen, 1999). Interpretivism sees reality as a social construction – it has multiple forms, with perspectives and interpretations which require thick descriptions and cannot be reduced to suit a positivist approach. Moreover, in this paradigm the relationship between the researcher and research participant is important, with the distance between researcher and participant minimised (Mason, 2002).

The interpretive approach was appropriate for my research as I wanted to focus on the experiences of individuals, including social phenomena such as historical factors, language and social interactions (Silverman, 2001) which impact on people's experience. This was important to me as I sought to reflect the diversity of cultural and social life of my participants and to include myself in the research.

Feminist theory also became an important part of the theoretical framework of this research. In chapter one I noted the contemporary representations of women, images that link slenderness with attractiveness, which are commonly found in advertisements, posters and popular reading material. However, even more than cultural imagery, it was reflection on everyday interaction with other women – the weight-reduction plans which emerged from conversations in settings as diverse as the supermarket queue to coffee breaks at academic conferences – that alerted me to the preoccupation with body size and shape that Bordo (2003) and Bartky (1990) argue has normalised a beauty discourse that regulates and controls women.

Feminist understandings of bodies and their differences show how these are located in relation to systems of power. Bordo (2003) notes the requirements of the postmodern body to constantly review, correct and transform itself in order to achieve an illusory image of feminine perfection. Women are required to transform themselves in myriad ways – creams for smoothing, food reduction and exercise for body shaping and size reduction, breast-binding or padding depending on the fashion of the year and the society in which they live. Bartky (1990) argues that whilst these body projects may be a source of satisfaction for women who have developed these systems and rituals to bolster their self-esteem and reduce feelings of inadequacy, those women are manipulated by corporate structures which profit from their sense of bodily deficiency.

These issues are also relevant to the field of health education. Evans and Rich *et al* (2008) have pointed to the ways in which both formal and informal pedagogy supports the use of body size as a proxy for health and the media framing of fat as unhealthy and irresponsible, reflecting health and education policies. Within performative cultures the effects of this obesity discourse can be serious, particularly for women who may regard their extreme behaviours in terms of food restriction as responsible and healthy.

These understandings raised my own consciousness of the gendered power structures that shape people's lives – much as Bartky's philosophy of feminism was articulated through her experience of personal transformation – becoming a feminist – as she examined patriarchal culture and its damaging effects on women. She looked at the embodied consciousness of women in terms of their social and historical position, the 'femininity that disempowers us even while it seduces us' (Bartky, 1990 p2) and I saw the relevance of that path for my own inquiry. The research questions began to evolve from these readings and were further informed by my own personal and professional biography.

My research, as an inquiry process to understanding a social phenomenon, reporting detailed views of a small number of participants within a natural setting, was thus qualitative (Creswell, 2007). 'Qualitative research, as a set of interpretive activities, privileges no single methodological practice over another' (Denzin & Lincoln, 2005 p7). However, the understanding of lived experience which is developed from participants themselves is central to the interpretive

paradigm (Garrick, 1999) and was appropriate for the study I planned - a comprehensive exploration of a small number of individuals' feelings, opinions and values (Denzin & Lincoln, 1994).

Narrative inquiry

I chose to carry out narrative inquiry to look at the way women present themselves in stories about their own life experiences, with opportunities to explore different layers of meaning and agency. Narrative inquiry is multidisciplinary. It originated in the study of literature and then became popular in other disciplines. It is now commonly used in anthropology, history, psychology and sociology, part of what Riessman calls 'the narrative turn' (Riessman, 2008, p14).

Narratives are defined in different ways. They can be stories that correspond to criteria such as containing sequenced events that have meaning for a specific audience (Gergen, 2009) or they can be seen as stories which help people to make sense of their experience and attempt to restore a sense of normality in their lives (Bruner, 1990). All forms of narrative are concerned with making sense of people's experience and communicating their meanings (Chase, 2003). Riessman notes that the life story tradition treats life story and narrative as broadly synonymous, and raises questions about representation in texts that privilege the interpretation of the author rather than the narrator (Riessman, 1993).

Connelly and Clandinin (2006) view narrative inquiry as investigating human experience, recognising that people lead storied lives through which they shape their identities and their everyday lives, using the medium of stories to interpret their past. This reflects individuals' perceptions, their experiences and the ways in which they are made personally meaningful. The details of lived experience can be gained through people's narrative accounts, whether long or short stories or accounts of particular events. The uniqueness of humans' actions is foregrounded in this approach, rather than focusing only on commonalities (Bruner, 1986). Identities can be determined through these narratives, which are shaped by hegemonic discourse and further developed moment by moment by influences which include context and audience.

Identity was shown in the literature review to be an important issue for my study. The sections Theoretical Understandings of Perfection and Control, and Constructions of the Self, discussed literature which shows how discourses shape and regulate women's identities, and the effects of differences in the construction of the feminine body. Thus the methodology chosen needed to be helpful in exploring the women's constructions of identity. Stories of people's experiences in their routine, everyday living, personal and professional relationships and work lives are useful ways of exploring constructions of the self and identity formation. Narrative opens up theories and perceptions of self and identity (Polkinghorne, 1988, Riessman, 2008). It can be useful in examining the ways in which identities are shaped socially and culturally and continue to be created and lived out in the context of interviews, with stories used as a way of fashioning selves and identities (Bamberg, 2004).

Representing the experiences of others cannot be carried out in a neutral way. Narrative represents and shapes social reality (Bruner, 1987). Trahar (2013) notes the importance of context in the construction of knowledge within narrative inquiry, and argues that the methodological approach should be grounded in the local context, particularly where voices of subjugated people have been ignored. This was something I valued in my own research. I wanted to hear people's feelings and attitudes about their daily lives, their interaction with others and how they view the culture and society in which they live, in relation to their concerns about their body weight. I was also interested in the ways in which participants construct, re-construct and perform their identities through their narratives in oral storytelling. It could be argued that identity is even more significant now, as society moves away from the common biography in which people could expect to live their lives in a particular way, and biographies are ruptured by issues such as redundancy and changing work patterns, particularly for women. The rise of part-time jobs in the eighties corresponded with the decline in secure, unionised employment and emergence of jobs in which workers clock on as customers arrive and clock-off as they leave – the situation coined by Kelly as the 'McJob' and the foundation of the current day zero-hours contract (Kelly, 2006). Beck (1992) noted that people now have to 'cobble together' their biographies as the common biography is

lost. People are now required to work on themselves and to see themselves as sites of creation.

A narrative inquiry approach was chosen because it allowed participants to foreground the aspects of their lives that they felt were most important to present and allowed me to investigate layers of meaning in the ways in which participants shaped their stories, the broader societal discourses they reflected, the identities they constructed and concepts that were generated. Stories as meaning-making structures cannot be replaced by investigative methods that pre-guess what interview respondents have to say, or impose boundaries on their responses. If stories are fragmented their meaning may not be preserved and their subjectivity and personal perspective may be lost. Social life and culture 'speaks itself' through narrators' stories (Riessman, 2003).

Participant sample

The study was undertaken with five participants, all of whom were recruited through a convenience sampling method. A convenience sample was necessary for two reasons. First I had already decided I needed to use a non-clinical sample. Although I recognised that this decision potentially limited access to participants it was appropriate as only small numbers of overweight/obese women seek treatment (Brownell, 1993) and a shift towards community based sampling has been recommended, rather than drawing from those using acute secondary care health services (Hill & Williams, 1998). Secondly, my participants were to be women who have lived experience of the topic area and would volunteer to participate in the study, sharing personal information about what they may see as a very sensitive issue. Participants were to meet the requirements of being unhappy with their weight and having repeatedly and unsuccessfully tried to lose weight.

This subject raises important ethical considerations. Overweight can affect women's self-esteem, their identity and feelings of control (Puhl & Heur, 2010). It was therefore important to avoid causing distress to the participants in all aspects of the research, including recruitment. I was therefore unable to ask specific women to participate as they might feel they had been targeted because of their size. I am aware that body size is a sensitive issue to many

people. To avoid causing distress or offence I decided to explain the research project to groups of women and say that I was looking for volunteers.

Seven women responded. However, two of these were not included in the study. One of them was a lecturer in a local college; she was about to move overseas and I was concerned that there could be difficulty in following up after interview if this had been necessary. Another, a patient from the local medical practice, volunteered after hearing informally about my research from a clinical member of staff. However, I had planned to have a non-clinical sample, and in any case felt it was ethically unsound to recruit someone who had presented as a patient when I had not sought ethical approval from the local National Health Service committee.

Thus the final sample comprised five women. They were aged between 45 and 65 years; all married or in committed relationships, and each had two or more children. Three of them had higher education or professional training beyond further education.

Two of the women were recruited from a local creative writing group. Another asked if she could volunteer after my research was mentioned by a mutual friend in conversation. One volunteer was a post-graduate student from the university. Following careful consideration and discussion with my supervisors I decided to include the fifth volunteer, my sister. At first this felt risky: interviewees are already warned about hearing what they want to hear or what fits in with preconceived notions (Andrews, 2007). An intimate relationship between narrator and listener could strain boundaries in the research relationship. However, when I examined the decision in more depth I began to see benefits that could not be achieved where the interviewer was unknown to the interviewee.

Acquaintance interviewing

The effect of prior relationship on interviews has been the subject of much research. Garton & Copland analyzed data to show how the value of their interviews was increased by invoking and making relevant prior relationships between interviewer and interviewee during their interviews. They suggest that so-called 'acquaintance interviews' form a subset of social science research

interviews which, although sharing similar features, differ in several respects. One is the neutrality of the interviewer. Two is negotiating new identities as interviewer and interviewee, where at any time, one or both of the parties can realign to a different relationship. Three is shared worlds as a resource with which to co-construct a relationship. They also noted the controversial style of the interaction in the data they examined, which allowed ongoing construction of narrative, instead of each participant giving their own narrative (Garton & Copland, 2010).

In my own case I was aware that I could not be a neutral interviewer. Neutrality would not have been appropriate for research that co-constructs meaning with participants and the interviewer. This does have ramifications for the boundaries of relationships and requires particular care in the case of a participant with whom one has a close relationship that could be affected now or in the future by the research. I explained to all of the participants the limits of my data collection, that I would only use data collected from the recorded interview, autobiographical writing, my own observations and reflections from field notes and diary entries, and any subsequent correspondence that we shared specifically in relation to the research. The boundaries were therefore set out clearly. We also discussed issues of confidentiality at length, including the future publication of the research, and the rights of participants to withdraw at any stage. This was stated in the consent forms signed by participants (appendix 3).

Qualitative researchers are concerned with establishing rapport and trust with interviewees, to aid the interview process. It could be argued that there are benefits to starting from a position of knowing interviewees before the interview as trust and rapport would already be in place. Oakley goes further in stating that the interviewer and interviewee are not 'objective instruments of data production' but rather 'that personal involvement is more than dangerous bias – it is the condition under which people come to know each other and to admit others into their lives' (Oakley, 1981 p58). I agree, as I found the interview with my sister to be a rich source of diverse and previously unknown data which I could not have anticipated. Furthermore it was a fascinating practical demonstration of the principles of interpretivism which argues for subjective, multiple realities. There were instances during the interview when I had to stop

myself from interjecting because my memory of a shared childhood experience that she spoke about was so different from her understanding of it. Reflexivity – being aware of my own position in the context of the interviews and interpretation of the data – was therefore important.

It is also the case that objectivity is not often a goal that interpretivist researchers aim for. Kvale (1989:76) argues that, ‘... from a *relativist* position, the multiple individual experiences of reality all have their own truth, none being more valid or real than others.’ My position mirrors these concerns in that I understand realities to be multiple, not just different perspectives on the same reality. This means that interviewing acquaintances need not be regarded with distrust. Such distrust may suggest that objectivity is more of an influence than qualitative researchers wish to admit.

It could be argued then that, far from viewing acquaintance interviews with suspicion, we may understand them to add a new perspective and richness to interview data. Knowing the interviewee well means the researcher already has some knowledge of the interviewee’s values, characteristics and behaviour in which to set the information. Existing knowledge also carries the advantage of shared experiences which can increase and enrich data. For instance, in the interview with my sister she gave in-depth accounts of experiences, knowing my existing level of knowledge because of our shared background. In an interview with a stranger, rather than a family member whose trustworthiness had been demonstrated over many years, these would have required far more initial explanation and may not have achieved the same depth or richness. There may be risks such as over familiarity but the use of reflexivity and the sharing of data with participants can help to address these.

Data Collection

The methods used in this study comprised narrative interviews, field notes, which were contextual notes written during and immediately after the interviews and autobiographical accounts of participants’ experiences in relation to their weight.

A single narrative interview with each participant was conducted over a six-month period and autobiographical accounts were collected in the three months

following the interviews. I gave participants the option of coming to my house but also offered to conduct the interview in a setting of their choice if they wished. Three of the women came to my house; one asked me to go to her house for the interview and the fifth was carried out in a hotel. I ensured we had privacy and provided comfortable chairs and refreshments for the interviews. This was part of attending to the research relationship. I felt this would help me to show participants that they were valued.

The five interviews were open and largely unstructured, following the opening question. They each lasted between one and two hours. I asked each participant to tell me the story of her life in relation to her weight, particularly in attempts she had made to lose weight throughout her life. I asked for clarification occasionally during the interviews and occasionally followed up points of interest. Other than this I maintained an active listening role, nodding, smiling and using non-lexical prompts. My aim was to provide a comfortable, positive setting in which participants would be happy to talk freely, with a minimum of prompts from me. Whilst I recognise that narratives are co-constructed between participants and the researcher I wanted participants to talk about experiences from their own perspective, without the constraint of a framework of questions or guides which could influence what they had to say - experiencing the 'problems and possibilities of interviewing that are not visible when attention is restricted to question-answer exchanges' (Mishler, 1986b p67). Chase (2005) noted how changing her interview questions to more open ones transformed replies from brief reports to long narratives. Less structure in interviews also increases the control that research participants have and can assist their joint construction of narrative. Although the research relationship will not be equal it is possible to reduce the disparity (Riessman, 2008).

I felt that narrative interviews would be a useful means of hearing people's stories in order to explore their experiences. Chase (2005) noted that narrative interviewers work at inviting stories, rather than merely attending to stories that happen to come up during interviews. In addition Hyden (2008) warns that standard interviewing approaches, in which stimulus questions are used with the intention of eliciting a particular response, may conceal untold stories. I invited my participants' stories with a single generative question that asked them to tell me the story of their life in relation to their weight, and attempts they

have made to lose weight. There were no further set questions but there were conversational points in each story where the transcripts noted my own response and field notes gave details of my participation in aspects of the settings. For instance, when participants showed photographs of their families I responded in a socially appropriate manner, discussing the holiday settings in which the photographs were taken or smiling at a participant's baby picture. In some instances I briefly shared my own position on an issue raised and occasionally I would reflect the words of the participant as part of active listening.

I recognise the narratives to be co-constructed not only because of my conversational input which had the potential to invite and shape the participants' stories but also through my responsiveness to the stories, for example non-verbal aspects such as body movements, facial expressions, gestures, and use of interview space. Narrators, together with listeners, produce and make meaning of the experiences that are reported (Mishler, 1986). Stories are created and developed in cultural, societal and historical context, in addition to further shaping through interaction within the interview. Fontana & Prokos (2007) point to an emerging consensus that considers an interview to be a joint accomplishment of the interviewer and interviewee.

The interviews were audio-recorded with the participants' permission. I transcribed the interviews myself to gain familiarity with the data. Fielding notes the importance of transcribing one's own interviews, despite the tedium of this lengthy process, pointing out that researchers have ideas as they transcribe; they gain familiarity with the data. 'It helps you to start making connections and identifying themes for analysis' (Fielding, 1993a, p147). This stage is also important as the decisions made in transcribing interviews represent the first level of analysis. Even typing the transcripts word for word as spoken inevitably requires decisions that could alter the meaning or intended meaning of the narrative. As Riessman (2008) suggests, transcription is an act of interpretation. Once stories are spoken and then written they are fixed within a text - an open work that can be read by others who may interpret it differently (Ricoeur, 1981). The narrative can have consequences in terms of other contexts and interpretive frames and these may lack congruence with the meaning intended by the original narrator (Gubrium & Holstein, 2009, Wells, 2011). In my own

practice I sought to fully transcribe participants' interviews myself, but no other linguistic features were included in the transcription because I did not plan to use structural methods of analysis. I presented transcripts to the participants in the form of re-storied accounts – a summary of their individual transcripts but with non-lexical items and my own comments removed, and I invited their comments. I chose not to give direct transcripts to the participants as I was concerned that directly reported speech, non-lexical utterances and interpolations may obscure the content and, as Sikes notes, 'may also serve to belittle or make the contributor appear 'stupid' (Sikes, 2010).

Four of the five participants also completed written autobiographical accounts of issues around their experiences regarding weight loss and maintenance. These were representations of themselves and were included in the analysis. I asked participants to do this as stories or life accounts they wrote themselves could capture aspects of their experience which might be lost during interviews – some issues could be easier to write than to say to an interviewer. I did not guide participants regarding the style of writing or length of their account. Flick (2009) has highlighted the value of participants' writing included in research data and analysis to balance the selectivity of the researcher's perceptions. A sample of the autobiographical writing can be seen in appendix 1.

Field notes were also taken to record the circumstances of each interview, for instance where it took place, and physical aspects that would not be captured by the tape recordings. For instance, I made field notes about photographs that were shown to emphasise a point – this was subsequently useful in interpretation. Also, one participant created a physical setting for the interview that supported the performance of her story – this was captured by the field notes which described the setting of each interview, but could not have been anticipated in advance. As Flick (2009 p297) states: 'The production of reality in texts starts with the taking of field notes'. A research journal was also compiled to note my own ideas, reflections and progress.

Data analysis

Approaches to analysis

Etherington distinguishes between the analysis of narratives in which 'stories provide us with a representation of an individual's reality, based on the idea that stories hold the raw material of inquiry' and narrative analysis in which stories are valued as the social reality of the narrator and 'the analysis is the creation of a coherent and resonant story' (Etherington, 2004 p81). In terms of the narratives that were generated in this research I decided as an early level of analysis to present them as stories, summarised and re-storied but using as much of the women's own words as possible to retain the integrity of their accounts.

It is interesting to note that in the final approach I did not make use of classic structural narrative analysis. Whilst I initially attempted to study the order in which elements and clauses appear in a story (Labov and Waletzky, 1967) and its poetic structure (Gee, 1991) this was found to be unsuccessful because of the way the participants had organised their narratives. Narrative clauses could not always be matched to events. This may well have been explained according to gender for Langellier & Peterson (1992) suggest that Labovian structure is more attuned to male narrative – it has also been criticised for its gender and culture-specificity (Patterson, 2008). Tannen (1994) also argues that men and women communicate differently so that methods appropriate for a masculine perspective may not transfer successfully to women.

It was also the case that the important issues were in the interactional aspects and broad social context of the narrative rather than its order and features of speech, although I can see the value of attending to both. The narratives I was analysing were not always temporally ordered in the event-based narrative clauses which the structural approaches of Labov rely upon, and as interviewer I was content for participants to organise their narratives in episodes or chronologically as they wished. I felt that the relational analysis structure of Riessman (2001) was more relevant in representing the interaction between the

narrators, other characters and myself as audience, as we co-constructed the narratives.

I also wanted to examine ways in which participants construct identities within their narrative. A personal narrative is always a narration of the self (Patterson, 2008) but this may be context-dependent. As Goodson (1992) states, a life is lived and experienced, told and then retold in the interaction between the narrator and researcher; however the life lived and experienced may be a representation of a life only in a particular context. For instance a participant in my study may have narrated a representation of her life as an overweight woman, which is different from the way she would narrate the life she has lived and experienced if her body size was not the issue in focus.

A multiple lens approach

I decided to analyse the data using a multiple lens approach (Chase, 2005) to take account of individual, collective and relational perspectives. Each lens corresponds to a form of analysis, as shown in Table 2.

	Re-storying	Thematic analysis	Relational analysis
Interview transcripts	Stories – summarised from the transcripts and shared with participants	Yes	Yes
Autobiographical writing	Yes	Yes	-
Field notes	Yes	Yes	Yes
Research diary	Yes	Yes	-

Table 2: Forms of data and analysis

The lenses I used are as follows: first the unique narrator, shown through each participant’s story; secondly context and content, explored through thematic analysis; and finally performance shown by relational analysis. These are outlined below.

The unique narrator

The first narrative lens adopted in my work is one which focuses on the narrator, expressing her emotions, points of view and interpretations. These can be seen in the stories created from transcripts of the interview data. The women's transcripts and autobiographical writing were re-storied and presented to them as a preliminary interpretation. This was not an attempt at respondent validation; rather these were interim texts – a first level of interpretation and analysis and an attempt to increase the opportunities for participants to remove anything they were not happy with and add anything that had not occurred to them at the time of the interview. One participant asked for minor changes and two supplied further information. The stories were corrected accordingly. I felt that the stories represented the multidimensional nature of the narratives as they were jointly constructed and represented oral and written accounts.

Thematic analysis

The second lens addressed the context – the constraints and resources that the narrator has within her/his setting or community and where s/he is located culturally, historically or in other ways. It is through this lens that the researcher sees similarities and differences in narratives - common threads or patterns across stories may be revealed. In my analysis I constructed and presented these as themes. Thematic analysis is concerned with the content of narrative data, rather than the way in which it is structured and it is regarded as a useful way to theorise across cases (Riessman, 2008).

Deductive and inductive approaches were used in developing these themes. I had already seen patterns emerge when I was typing up the transcripts, noting common threads and shared beliefs or understandings in an attempt to move towards a form of open coding. I then re-read each transcript and autobiographical account several times, using coloured pens to mark them and labelling segments with more refined codes that appeared to describe their meaning and lever them to a conceptual level. Segments, rather than individual words or smaller sections, were used as I was concerned not to fragment the data too much, thus losing the shape of the narrative (Saldana, 2009). I typed

up the coded narrative segments under categories that were developed from the coding process and then collapsed them into three over-arching themes. See appendix 2 for an example of transcript labelling and subsequent coding and development of themes.

Relational analysis

However, I recognised that a thematic analysis alone would not be sufficient to address my research question. I had seen in Riessman's work that when she compared and contrasted the accounts of several participants who responded to a question about the reasons for their divorce, she was able to show that the same reason had different implications for each. As she states: 'What, on the surface, appeared to be the same events turned out to be quite different ones ...' (Riessman, 2008 p87). This is a concern which was also shared by Hollway & Jefferson (2000); when these authors tried to categorise and cluster data that appeared similar but had different meanings they concluded that biographical issues were important in interpreting their participants' accounts. Such accounts often resist fragmentation.

I also wanted my analysis to take account of ways in which participants constructed their stories, highlighting narrative creation rather than factual accounts and acknowledging that there is a gap between research interviewing and the ways in which people interact (Mishler 1986a). I therefore used another lens – that of performance, shown by relational analysis which sees the narrator as actor, constructing and performing his/her reality. The socially situated performance of storytelling is important in order to attend to the issue of stories told to a particular audience at a particular time, thus emphasising the performative element. I used relational analysis to investigate the performative elements of the narratives (Riessman, 2001, Bamberg, 1997). Bamberg proposed a form of relational analysis, suggesting that positioning of narrators could be analysed in order to examine the development of identities, rather than using the form or structure of Labov & Waletzky's (1967) traditional approach. He suggested considering how characters are positioned in relation to each other; how the narrator positions him or herself to the audience; and finally how narrators position themselves in relation to themselves (Bamberg, 1997). Riessman develops this approach further in her interpretation of data by

demonstrating ways in which narrators position audiences, in order to constitute identities. She also warns that readers may form different conclusions, contesting the meanings attributed by the researcher (Riessman, 2001). In this approach the context of production is just as important as the content of what has been said. I used Bamberg and Riessman's approach to carry out a relational analysis of each narrative interview, interpreting data under the following headings suggested by Bamberg (1997) and Riessman (2001):

In what kind of story does the narrator place herself?

How does she position herself in relation to the audience?

How does the audience position themselves in relation to the narrator?

How does the narrator position other people in relation to herself?

Finally narrative researchers become narrators themselves as they interpret the work of others, and then present that work to further audiences – this reflects the role of the researcher in co-constructing meaning through interviewing, analysis and representation within a written report. I found that as Chase (2005) noted the lenses, which initially appeared distinct are really interconnected as the researcher moves back and forth between them. The events and experiences that give rise to the stories are reported by the narrator and produced by the researcher. Through the lens of narrators these become stories about events that they have experienced and remembered, ending up as 'truthful' narrative - stories that are believed and from which others may find alternative meanings.

Ethical Issues

Ethics are important in planning and carrying out research. Ethical issues within research include issues such as confidentiality, privacy, informed consent, and power relationships. Many of these issues are regulated by codes of practice and monitored by ethics committees. The British Educational Research Association's revised guidelines (BERA, 2004, 2011) detail the principles of respect for persons and for knowledge, democratic values, and the quality of educational research that is expected in all educational research. These issues are also reflected in the questions asked by the University Ethics Committee

when reviewing research proposals. Approval was gained from the University Ethics Committee (appendix 4).

As Flick notes, the openness of qualitative research can lead to comprehensiveness in data collection, rather than having focused and limited questions which tend to be easier to review by an ethics committee (Flick, 2009). In this study my approach to data collection was comprehensive. I asked participants to tell me the story of their lives in terms of their weight and attempts they had made to lose weight. I also asked them to write autobiographical accounts of significant events in their lives that were relevant to their weight. However, I thought carefully about issues of privacy, informed consent, anonymity, and how data would be reported, including future publication.

The first issue to consider was recruitment. I was careful about the way in which I recruited participants. I asked for volunteers amongst groups of women rather than asking individuals directly so that no one would feel that she had been targeted because of her appearance.

Once I had chosen the sample I talked to each participant about the research I had planned and also explained that my own experiences would be included. I talked about my own experiences of dieting and my continuing difficulties in maintaining weight loss. This was important to me in addressing power relationships and in making my aims transparent. I was committed to Oakley's approach to adopting a non-exploitative, experience-sharing approach to participants which allows for a more equal relationship between researcher and researched (Oakley, 1992). However I was also aware of the difficulty of establishing and maintaining an equal partnership. Merrill and West cited Seidman (1991) to point out that experience-sharing can be a form of 'seductive imperialism' – however supposedly egalitarian (Merrill & West, 2009, p173). My study design did not allow for sufficient input from participants in the research design, interpretation and evaluation and publication stages for me to claim partnership but it was possible to minimise the power difference within the research relationship.

There was a danger that in the process of talking to women about their experiences of weight management I might appear to be supporting the

dominant obesity discourse that blames and stigmatises individuals for not conforming to the current ideals of appearance and performativity. To counteract this I prepared details of local and national resources (groups and websites that give positive support not only in weight management but in body image and challenging size discrimination) to give to participants at the end of each interview. The openness of the interview question meant that it was difficult to anticipate the issues that might come up during the interviews. However, body size can be a sensitive issue and I was concerned that participants might feel distressed after discussing issues such as stigma which are commonly experienced by people who are overweight or obese. I was also careful during interviews to observe participants for any signs of distress that would require the interview to be discontinued. I ensured that interviews were comfortable, informal and conducted in a setting of the participants' choice.

Etherington (2004) addresses the issue of providing a platform for those who have been marginalized or victimised and the difficulty in maintaining a balance. She suggests letting go of judgements, acknowledging that everyone is capable of being either perpetrator or victim depending on circumstances, and reminding ourselves of ethical responsibilities to ourselves and to research participants. This includes trusting participants to take some responsibility for themselves and their part in the process. Relationships with participants was an important issue for Oakley (1981) who proposed that friendship could exist within the research relationship and for other feminist qualitative researchers who noted ethical issues arising from concern for participants (Denzin & Lincoln, 2005).

A challenging situation did occur during the interviews. One of the participants made a casual racist comment which usually I would have challenged. In this case I found myself unable to decide what to do. I am committed to challenging every case of racism I encounter personally – I have done this consistently for many years, even as a teacher re-focusing whole lessons on occasions when it became apparent that an issue had to be addressed at length. However on this occasion I was torn between the need to consider a vulnerable research participant who was sharing difficult, sensitive information, and being true to my values. The participant moved on, unaware of my dilemma. I was aware of my complicity in this situation and it was something I was not fully prepared for.

This draws attention to the way in which a non-judgemental interview space may be difficult to achieve and mediate in reality.

I also considered the ethics of interpretation and presentation, particularly with regard to confidentiality. With a small number of respondents it is difficult to anonymise data. There is inevitably a tension between extensive use of transcript quotations, which increases trustworthiness by allowing readers to see how I reached my interpretation and to form alternative interpretations, and editing or removal of particular information to assure anonymity. I used pseudonyms for participants and for people they mentioned within their stories, and fictionalised some details of those mentioned, for instance place names and information about their families, to assist confidentiality, although total anonymity could not be guaranteed. There are also responsibilities towards others, for instance family members who are present in narratives and who do not give consent over whether or not they are included. Israel (2006) explores measures that can be taken to safeguard confidentiality but states that these obligations cannot be absolute. I discussed this with the participants before interview – two of them chose their own pseudonyms, although one of these had to be changed later as it became evident that some readers may have been able to identify the participant through the pseudonym chosen. Also with regard to confidentiality I stored electronic files on a password-protected computer, in a study which is not used by anyone else. Everything was labelled by pseudonym with no-one but me knowing participants' names.

Evaluation of qualitative research

The evaluation of qualitative research may differ from that used for positivist research. Connelly & Clandinin (1990, p7) wrote, 'Like other qualitative methods, narrative relies on criteria other than validity, reliability, and generalizability. It is important not to squeeze the language of narrative criteria into a language created for other forms of research.' Bryman (2004) also noted that reliability is a term which can be questioned in qualitative methodologies generally, as these methodologies are often context-determined, whilst Guba and Lincoln (1989) argue that authenticity is a more important notion than validity.

Narrative analysis of five women's stories would not fit the criterion of external validity because the findings from such small numbers are not generalizable. However findings from small studies can be important in generating concepts. For instance in 1981 a paper detailing eight unusual case studies of young, gay men with Kaposi's sarcoma, a rare cancer more usually associated with older men, was published by the Lancet (Hymes *et al* 1981). This led to the early identification of human immunodeficiency virus (HIV) infection, which was crucial in developing funding policy, research and clinical management regimes to treat those infected and protect others. Riessman also notes that important theories in psychology and natural sciences have been developed by studying particular cases, for instance by Galileo, Newton and Darwin. She asserts that 'trustworthiness of case-based research has been demonstrated by pragmatic use' (Riessman, 2004 p195).

The outcomes of qualitative research may not have the validity and generalizability that would be expected from experimental research; however, presentation of the process and outcomes of research can to some extent influence this. As Creswell (2007) points out, description that is rich and thick allows readers to form their own decisions about whether findings of a study are transferable, and Coffey & Atkinson (1996) note that narrative analysis counteracts the culture of fragmentation that exists in the coding and categorising of data. However, qualitative research can be evaluated appropriately using indicators which demonstrate the trustworthiness of the data and the relevance of the methodological path followed. In this study, rather than seeking objectivity and reliability, rigour has been addressed in ways that are more relevant to qualitative research – coherence, reflexivity, and trustworthiness. Richardson's crystal analogy is particularly useful in evaluating creative analytical process texts. She uses the concept to explain a multi-dimensional model which throws light, colour and infinite shapes externally whilst also refracting light and offering multiple and constantly shifting possibilities (Richardson, 2005). In the same way, evaluating qualitative research can include multiple ways of assessing its authenticity and value.

Coherence

Polkinghorne (1995) describes narrative as a medium which draws the disparate events of human life into a unified process. Conversely, stories have a complex nature which can include aspects such as multiple identities, changes in direction, and cultural metaphors that help people to organise their understanding of the world (Riessman, 2003, Clandinin & Connelly, 2000). These features may be used to indicate coherence, thus demonstrating credibility. However, as a positive feature of narrative coherence is itself a contested issue. Squire points out that her narratives within HIV research in South Africa did not always fit in with coherent western health education narratives and accounts but instead required other, culturally-sensitive frames in which they could be read. Some worlds will retain their autonomy and resist coming into congruence (Andrews, Squire, & Tamboukou, 2008). Accounts may be incoherent for different reasons; one being the age of the narrator – for instance young children who are still developing narrative capacity; or accounts may lack temporal ordering for other reasons.

Narratives may be disrupted because of the issues that are the main point of a story; for instance one of my participants' accounts lacked temporal ordering when she told me about a tragic situation in her life. Nevertheless Frank (1995) identified a 'chaos narrative' in illness accounts and showed that they could be understood even whilst they lacked a neat beginning, middle and end. I knew that my participants were talking about a sensitive topic and that they might approach their stories from different points. I allowed for this by encouraging participants to speak freely without more than the initial question guide and using forms of analysis that did not rely on coherent temporal ordering.

Reflexivity

For my research question, subjectivity – the ability to consider one's relationship to the focus of the observation - is important. I believe that understanding human behaviour within the social reality that individuals experience requires the researcher to acknowledge the values, culture, and beliefs that they bring to the research. I needed to explore the perspective of individuals and to acknowledge my position and role as researcher in interpreting participants'

meanings about their experiences. Researcher reflexivity is important in this study as my own knowledge/experience of being a woman who has had difficulty in losing weight and maintaining a desired weight is an explicit part of the research process. In terms of reflexivity, lowering the barrier between researcher and the researched means taking responsibility for values and views expressed and for how we position ourselves in what we write. As Etherington points out, this is a growing theme in social research and requires 'losing the security of the anonymous third person ...' (Etherington, 2004, p27).

As Bruner wrote, 'The qualitative researcher is not an objective, authoritative, politically neutral observer standing outside and above the text (Bruner, 1993 in Lincoln and Denzin, 2000 p 1049). I had engaged in a collaborative process in which I would interpret and report on narratives produced by participants but mediated by me. I was committed to including myself within the research and being transparent about this.

Etherington emphasises context, stating that validity is dependent on 'whether researcher reflexivity has provided enough information about the social, cultural, historical, racial, sexual context in which all the stories are located ...' (Etherington, 2004 p82). Life stories will inevitably be affected by the culture in which they are situated and the conditions under which they were narrated – this will inevitably affect accounts (Runyan, 1980). I have given biographical details about each participant and myself, subject to confidentiality boundaries agreed with participants in relation to the details they have provided. I have also documented the research processes, including my own role, to enable readers to judge the trustworthiness of the research.

Trustworthiness

The findings of my study are not generalizable in the way that outcomes of research in the positivist paradigm are assumed to be, as the study is specific to my five participants and reproducibility has not been claimed. However, Lincoln & Guba's (1985) concept of transferability removes the emphasis from generalizability. There is some commonality between these women and others who share their difficulties. The fullest description possible, without breaching confidentiality, enables others to decide how transferable the findings are. The

possibility of transferability is derived from trustworthiness so it is important that research is clear and transparent, considering reflexivity and ethics so that readers can assess its trustworthiness (Wells, 2011). In my study I aimed to be transparent about the research methods used, clear about the conditions under which the narratives were produced and to include as much of the narrators' own words as possible, even whilst showing the themes that were emerging, so that readers could form their own judgments about the analytical decisions I made. I have included many direct quotations from the participants in my study to allow the reader to make judgements on feasibility and credibility. This is important as the concept of narrative truth is far from being straightforward - Denzin (1989) proposed that narratives are fictional statements about real lives. Evaluation relies more on clear and transparent processes and sound ethics than on the application of an abstract rule.

When evaluating the reliability of qualitative research Lincoln and Guba (1985) look for accuracy in data collection and analysis processes and in the extent to which findings are a true representation. They also stress the need for credibility to demonstrate that findings are feasible and trustworthy. I have aimed for transparency in the processes I have used and have kept detailed records so that data is verifiable. I have also shared with participants the summarised stories drawn up from the transcripts, as an extra check for accuracy. These stories are re-presented in the following chapter.

Chapter Four

Re-presentation of findings: Re-storying

In this and the next two chapters findings from interpretation of the women's narrative accounts, autobiographical writing and my own field notes are presented and discussed. The results of the study were derived from the narrative analysis described in detail in chapter three. Initially I read the narrative interviews carefully and re-storied each one, using selected quotations to illustrate the shape and main points of each narrative account. The stories are presented in this chapter. Next, thematic analysis identified three overarching themes and finally, a relational analysis was constructed for each participant. These findings are presented and discussed in chapters five and six.

The Women's Stories

This chapter focuses on the unique narrators and their expression of emotions, points of view and interpretations of their experiences. My own story is included and my own interpretations acknowledged, in re-storying the narrative accounts. As Connelly and Clandinin (1990) point out, narrative inquiry is collaborative. They note the importance of creating a relationship in which the voice of the researcher as well as the storyteller is heard, thus acknowledging the mutual storytelling and re-storying that occurs as the research process goes on.

Stories were developed mostly from transcripts of the interviews, using as much of the women's own words as possible, and checking against field notes for any relevant observations, for instance identification of participants' relationship with people they have named in their stories, where this was not already clear. Field notes described photographs and documents that participants referred to but did not explain in their narrative interviews. Elements of participants' autobiographical writing were used in some of the stories to add biographical detail; for instance, details of Sue's social history came from her autobiographical writing rather than the interview transcript. It was also used where participants' writing added clarification to parts of the stories that they narrated in the interview, for instance details of the food Lizzie and Sue ate in

childhood. Reflections from my research diary were used in writing my own story.

Jen's Story

Jen describes herself as '*.. born with weight problems because I was very premature. I was only four pounds ...*' She went from being a baby who was hard to feed, to being a '*... picky, difficult eater, and it worried my mother a lot.*' But by the time she was seven she was '*a very, very chubby kid ... not very able to move about or run around ...*' Her mother lavished sweets and treats upon her children, because of her experience of rationing as a child during the Second World War '*... so there were always cakes, biscuits, sweets in the house, all the time and there was always a proper cooked meat and two veg meal every night.*'

There were also three brothers, who played golf with their father. Jen's mother was not active as she had a heart problem. She had also struggled with her weight throughout Jen's childhood. '*... I've seen her go to slimming club after slimming club ... and various sisters-in-law going with her ...*' Jen's parents addressed her overweight at age seven by taking her to dance classes. They discovered that she was '*... quite good at it at seven, even though, I mean can you imagine what I must have ... I, they used to call me, my dad used to refer to me as his barrelina, because of the way I looked in a, in a leotard.*' Over the next three years her weight '*... naturally adjusted ... I just started to look more normal.*'

When she was ten years old it was decided that, whilst a good dancer, Jen was '*... perhaps not very academic so they decided to send me to stage school.*' She modelled Marks & Spencer's clothes for age ten children. However, she points out that the stage school were not satisfied with her size. '*They wanted me to be a, you know, pencil-thin ballerina ...*'

The stage school separated the children at meal times and put the children they considered '*... too fat*' into a different queue from the other children. Jen calls it the '*salad queue.*' On cold mornings children were allowed to come in for hot soup. '*Unless you were one of the salad kids and then you were only allowed a cup of water ... if I was allowed soup I used to get so excited.*' Even at the age

of ten, she felt guilty about eating, '*... there was a little cafe a couple of doors up. I used to sneak off and get myself some toast, 'cause salad – we used to dance four or five hours a day, on a plate of salad. I was starving most of the time.*' The school was a '*... dance until you drop type ... the dance teacher used to walk about with a cane in her hand, which she used to whip past your ear if, if ... to let you know you weren't working hard enough...*'

Jen believes that she had a good figure at that time but that there were always girls who looked better in their leotard '*... there were always thinner ones or bigger-boobed ones, or the girls that got the boys – I mean, this is my teenage years now, you know?*' Looking back at photographs now of herself as a teenager, Jen can see that she was a size ten and looked good, but she feels it was '*wasted*' as she didn't know she looked good at that time. '*Everybody was so obsessed.*'

She left the school at the age of nineteen, planning to have a year of working to get some life experience, before becoming an actress, but then she became ill. '*Very stressed, very unhappy, all the excitement I think, for all those years of being in a stage school and all that. Then ... living with, in a hindsight, what was a very boring person.*' Jen had an overactive thyroid and lost a great deal of weight. She was treated with medication initially, her thyroid function dropped '*... to being slightly on the low side and I immediately started putting on weight.*' She lost all the muscle she had built up through dancing.

When Jen reached a size fourteen the man she lived with moved into the spare bedroom '*... because he couldn't bear how fat I'd become.*' The relationship ended and at the age of twenty one she went back to live with her mother. For the next seven years she was single, and having a good time. '*I had a nice ... period of time when I probably sat at around fourteen, up to sixteen, back to fourteen again ... that sort of size is okay.*' Then Jen met her first husband, got married and got pregnant on her honeymoon. She began trying different diets. Jen had '*... again, a lot of trouble with being very anxious. They put me on antidepressants for post-natal depression ...*' The next diet she tried was the Atkins, which worked very well for her. She had a cholesterol test prior to starting the diet, then again three months later, as she had been worried about

the fat content on the Atkins plan. The result showed that her cholesterol level had gone down considerably following the diet.

Jen split up from her husband when her daughter was two and moved in with her parents. *'... When I was single I was fine because I wasn't in a sort of ... domestic routine; I wasn't cooking for somebody else and sitting down to a meal ... I wasn't consumed with food.'* She met another man, *'... a bit of a pseudo-scientist really,'* and got engaged to him. He tried to control Jen's eating programme. With him she tried the Cambridge diet, then the South Beach diet, which was a variation on the Atkins plan. She also tried a food-combining approach which she found complicated although it was effective. *'I did lose weight doing that but, for whatever reason, it's not a way of life, it's a temporary fix. So that just didn't work.'* The relationship also didn't work, so Jen was single again for the next six months. By this time she had moved with her family to the seaside and bought a business.

On 1 January as a New Year resolution she went online and joined a dating agency. This is when she met Stefan, her current husband. He had been accustomed to looking after his mother, who weighed between 22 and 25 stone, and did not see Jen as overweight, *'... a bit revolutionary really...'* Jen noted that it was nice to meet Stefan as he wasn't *'... consumed with how you were.'* Her experience of dating websites was not positive as most of the men made it clear that they were not interested in women who were overweight. Jen and Stefan moved in together and married.

After having another baby Jen weighed fourteen and a half stone. She tried the Diet Chef to your Door diet again but *'... couldn't get back into it properly and it was also, you know, very expensive – about fifteen pounds a day.'* She has researched the raw food diet and had hypnosis. Jen believes *'... the problem's not in what I'm eating ... I can't think of a diet that I haven't really tried ... or at least read about or looked into.'* She believes *'... it's a mental problem more than it is a physical one ... but I still can't do it.'*

Jen believes that she sabotages herself but doesn't know why. *'First of all, as soon as I experience moderate success I stop ... I certainly wouldn't choose to carry on looking the way I do, or carrying the weight I'm carrying now ... but in some ways ... maybe it's almost easier if you are overweight.'* Jen has a

catering business which employs ten people. *'But there's still a part of me that thinks that, so long as I'm fat and overweight, people ... don't expect too much of me...'*

She goes on to consider how, years ago, either being overweight or believing she was overweight may have prevented her from succeeding at some things. Jen names a well-known actress from a popular television programme, with whom she competed at auditions. *'... she was kind of my nemesis. We went through school together ... but she was always that little bit thinner than me ... and bigger-boobed, later on in life anyway. So she always seemed to get it ...'* And *'there was always a failure there ... you were shortlisted. You would have been our second choice. That was always there ... I did a lot of work but I never got any of the leading roles as a child.'*

Jen notes how competitive the entertainment business is. *'And I suppose I am quite a competitive person really, but um, yeah, got to compete really.'* Jen's mother believes that her daughter is *'... destined to be fat'* as she takes after her Aunt who was very overweight. The catering business is also very competitive and Jen has experienced overt challenges. *'... another sandwich van trying to carve us up, or nick our customers or vandalising our vans ... a juggernaut driven at one of the drivers, uh – we had to report that one to the police.'*

Being around food is also a problem for Jen at work and the hours that she works are identified as a particular difficulty. She has a long day then goes home to start again with the children. She often eats no meals before two o'clock in the afternoon and is then *'starving ... there's a warehouse outside the office door that holds all our stock and that's all instant. I've before now gone to bed on one evening meal, two Twixes and three packets of crisps. I mean, that would be my normal, my normal day.'*

Jen's daughter takes after her mother. She used to be an athlete but since stopping competitive activity she has gained weight, *'... but again you know, someone's patted her on the tummy and gone oh, getting a bit podgy there ... that was my father did that ... and then she's upstairs booing her eyes out - I told you I was getting fat. I could go and punch him.'*

Jen notes that, however good slimming clubs are, nothing seems to be possible to do for *'... anything more than about two weeks... there is still also that element of, oh I've had a bad day, I deserve something as well. Back to when mum used to, you know, if you'd hurt yourself you got a packet of sweets, or, ... if I'd been a good girl in the dentist she'd take me to the sweet shop.'*

Jen describes the food she ate as a child, noting that everyone knew what each night's meal would be, depending on the day of the week. *'Sunday would always be a roast and Monday would be the roast made into a shepherd's pie ... the worst night of the week was faggots. Bloody faggots ... hideous.'* Saturday nights were *'... free for all. You could have whatever you wanted on Saturday.'* Jen's mother shopped on a Friday afternoon so the cupboards would be full. *'Quantities of 'treat' food were large. '... we'd have cases of Coke or Fanta. We wouldn't have ... one or two cans, you'd have a case of 12 or, there was plenty.'* And at Christmas *'... all the kids would get their own tin of Quality Street. We wouldn't have one for the family. We'd all have our own tin.'*

Jen refers to her mother as *'... a feeder ... to her it's a kindness, it's her way of, you know, treating me, treating the kids. It's her way of saying I love you, really.'* Her mother was the same with all of her children. *'... I remember my brother eating vast amounts of food and she would be so proud that, God, he's got a good appetite.'*

This is an ongoing issue as Jen's mother continues to provide treats for Jen and Jen's children. *'... even now... she brings us a bag of what she calls treats – poison treats.'*

Lucy is Jen's younger daughter. She is five years old, and *'... instinctively knows how to eat exactly what she needs and stops the minute she's had enough ... I'm quite confident that that was probably what I was like, when they said I was a picky eater.'* Jen believes that her ability to know when she had eaten enough was over-ridden. *'... that was definitely drummed out of me because I wasn't eating enough as far as they were concerned.'* She is determined that this will not happen to Lucy. *'She says she's had enough then I take the plate away and that's it. She's had enough. And she's a very healthy, incredibly energetic but very light child.'*

Jen believes that women who get 'a bit tubby' after the menopause is '*... a totally different issue to, to seeing a girl of 18, 19 walking down the road, absolutely enormous - totally different thing.*' She believes that the generation she and I belong to did not learn the lessons of healthy eating because our parents were not educated in this way. '*Now we're all talking about it. Should have been two generations ago ... it's skipped a couple of generations and it's too little, too late I'm afraid.*' Jen believes that '*... reprogramming neural pathways ...*' is required, and that '*I've got some very deep pathways. They're very determined ... how do you over-programme that, I just don't know. I don't know the answer. I keep waiting for the epiphany. I hope it comes soon.*'

Jen believes that people who were overweight as children have greater problems with losing weight as adults.

'I do believe that there is a difference between people who had a certain attitude, or didn't need, or weren't aware of their relationship with food at an early age, weren't aware of it, and they could eat and it was no issue. You ate to survive or whatever, it's easier for that person to get back to where they were. Somebody that has struggled with different mental attitudes as a child or has had food given to them as rewards or treats and it's been a big part of their family life, are more likely to have, more mess to unscramble to get back to where they need to be.'

Lizzie's Story

In her autobiographical writing Lizzie wrote that she was born prematurely, remaining in hospital for the first nine months of her life, despite being a big baby, '*nine pounds something*' – all her family had big builds. She remembers that her Uncles were 6ft 5in tall. All the children were bottle-fed and Lizzie notes '*that was the era when they used to top-up.*'

Lizzie doesn't remember any issues with weight until she was '*about nine or ten and getting very chubby around the middle ... getting rolls of fat around the middle ... they used to call it puppy fat I think.*' Her mother '*always said I had eyes bigger than my belly so I think I always had a hearty appetite.*'

She believes that her mother's concern about her weight transferred to her, and feels that happens often with mothers and daughters. 'I think she probably

looked at me and thought, *'ooh I don't want her to get like I've got or something, so let's do something about it now.'* Lizzie's mother had problems with her own weight. *'She was probably 14, 14 stone and 5 foot six or seven so overweight, but also had health issues. There's heart disease in the family.'*

Her mother worked in a *'frustrating job'* and there was no money left over. However, she would come home every Saturday night with a bag full of bread and cakes and sweets – *'we all tucked in ... we loved all of that.'* Lizzie can see now why her mother did that *'because she wasn't there all Saturday ... and she liked those things too.'* They ate a lot of convenience food and *'fantastic puddings'* that her mother made. Lizzie became very interested in food. During her secondary school years she became stressed, with GCSEs, falling in love and so on, and went down in weight from ten and a half to nine stone *'which looked great but it did make me look ill.'* Other girls had boyfriends and looked the way she wanted to look – Twiggy was a big influence when Lizzie was 16 and 17. She remembers taking crisp-breads to work and being a dress size 12 at that time.

When Lizzie left home at 20 or 21 she shared fad diets with her house mates. They tried the grapefruit and high-fibre diets. She bought her first cookery book – Marguerite Patten, which she still has. *'It explained to me what piece of meat, where it came from and what you're supposed to do with it and how you bought it.'* She was interested in food and made nice meals if a boyfriend stayed for a weekend. When she married, she was conscious of her responsibility and changed her husband's diet. She remembers going back to see people at her old place of work, six months after she had left. They said *'gosh, you know your hair's changed, you're thinner'*. Lizzie felt that she had indeed changed. *'I was, although I'd left home some years before, I felt I was in control of two people's life and diet and it was an important job and I did read; I was very interested in nutrition ...'*

Lizzie and her husband didn't eat out much for the first 30 years of their marriage, only on birthdays and anniversaries. They had fresh, home-cooked food. She thinks she was lucky that she had time for home cooking and notes that a lot of women have to work now *'because it takes two incomes to have a mortgage.'* They had three boys and, after the early years Lizzie began putting

the children's food in the middle of the table so they could help themselves. The younger son '*did get very chubby*' but he lost the extra weight once he was 15 or 16 '*when he discovered sport.*' The children were given 15p every Friday, to go to the local shop and buy sweets. At that time, 15p was the price of a Mars bar.

Lizzie identifies herself as '*a nibbler*' who grazes in the evening. She joined Weightwatchers after having her third son when she '*didn't want to be twelve and a half stone.*' She almost reached her target weight, then left. She now wishes she had stayed to reach target weight so she could go monthly and '*it would never have gone up again.*' She has returned to it a couple of times but then found she was paying to go every week, whilst not following the plan so she stopped going.

Three years later she began a stressful freelance job, producing an in-house national magazine. She had an early menopause, '*double whammy really*' and, over the next five years gained two and a half stone. She remembers batch-baking enough lasagne to cover the days she was working. She then had to come home from work and defrost and heat the food. Feeling cross, she began to overeat whilst preparing the evening meal.

Lizzie likes cooking – she cooks healthy weightwatcher recipes with low-fat ingredients and '*throws beans in with meat recipes.*' However, sometimes she '*can't be bothered.*' She and her husband have supper in the evening and, if she's not organised and gets tired and cross she will start eating whilst preparing the meal. She has tried to address her grazing habit by sipping a large glass of iced water whilst preparing supper but '*a little voice inside me is saying why don't you have a bit of bread and cheese and a spot of that nice pickle? You deserve it ...*' Sometimes she sits at supper, not really wanting it and thinking, '*My God, how much must I have eaten while I was out there ..*' She has thought about the reasons for this. '*I think it's tiredness and do I have to do this that makes me reach out for something else to eat, or the sudden realisation of what's in the cupboard. If I wasn't in charge of the kitchen I wouldn't be overweight.*'

Lizzie and her husband both exercise, eat healthily and she weighs exactly the same as she did in 1994. She feels that she maintains her weight well but

cannot get it down to a level she would like to maintain, because of *'this business of eating in the evening and, because I'm really, really hungry by then.'* She likes herself *'I don't feel I am a fat woman but I know I am overweight'* and doesn't think she has hang-ups. *'I want to be fit and active, I don't look too bad.'* She is a dress size 16 and *'doesn't mind enough to do anything about it'* but feels she would do something if she went up to a size 18. *'I wouldn't contemplate it so that will shock me enough.'*

She has some health issues. *'A few medical things. Cholesterol, stuff like that ...'* Also, *'I can feel that the cartilage is going in my left knee the same as I did in my right ... the less you weigh, the less strain there is on your joints ...'* She checks portion size but *'it creeps up every time I look.'* She has noticed that when she visits her niece she is served huge portions so she thinks perhaps her own are not so bad – but if she makes dessert for people coming to dinner she will eat the left-overs, *'even if it is one o'clock in the morning.'*

Lizzie is horrified now at the idea of going on a diet and *'certainly would never have liposuction'*. If her clothes are tight she'll watch what she's doing for a while, but *'I mean people who go on a diet and do brilliantly and then go back to what they did before, they don't keep it off.'* She thinks it is about lifestyle changes, and she *'made loads of those years ago.'* She would hate to be a *'diet bore ... a real obsessive.'* She says, *'Food is not your enemy. I've had friends say, God you have two eggs in your scrambled egg, do you know how many calories there are in an egg? I say, they are calories you need for your body organs to function ...'* She knows many people who are afraid to eat normally, even smoking to help them stay slim. This includes her niece who stopped smoking for four months, then started again because she gained a little weight.

Lizzie explains *'I think you have to make the changes yourself – if you can be assed ... somehow I can't be assed enough'* and *'... if I ate rubbish all the time I, I do think you'd feel so much worse, you know, you'd feel stodgy and horrible.'* *'I know I am overweight and probably not a good idea to be, but how much do I care enough to do enough about it?'*

A friend who has done the Lighter Life diet *'... has made it work; she's the exception. She is savage in what she won't let herself have. She doesn't have any carbs and I don't want to try that hard.'* Lizzie believes that, despite

Weightwatchers being very helpful, the diet industry generally makes its money out of keeping us fat. *'Well they know human nature ... and they also, they come out with ready-made things ... okay it's ... lower fat but piled with sugar.'* She also believes that current accessibility of food through constantly-open supermarkets selling cheap food is another problem.

Kara's Story

Kara was born to a mother who was a former model and air hostess. *'She was very beautiful and incredibly skinny ... but that's not a mother I ever knew. She'd always been very, very large in my lifetime.'* Kara believes that her father desperately wanted to have a son. She and her sisters *'have had to live with that fact for all of our lives, that none of us ever managed to be a boy ... And boy, have we tried to be boys ...'*

She was premature and weighed only five pounds at birth and was fed on watered-down, evaporated milk. She grew into *'a very bonny baby'* and weight was not a consideration until she went to secondary school, where food was *'very regimented'*. It was an all-girls boarding school. *'... when I was about eleven or twelve, the comparison between shape and size of women or girls was just the major topic of conversation, you know, who could fit into the clothes, swapping, the fashion ... that was probably quite an important factor in the self-examination.'* She was fit and participated in sports activities.

Kara remembers after leaving school, she visited a girl friend who had been admitted to a London Hospital with Anorexia. She describes the uproar and distress when the girl had to be weighed naked. They complained to the Matron, who explained this was necessary because the patient had been sewing weights into her clothing to appear heavier. Kara is still in contact with the girl, who has been left with health problems due to potassium deficiency and other problems, and who looks *'... positively skeletal ...'*

Kara met her future husband at the age of sixteen, then went to secretarial college in London, left home and shared a flat in Notting Hill with friends. Kara noted a *'burgeoning adult identity'* at this time. She was also made aware *'that ... I needed to sharpen up a bit,'* by the attitude of her boyfriend's mother.

'... his mother was very, very self-aware, in terms of weight. She was tiny. She was about size eight, ten, and she would always, always comment on other people's shape or size or clothes or fashion ... so I think I became quite aware of my own deficiencies at that time, or perceived deficiencies in comparison to the language she was using about others, really.' Kara identified that this was *'probably the beginning of a problem with food ...'*

She married at twenty-one and remembers having panic attacks, *'about being grown-up and needing to do everything perfectly because that's the model that I was being given, that everything had to be perfect ...'* Her first baby was born a year later and she identifies that she had a problem after that, *'.. I remember getting quite bulimic ...'* A couple of years later, Kara had another baby and was *'... very, very thin ...'* and was *'... quite worried about my weight all the time. That I was never going to be thin enough and get back that pre um pregnancy figure, which you don't but nobody tells you that.'*

Kara began undergraduate studies and had gained some weight after having another baby. She then discovered that her husband was having an affair. She lost all the weight she had gained *'... 'cause I thought that would make it happy but it doesn't ...'* She felt that she was never good enough *'... in terms of, the light of my mother-in-law ... and every time we'd meet there'd be some sort of snide comment about not fitting the bill, really. So I think I got a bit strange after that, really, in terms of my weight.'*

Kara became pregnant again *'... a complete surprise ... we were very excited ...'* Tragically, their baby was stillborn at twenty-eight weeks. The same thing happened with another pregnancy soon afterwards, and that was *'... the end of our relationship I think.'*

Kara felt that she needed to *'... make a statement, to say that I can get over this and I can do something to help, so I decided to put myself in for the London Marathon a year or so later.'* She lost a great deal of weight and became very fit. During the time she was running she met her current partner and her marriage broke down. *'... I think probably I'd fictionalised an escape in my head and it, you know, doesn't match up to the reality, does it?'* She describes their relationship as making the best of what they can. *'... given the choice, I wouldn't do it again. I wouldn't break up my family ...'*

Since then Kara notes that she has gained three stone in weight. She *'had to work to support – cause we're not married and ... I sort of have to lead a quasi-independent life so I had to work full-time ...'* Later, she talks about *'... the financial commitments we've got. Carl's work is very, very feast or famine, so I'm the stable income earner, um, and we need that income at the moment ...'* explaining that she is not happy in her job but doesn't know how to get out of it.

Her job is stressful and involves sitting at a computer for work and study, for many hours. Her only exercise is walking dogs. *'... I do know eating has become such a comfort really, which is really, really sad, so there's this, it's definitely this psychological thing, not just, not just the lack of exercise or anything, but there's ... I eat things that I would never have used to eat, though it's, it's a bit of a strange thing really. So I don't feel good about my body now, and I don't know it. It's not the body I used to have.'* She is also concerned about her health. Her mother had a heart bypass operation recently, and Kara feels *'... that could be my destiny if I don't look after myself.'*

Kara has dieted in the past, and has been to a slimming club and gyms. She dislikes gyms, preferring to be active outdoors and close to nature. She used to lose half a stone in a week through crash dieting. *'I would be very regimented about it and I think that that's the tendency to control freakery ... I need to get a bit of control freakery back. But I think it's because I have to control so many other factors of my life, that I can't – I haven't got the energy or the incentive to control my eating as well ...'*

Kara believes that her weight gain is *'evidence of a deep-seated and underlying unhappiness that I need to tackle. Or maybe it's not the weight I need to tackle; it's other aspects of my life, so ... but I can't; that's not within my gift to be able to manage at the moment.'* She identified underlying, deep-seated guilt at breaking up her family as a cause of her unhappiness. *'You know, I've just, just gone against everything that is the creed of the Catholic faith, about being wholly true, to your family and to a life that is, is you know, that gift and I turned my back on my marriage and my family and that is considered a cardinal sin in the Catholic church. It really is, um, and I have to say probably I was young and foolish and had my head turned too much, but I wouldn't do it again.'* Another cause of her unhappiness is her job. *'... there's a mismatch between my values*

and what I'm doing.' Also, '... I wouldn't say that my relationship .. is particularly brilliant. All that glitters is not gold, really. Um, he's not always a kind person.'

A positive vision of the future '*... within reach*' is presented, however, with plans to pay off the mortgage. Kara talked through her blessings: wonderful children, living in a beautiful place, and not needing to work quite so hard once the mortgage is paid off.

'So the future is good and the future is within, within reach ... and maybe I can just take more time for myself than I've been able to up to this point, or certainly over the last eight years, and begin to sort of come to terms with number one, rather than worrying about everyone else.'

Kara's autobiographical writing is presented here:

Perspectives on self and size

When you are taught to juggle by a circus skills expert, one of the first exercises they get you to do is to throw a ball up into the air in front of you and then catch it behind you, without turning round. The aim of this exercise is to allow you to work within the frame of reference your body shape/size allows in understanding space and distance. I can't do this exercise.

Because I no longer understand my body. Its shape and dimensions are a foreign territory. I have a landscape of crevices and undulations, creeks and canyons that I have no wish to explore.

Ten years ago

I ran a marathon.

I was a size 12, weighing between 60 and 62 kilos.

I cycled to work.

I was married

And had three wonderful children

And a lover

Who said to me the first time I undressed... "oh, you are so skinny."

Now

I can't run to the end of the lane

I am size 16/18 weighing 85 kilos

I drive to work and sit in front of a computer for up to 8 hrs/day

I am divorced

But have three wonderful children

I have a no-commitments relationship with my lover

Who makes jokes about my size

I catch glimpses of myself in shop windows and think "oh my heavens is that really me? I am so big!"

Last year my overweight mother had a quadruple heart bypass.

I know that is my future unless I deal with my obesity.

But I eat to forget. I eat for comfort. I eat to appease my guilt. I eat to deal with my workload.

I eat and eat and eat and wish to forget.

Sue's Story

Sue was born into a family in which there were large women on both her mother and father's side. She has a large frame. *'My skeleton is a size 16 plus' and '... even if I was thin I looked podgy.'* She also says she used to be five foot ten but is now five foot seven inches, due to back problems. When younger she was fit and sporty so *'used to be able to get away with it.'* She believes that her eating habits were probably laid down in childhood. Her parents were children in the war years and *'... knew the paucity of the war-time diet. They provided the best they could within their limitations at that time. My parents did their best to fill us up on a very limited budget and did not like to see (and could not afford) waste. My dad worked three jobs to keep us going. Therefore they provided food we would definitely eat. It may have been stodge but I don't ever remember being hungry.'*

Sue describes the leftovers from the Sunday roast being used for cold meat and bubble and squeak on Monday. Meals were *'solid' and 'old-fashioned ... no foreign muck – with plenty of stodge to fill us up.'* These eating habits have persisted. *'I don't consider a meal a proper meal if it doesn't come with potatoes or bread, preferably both.'* Also, *'for reasons of economy we had bread and butter or bread and jam but never bread with butter and jam ... and that's still the way I prefer things.'*

At the age of 18 Sue was ill and went down to nine and a half stone which she felt was too thin for her height. After meeting her current husband and two years of courting she was twelve stone when they married, then rose to seventeen stone (but '*fairly fit with it*') at the time she was trying to start a family. She swam and played squash regularly.

Sue describes her eating habits as '*peculiar*.' She says '*I can't just eat one taste, no matter how hungry I am; I must have different tastes available. Consequently I don't have sauces and gravies because, by spreading round the plate they make everything just one taste ... it turned out that my grandfather was just the same ... I also react badly to some foods. Strong, rich or fatty foods – creamy milk or pork or duck – have always made me feel sick afterwards so I avoid them.*' She is also squeamish about some foods – '*liver ... kidneys and tongue ...*' she prefers vegetables remembered from her childhood, '*nothing exotic,*' and believes there are '*pesticides, growth hormone and 'all sorts of stuff' in 'even what you think of as natural food.'*' She mentions additives '*which are approved*' that are used for longer life, colour, texture etc.

After getting married Sue gradually put on weight, partly through contentment and partly through a change in meal patterns. '*... I used to skip breakfast and have a big lunch and no dinner ... of course, once you get married ... I still couldn't eat breakfast but I couldn't get through to dinner without anything so I was eating lunch and dinner ...*' Sue and her husband both tried to lose weight through eating healthier food and preparing it in healthier ways, grilling or poaching instead of frying. At the end of the first week Sue remained the same weight but her husband lost half a stone, and then she gave up the attempt to lose weight.

Sue believes that she is genetically predisposed to the shape that she is, particularly as her two children have always been different shapes and sizes, despite having similar food and exercise patterns. Sue also believes that there are pollutants in food and drink which some people react to and others don't, depending on their genetic make-up. She points out that one percent of the population affected in this way would go unnoticed. It would simply be thought that they were overweight. Sue has read that ten per cent of the population can taste the chemicals in diet drinks. She believes that she is amongst that ten per

cent. *'People swig back diet drinks and I think, how can they, but they don't taste it the same way I do.'* Also, *'If there's a gene that gives you a taste thing like that I'm sure there are genes that ... well, this is what I wrote to (a daily newspaper) that I believe that there's a large genetic component brought on by what they put into food nowadays. On TV, they've done some research on fruit flies or something, decided that obesity was genetic. I've seen this article. There's Janet and Lily. Janet's a lot fatter than Lily. They eat exactly the same, get the same amount of exercise, well, Lily more a little bit but I mean physically they're different because one's predisposed to being large for some reason, whether it's the gene package that she's got makes her a fat person, or whether she does react to the stuff in food or, or anything...'* (Janet and Lily are Sue's children).

Sue wrote to a newspaper in response to a reader's letter comment about the problem of obesity. The reader had pointed out that there was no obesity problem in the days of the last world war. Sue wrote to the newspaper, outlining her theory that obesity may be caused by pollutants in food that some people were sensitive to, and used the example of her daughters to demonstrate this. *'I believe that there is so much artificial stuff in food, which wasn't in food then but I'm sure that has an influence and even if it's only a proportion of the population it would account for that, and secondly I do think that certain people have a genetic makeup that makes them sensitive to what's in food. Janet reacts to it and Lily doesn't.'* The newspaper sent a photographer and Sue's letter and photograph of herself with her daughters was featured. Sue was then approached by a television company and she appeared on a television show to talk about her theory.

'It's all propaganda. If they want, if they really wanted to do something about it, analyze the food that the manufacturers are producing and do something about it. Take all these additives out, take the growth hormones ... why have a go at the individual, try to brainwash them into thinking, why you know, you're killing yourself. Do something about the problem of the actual food. You don't have these problems on the continent because they won't allow all this stuff in their food ... French bread goes off in a day ... because they've got no stuff in it ... it's the same in Germany. They're not allowed to put all this stuff in the foods ... I

strongly believe that we're poisoning ourselves with what we're putting into our ... foods.'

After last Christmas Sue started to cut down *'on everything really'* - she was concerned about her own blood pressure and about a worrying result from a liver function test. *'... I said well ... I'm fatter now than I was then so I expect my liver's even fatter ...'* However Sue was worried about her daughter so cut out shop-bought sweet things, replacing biscuits and chocolate with fruit and vegetables, fizzy water and juice, and diet drinks for her daughter. She lost a stone and a half, and Janet lost over a stone in about six months.

'Unfortunately, feeling pleased with ourselves (and Janet having fitted into my old dress for her prom and looking great) we lapsed ...'

Sue believes that willpower and state of mind also has an effect on *her weight*. She has been in *'absolute misery and feeling like a victim for ... the last ten years.'* Her husband was made redundant from his job twice within a four year period, just at the time when Sue's father died, leaving her money. The money then had to be used for living expenses. Suddenly their comfortable lifestyle, *'cruising towards retirement'* had gone and *'you just get into a downward spiral ... our expectations get less and less every year.'* As Sue pointed out *'Worrying about what I was stuffing in my gob and what effect it's going to have ten years down the line is one of the last things on my mind, you know?'*

Ann's Story

Ann had no problems with her weight until she was around 17 years old. She remembers living abroad as a child and has photographs of herself in which she was *'really, really trim.'* When she came back to England, in time for the second year of secondary school, she was faced with the same friends she had left behind in junior school (the *'in-crowd'* who were *'horrible because they were real bullies'*) and having to decide whether to remain friends with them or go with a new crowd. She felt mortified at being moved from *'the clever class to the not-so-clever class'*. She remembers developing a sweet tooth at this time, and cultivating a friendship with a girl who didn't eat dessert, so that she could sit next to her and have an extra dessert. She also remembers her sister

threatening another child on Ann's behalf, as the other child, who was server on Ann's table, consistently gave Ann smaller portions than she gave the other pupils.

When Ann left school she was '*devastated*' because she had no plan and didn't know what to do. '*So I just left school one day and the next day, and I remember, the feeling of overwhelming loss, of what do I do and what happens now?*' Ann's mother got her a full-time job at the restaurant where she worked, and where Ann herself had been working part-time at weekends.

Ann remembers at that age going into town during her lunch break, rather than eating the free meal provided at work, so feels she probably wasn't obsessed with food or her weight, although she joined her first slimming club with a friend at that time. She changed jobs, becoming a Leisure Assistant, where she was '*incredibly healthy,*' had no issues and '*might have been carrying an extra stone, half a stone, but certainly wasn't big at all.*'

Ann identifies her problems as beginning when she moved up to London to a managerial job, where she had no friends. She began to eat compulsively and was unable to stop herself once she started eating. She remembers seeing another woman eating four cakes in the cafe section of the bakery near her workplace and identifying that the woman was eating obsessively, '*cramming them in her mouth with absolutely no enjoyment at all.*'

Ann feels that she must have believed she was overweight at that time as she obtained slimming tablets and took six times the dose that a doctor would usually prescribe. She was on a '*permanent high.*' This continued until she was thirty, when she had her first panic attack. At this time she had moved house, changed to a better job and began studying for professional qualifications, met her future husband and decided to marry.

Ann realised the panic attacks were provoked by the slimming tablets. She stopped taking them and was referred by her doctor to a psychiatric nurse who helped her. She never took slimming tablets again. She was very happy in her marriage, job and new house. Everything '*fell into place really*'. She began to '*eat for contentment*' and put on three or four stone in a year. She put on more weight during a holiday to America and didn't lose it when she came back. She

identified that this was not really comfort eating '*...it was just eating obsessively, and knowing that I actually can't stop myself...*'

Ann remembers that during her teenage years she had problems at home. Her father left and her mother '*seemed to go totally off the rails*' and did not provide the support Ann needed. She felt that she had lost both her mother and father and did not feel that she had a place anywhere. She dealt with this by rebellious behaviour. She remembers going into clubs when she was fifteen, and going on the beach with a bottle, but doesn't remember anything she ate at that time, including family meals.

Ann has been successful and has a good lifestyle with no money worries; she believes this is due to that an opportunity she was given as a teenager, when a manager helped her to obtain a managerial post in London.

Ann now attends a slimming club and has lost almost three stone. She identifies leftover food as a particular problem for her in losing weight, and believes this has been passed down to her by her parents, who made her eat everything because they were '*war generation people and so there ... was no waste. There was absolutely no waste.*'

Ann believes she could lose weight easily if she could eat microwave meals – if they were healthy and not dangerous – as '*it's put in front of you and that's what you've got to eat and you would just do it*' - also, if she ate at regular times and never got too hungry.

Ann also identifies what she believes is an obsession with eating. She has never been to an all-inclusive holiday because she believes she would think about food the whole time, instead of enjoying the holiday. Ann admires her husband because of his attitude towards food. He's happy to go to the buffet table last and take what is left. She is afraid to go on her dream holiday – a cruise – because there would be food available all the time and she feels she would have to '*have breakfast, the mid-morning snack, the lunch, the afternoon high tea and then supper, and then even possibly the midnight feast.*'

Ann also recognises this obsession in some other people. '*I recognise their obsession because I recognise traits in myself ... I feel sorry for them because I know that unless they control it, that's how they're gonna be for life.*'

My own story:

Healthy Eating Made Me Fat!

I never had problems with my weight as a child or teenager. I was slim, healthy and active, just like the rest of my family. Food was never an issue or something I gave much thought to.

When I was 19 I began nursing training. Shift work, especially night duty, together with stodgy canteen food, added a few pounds and I mentioned this to a colleague, Lesley, whom I had met at a hospital party. I remember her telling me not to worry – she was always on a diet and she would help me to lose weight in no time. Lesley gave me a diet sheet and told me we would plan meals and eat together to keep each other motivated.

I discovered there was no shortage of diet sheets for different eating plans. Details of the steak and grapefruit, and hardboiled egg diets were passed around the nurses' home and I bought a calorie directory to help me stick to 1000 calories a day. The day I fitted back into my size 12 clothes and found them a bit too big Lesley was so excited she insisted we go out to show off my new 'skinny' figure. I remember how gratifying it was to be called skinny; I continued dieting with a new enthusiasm.

It didn't occur to me then that Lesley was much bigger than me so would need to diet for much longer if she was to achieve the size 10 dress size that she was aiming for. Consequently when I had lost the extra weight I had gained – it took me two weeks – I simply continued to diet, along with Lesley, until we were both so hungry we decided to 'break the diet'. This was the cue for a period of bingeing on all the food we had denied ourselves whilst we dieted. This was my first experience of firstly denying myself food when I was hungry and secondly, continuing to eat long after I had stopped feeling any hunger. This cycle was repeated frequently for the two years in which we were friends. On reflection I realise that this was the time that I stopped experiencing the normal body signals that would tell me when to eat and when to stop.

Most of my fellow students dieted so I fitted in well to the culture and over the next three years I gained and lost the same stone or so every few months, moving between dress sizes of 10 and 14. At size 10 I felt great and life was

wonderful. I felt invincible. At size 14 I began to stay in my room on my own as much as possible and wore old-fashioned, matronly clothes in neutral colours that concealed my body. My wardrobe contained clothes in three dress sizes. I even had work uniforms in different sizes. It is hard to believe now that an extra stone would affect my confidence and change the way I felt about everything in my life. When I think back to that time I see that the whole issue of competence and confidence in my ability to do my job successfully, and my sense of self-worth had become bound up with my appearance and my weight.

A complicating factor was in the emotionally fraught aspects of my work. In the 1970s nursing training was carried out largely in clinical areas of hospitals. Student nurses were full-time, paid employees for 42 hours weekly and received time off each term for an academic 'block' of two weeks in the training school on-site. We identified mostly as very lowly workers, subject to the whims and fancies of senior staff and ward managers. However, our responsibilities could be immense. My third ward placement, that is six months in to my nursing training, was back to the first placement ward – in my case male surgical, on night duty. It was an exciting time but also terrifying.

The night shift was poorly staffed, with one qualified and one student nurse on the eleven-hour shift, looking after around 24 patients, some of whom would be pre-operative, and others in different stages of post-operative recovery, or receiving palliative care. When my colleague went on a meal break I would be in sole charge of the ward, armed with the telephone extension of the night sister who could be called in emergencies. I would spend the hour pacing up and down the ward, checking each patient in an attempt to spot early signs of haemorrhage or imminent cardiac arrest. By morning I would be exhausted.

Student nurses were not inducted gently into their duties. On my first ward I became fond of a patient in his forties who was admitted as an emergency but had recovered sufficiently to chat to the nurses at length about his interesting job and overseas travel. When he died suddenly during surgery and I had to lay out his body for the mortuary I was devastated. In ward culture it was unthinkable to show distress at the death of a patient. We prided ourselves on professionalism, which at that time meant doing our best for patients in our care, and not showing emotion. We dealt with our distress in different ways,

some seeking comfort with promiscuous behaviour, some by drinking heavily, some eating compulsively – during my training at least three other students were hospitalised for psychiatric care after developing eating disorders. I would never have admitted my problem to anyone. It was well-known that nurses who had been treated for anything other than physical disorders would never be allocated to general wards again. They would go to the least popular wards, under strict supervision.

A few months into my training I was sent to another ward to help out as they were short-staffed. The ward sister asked me to dress the stump of an elderly diabetic man whose leg had been recently amputated because of gangrene. I was mindful of the training we had received in our preliminary training school before we were sent to the wards. The tutors had stressed repeatedly that we must never reveal fear or distaste in our words or expressions or body language when carrying out intimate tasks for patients. I approved of these sentiments, feeling very strongly that kindness was the hallmark of a good nurse, and I was determined that I would be a good nurse. So, when I removed the bandage on Mr X's above-knee amputation and was faced with a large, foul-smelling, pus-filled wound that had a colony of maggots crawling in it, I maintained a cheerful smile, covered the wound with a sterile sheet and told the patient in steady tones that Sister had asked to see the wound before I dressed it. The next hour was spent helping the ward sister to carry out the complex dressing and bandaging procedure whilst she chatted to the patient. I marvelled at her professionalism. I modelled myself on good senior nurses but my iron discipline at work counted for nothing when I went home with boxes of chocolates from grateful patients.

My training was filled with challenging and stressful situations. It was physically and emotionally demanding and I loved it. If only I could keep my weight down I felt I would be in control and my life would be perfect.

I began to develop unhealthy and even dangerous habits in an attempt to control my weight. If my clothes became tight or if I needed extra confidence for a forthcoming event – a party or social occasion, or even a work-related assessment, I would take extreme steps to lose weight quickly. These included fasting for up to three days or eating less than 500 calories a day, and cutting

out whole food groups – the Atkins diet worked particularly well but my breath would smell of ketones and my face erupted in spots for the first time ever. I went to a diet clinic and paid for slimming tablets and injections to stop the feelings of hunger and help me to lose weight quickly. The tablets stopped me feeling hungry but my heart raced worryingly and I couldn't sleep for twenty-four hours after taking one. I visited a hypnotist – that was expensive but didn't work.

When I met the doctor who is now my husband, everything fell into place. The first time we met I refused to eat the take-away meal he and his friends had bought, because I was again on a diet. This was usual and others took no notice but he was concerned. At the end of the evening we all had coffee in the doctor's common room and he appeared with a huge toasted sandwich he had gone to the kitchens to make for me. It was the start of a different way of life. He was horrified at the idea of missing a meal and didn't see the point of eating snacks. When we eventually moved in together we ate three meals each day and my weight stabilised for the first time in many years.

Healthy living was important to both of us. We cooked fresh meals; mostly meat, fish, rice and vegetables, with roast dinners and puddings at weekends. My weight continued to be stable and life was good. When our children were born I continued to work full-time. Money was a bit tight at that time and we were keen to move from our one-bedroom flat to a house with a garden. The pressure of working full-time with two young children to drop off and collect from a childminder was enormous and our healthy meals soon became confined to weekends, with takeaways and microwave curries replacing fresh food during the week. My weight crept up and I began to buy size 14 clothes, telling myself that I couldn't expect to be the same size after having children.

We moved to the seaside and a less stressful life. I began to cook healthy meals again but this time I added the desserts that my family enjoyed so much. I told myself that old-fashioned fruit crumbles and puddings were healthier than convenience food as I finished off the left-overs the next day. As my weight went up I began to cut down on meals, expecting the quick weight-losses I was accustomed to in my teens. I also replaced cakes with 'healthy' cheese and wholemeal biscuits or nuts, never stopping to think that the amount of fat and calories were the same. Not surprisingly I didn't lose weight and eventually I

packed away my size 14 clothes, telling myself that size 16 was acceptable for a woman in her forties with two children.

At that point I went into a kind of denial. I had completed further training and education, my husband and I both had good but demanding jobs and life was happy but busy. Between working full-time and caring for my family, there was little time left for myself. I hated looking in the mirror, remembering the clothes I used to wear and comparing them with the loose tops and trousers I wore now to cover my body. I took care not to look in full-length mirrors, and to avoid being photographed.

My lowest moment came one day when I was going out to dinner with my husband. The weather was fine and I decided to wear a summer dress I had bought the previous year. It felt a bit tight as I pulled it on but I knew the heavy folds would help disguise any bulges. My husband battled to pull the zip up for me then he stood back and said, 'I don't think you can wear that. It doesn't look good – you kind of fill it up.' My husband was always my greatest supporter so I knew I had to listen if he told me something was wrong. I looked at myself in the mirror and saw each new bump and bulge, straining against the pretty dress. I realised that most of my clothes didn't fit and I only wore a few items – those that camouflaged the body I was ashamed of. I reached for the old faithful black dress that I always wore for evenings out, and packed away the summer dress with all the other clothes that no longer fitted me.

Even then I felt aggrieved that my 'healthy' diet should have made me so fat. I told myself that I cooked proper meals and had no snacks in between. I rarely bought biscuits and cakes, and never dipped into the children's chocolate tin as I saw other mothers do. The truth was that my 'healthy diet' included king-sized roast dinners and salads drenched in olive oil, full-fat houmous and nuts, and hunks of bread and cheese.

My sister became my saviour when she asked me to come with her to a slimming group. She had gained even more weight than me over the years and I was keen to support her efforts to lose it, although privately I didn't believe a group would work for me. After all, I ate so healthily already – I just needed more willpower to help me eat less. I'm glad now that we went to Slimming World rather than one of the other groups in our area. A friend had gone to one

of these for a short time and, watching her weighing out tiny portions of her favourite foods, I wasn't surprised when she gave it up. I knew I needed a plan that felt more natural – one I could follow for a lifetime.

When I first registered I weighed in at over 2 stone more than I expected. I couldn't believe it, but all around me people were happily talking about their weight loss, swapping recipes and setting mini-targets for their weight-loss the following week. The free and easy plan looked ideal for me and my lifestyle. At first I thought it was too good to be true – it was so much like my normal way of eating that I found it hard to believe it could work. However, I took a leap of faith and started the plan. At the end of my first week I went back to Slimming World, convinced that I couldn't have lost anything as I had eaten so much. To my surprise I found I had lost 4 ½ lb. After that first week I was averaging a pound a week weight loss.

Three months after joining Slimming World I was presented with an award, closely followed by my sister, who was losing similar amounts of weight. It did slow down a little as I approached my target weight. The day I finally weighed in at 1 lb below my target weight was also the day I was awarded slimmer of the week and slimmer of the month. I had lost a total of 2 stone 10 ½ lb and gone from a size 16-18 to a size 12 - 14.

I don't cover anything up now – I don't need to. The pretty summer dress that strained over every bulge two years ago is too big for me now. I've bought a whole new wardrobe and my daughters have noticed how much happier I am. The youngest has celebrated each weekly achievement with me whereas the eldest daughter has been away at university. She came home on holiday two weeks before I reached my target weight. As she came through the front door I walked down the stairs and gave a twirl as she called out, 'Oh my God Mum, where has your bum gone?' I'm embarrassed to report that it was a wonderful moment.

I thought I knew so much about healthy eating but following this plan has shown me what really works and also stopped me from deceiving myself. Since then I have gained and lost a little weight again – sadly, I still comfort-eat, but the difference is that I don't eat compulsively and I don't starve myself until I snap and begin eating junk food compulsively as I did when I was younger.

Since conducting my research I recognise the powerful forces that regulate women's desire to be slender. I wish I could just stop worrying about what I weigh but my obedience to cultural norms and regulative, moral discourses shape me despite myself. This is work-in-progress.

Conclusion

Each story is unique but there are notable issues that emerge. Some are specific to individuals, for instance Sue's theory of obesity being caused by a combination of genes and modern food production methods, and Jen's childhood experience of food restriction at a stage school. Others are common to several or all participants. These include the women's childhood experiences of being required to eat everything on their plates by parents whose attitudes to waste were shaped by wartime experiences of food rationing. The traditional approach the women showed towards their roles as food providers for their families was also notable, although the participants were all over the age of 45 so were raised in an era which was associated with women taking responsibility for feeding their families.

This traditional role was also referred to by some participants to explain their overweight. Jen pointed out that she could lose weight, as she did when using the 'Diet chef to the door' scheme, if every meal was provided for her and she was not required to cook. Ann expressed a wish that micro-waved ready meals could be a healthy alternative as having a set meal that she did not have to prepare and cook would make it easy for her to lose weight, whilst Lizzie stated that she would not be overweight at all if she were not in charge of the kitchen.

Experiences of emotional distress were shared by all participants, with descriptions of anxiety, panic attacks and depression in the women's lives. Experiences of stigma and fear of negative judgement were also common, with participants stigmatised by family as well as strangers.

As described and explained in the methodology chapter, three different forms of analysis were undertaken. Findings from the first form, re-storying of the

narrative accounts, were presented in this chapter and included my own story. The next two chapters re-present findings from thematic analysis, and relational analysis.

Chapter Five

Analysis of findings: Thematic analysis

This chapter returns to the data, exploring the women's narratives and artefacts – their written autobiographical accounts – through the process of thematic analysis (see chapter three). Further findings from interpretation of the data are presented as themes and discussed.

Through the analysis process three overarching themes were developed:

- Control and being out of control
- Comfort, pleasure and pain
- Embodiment and alienation

These are presented and discussed in this chapter.

Control and being out of control

In my own autobiographical writing I identified health as an important issue in my story which I called 'Healthy Eating Made Me Fat' (chapter 4). The provocative title signposted my intention to explore the ploys I used over many years to maintain an identity as a sensible, healthy (although overweight) person who was scornful of controlling diets and contrived exercise regimes. I recognise Lizzie's aversion to diets, '*... the thought of actually going on a diet now fills me with horror*' and her approach to healthy living, '*... it's actually about lifestyle changes and I consider I made loads of those years ago.*' Kara's approach to exercise is also relevant. '*I don't enjoy gyms ... For me health and exercise must be outside – outside in the fresh air, outside in the garden, outside playing, that's what it should be about, um, not going into a hamster wheel ...*' With this assertive approach Kara resists the regulation associated with a gym, taking control of her own exercise regime by promoting healthy outdoor play as an alternative.

However, taking control may be less about assertiveness and more about protection. Orbach (2006) suggests that becoming overweight may be a form of physical protection against vulnerability, with loss of control demonstrated by compulsive eating an attempt to anaesthetise unacceptable feelings. Women

may be unaware of their personal responses to challenge – without this insight, feelings of compulsion may seem overwhelming and inexplicable.

A sense of helplessness was portrayed by each of the participants in their inability to lose weight and maintain a body weight they felt was appropriate for them. None of them suggested that they did not have knowledge of how to lose weight. On the contrary, they gave detailed accounts of a variety of weight-reduction diets, exercise plans and healthy changes that reflect the health education messages found in the resources. The reasons they gave for continuing to be overweight were different for each. These are presented in Table 3:

	Reasons for and consequences of overweight
Kara	Deep-seated and underlying unhappiness
Ann	Addiction; compulsive eating; eating leftovers
Sue	Sensitivity to additives; willpower; misery
Lizzie	Sweet tooth; grazing in the evening; eating leftovers
Jen	Legacy from overfeeding in childhood; eating snacks instead of regular meals

Table 3: Reasons for and consequences of overweight

Each participant talked about different measures they had taken to control their weight. Complex, shared issues also emerged from the analysis. These included repeated attempts to gain control, the effects of stigma and the fear of stigma, and influences from childhood. Strategies the participants have used to gain control and resist regulation are also notable in the data.

The steps taken included methods they used and had often used for many years, to try to reduce their weight. As Jen said, *'I can't think of a diet that I haven't really tried.'* They reduced food intake, changed the types of food they ate and increased their physical activity. Jen had attended Paul McKenna hypnosis seminars in addition to a 'Lighter-Life' counselling group. Ann visited a private clinic for appetite-suppressant tablets and four participants had attended private slimming groups. These measures may demonstrate steps to take control, or a desire for the social support that groups can offer. However, none

used primary health care provision for weight reduction or maintenance, despite in two cases practice nurses using health care consultations as opportunities to discuss weight. Sue said, '*... it's the asthma nurse that nags me ... eventually she got me.*'

The use of private slimming groups is now widespread and includes healthcare practitioner referrals of patients in the higher BMI groups (ie over 30) who can access 12 weeks free membership, funded by the health authority. This may reflect the policy of assigning responsibility to individuals for managing their own weight, by promoting private slimming groups whilst restricting weight loss consultations within primary care. The former Primary Care Practice Nurse interviewed (see chapter one) said that she had rarely seen patients present in her clinic solely for help with weight loss and that it would be difficult to fund such a service. Weight was generally addressed as a secondary issue. Health education resources reflected this. Only one resource, a poster titled 'Managing your Weight', addressed weight specifically. The other resources addressed weight as secondary to health problems such as heart disease.

This raises the issue of how useful and relevant the literature would be to people who were keen to lose weight. Health messages are mediated by political intent, public policy and local health service practices and can reinforce assumptions about positive and negative aspects of lifestyle and social practices. Health education literature may be complicit in the construction and reproduction of understandings of health which are informed less by the embodied experiences of people than by political expediency. In this case the message from the health education resources seen focused on disease and on solutions and preventive practices for which individuals have responsibility. This framing of health may not have relevance for women who may be responding to quite different pressures, for instance competing successfully in being slender and glamorous.

For the participants the diets and exercise regimes described began in the teenage years and have continued through adulthood. All participants tried to lose weight in their teenage years or early twenties and talked about methods they are currently using to do the same. There were further and in some cases

drastic attempts to lose weight in the intervening years as shown by the following excerpts:

'I wanted to kill everyone in my wake when I did Lighter-Life.' (Jen)

'I realised that I could never take another slimming tablet again, ever, because I could never ... have that, what I just had, but then I did go in to panic attacks ... that all stemmed from those slimming tablets.' (Ann)

'if I was on what I would call a diet ... I would be very regimented about it and I think that that's the tendency to control freakery ...' (Kara)

'cut down ... on everything really ... but the only reason I'm doing it really is because of my blood pressure' (Sue)

'It's usually when you can't get your clothes on, you think, oh God, let's cut out this and that.' (Lizzie)

Dieting as a means of losing weight and maintaining a desired weight has clearly not worked for these participants, reflecting the argument that dieting is ineffective as a means of long-term weight loss (Mann *et al*, 2007, Aphramor, 2010).

As Bordo suggests, the total control over food that many dieters expect to have ignores the biological processes that are activated by food deprivation and which render the diet itself 'a precarious, unstable self-defeating state for the body to be in' (Bordo, 2003 p59). These include the cravings, bingeing and food obsessions that the participants have described experiencing. For instance, Ann claimed to be obsessed with food, *'I feel I can relate to alcoholics, drug addicts ...'* as she would control her food intake strictly but *'... when I started eating I could just eat and eat and eat and eat and it's just something that I just couldn't stop myself doing.'* As Bordo warned, her body reacted to her dieting by craving food so urgently it became a compulsion. Lizzie described her low-fat, moderate eating plan, which denied her the food she wanted all day. However, she was angry with herself for *'stuff(ing) in bread and cheese'* whilst preparing the family dinner, as her body rebelled against the deprivation, activating food cravings that she could not resist.

Similarly I had followed an 'all or nothing' approach to weight loss and maintenance for most of my adult life, with either restrictive eating regimes used for weight loss, or a free lifestyle which did not restrict food. I called this latter

lifestyle a 'healthy' one. It was a step on my journey but during that time I remained as ignorant of my body's needs as I was during the years of disordered eating. I was unable to distinguish hunger from other physical and emotional needs, reflecting the body's 'self-defeating state' following persistent food deprivation (Bordo, 2003 p59) and an alienation of body from self.

Orbach's goal in therapy with women who eat compulsively is for them to hear and respond to the signals of their bodies rather than focusing on their body size. 'For a compulsive eater it is an ... astonishing idea that people who do not have difficulty with food rely on their stomachs to tell them what, how much and when to eat' (Orbach, 2006 p101). If dieting is such a problem for women that it leads to compulsive, disordered eating and the seeking of medication to control hunger, the recommendation of diets to address overweight may represent a health risk to women and thus has implications for health education strategies.

Interestingly the women did adhere to a health model in terms of the food they prepared for their families. Participants all talked about healthy eating or health education, particularly food for their families and food rules for their children, for instance restricting sweets and making healthier, lower-fat meals and desserts. Jen mentioned health education, in pointing out that it came too late for her generation, but that children should be taught about healthy eating. *'But nobody was talking about obesity then ... the lessons that they taught their children are bad. Now we're all talking about it ... it's skipped a couple of generations and it's too little, too late I'm afraid'*. Alternatively, Sue said *'It's all propaganda. If they want, if they really want to do something about it, analyze the food that the manufacturers are producing and do something about it. Take all these additives out, take the growth hormones ... why have a go at the individual and try and brainwash them into thinking why, you know, you're killing yourself.'*

When talking about their own eating the women described scenes that bore little relation to the controlling diets previously mentioned. Interestingly when describing their loss of control around food each participant used disparaging terms. These included *'stuffing in my gob,' 'cram it in my mouth,' 'stuff it in,'* and *'sit and scoff all day.'* Kara said, *'I'll just go and have that bun or, or that piece of cake or that half-packet of biscuits ... and then, oh I'll start again tomorrow.'*

It was also interesting that these discussions had little to do with enjoyment. Stuffing, cramming and scoffing seems to be a long way from taking pleasure in food. Klein (2010) explores Epicureanism, in which pleasure represents the highest value. He acknowledges the difficulty of moderation even for Epicureans who eat and drink for pleasure, stating 'Each of us would like to know how to draw the fine line between the moderation Epicurus practised and the intemperance he deplored' (Klein, 2010 p20). Furthermore, lack of moderation in food intake is not always visible in body size. As Lebesco has pointed out, reasons such as bulimia or high metabolism may prevent overeating from being visible on bodies (Lebesco, 2010).

Not all participants blamed weight problems on their own loss of control. The role of the food industry was also highlighted. Sue believes that she and one of her children may be sensitive to additives in food, and that they may make her susceptible to being overweight. She also suggested, as already noted, that the appropriate way of tackling the problem of overweight is to *'take all these additives out, take the growth hormones ...'* rather than giving health education messages. This is an interesting contradiction in that theories of weight gain using a medical/scientific model are resisted but the same model used to explain a weight-gain theory that does not blame the individual. This may be because of the stigma attached to being seen as overweight. Goffman notes that stigma has a negative effect on identity and his theory of spoiled identities outlines the role of society in this (Goffman, 1963). Sue's theory may be a form of resistance to obesity discourse that has the effect of stigmatising her and one of her daughters. Sue is a professional woman with responsibility for her family. However, she is still represented by her physical self. When confronted with evidence in the form of a newspaper report that as a large woman she is seen as irresponsible or an object of derision and her size is blamed on unconstrained appetite, it is unsurprising that she might mount a determined resistance to discourse that has the power to undermine her. This resistance to the dominant discourse may take different forms, depending on the characteristics of the woman herself and the way in which she perceives power. In Sue's case she had written to a newspaper to explain her theory about an alternative cause of obesity which does not blame the affected individual, after reading disparaging remarks about people being responsible for their own

weight. Sue has also appeared on a television show to talk further about her ideas. This is not unusual. Visual media is increasingly a source of health discussion and there are many reality television shows that focus on the issue of obesity (Lupton, 1999, Rich, 2011).

The data appears to demonstrate the women's feelings about being out of control and their need for strategies to address this. It may be that in a post-modern individualist society, in which people are expected to take responsibility for themselves, an overly directive and controlling medical model is being resisted and alternative strategies sought. As Bauman (2000) suggests, post-modern society is characterised by eroded belief-structures, such that people who no longer turn to authoritative sources for help, look instead for examples to see how others cope. People increasingly rely on reality shows to address their problems. Bauman referred to the compulsive viewing of TV chat-shows, illustrating people's need to see others like themselves, dealing with similar problems (Bauman, 2000, p61). He suggested that these shows legitimize public discourse about sensitive, difficult matters, rendering 'the unspeakable speakable, the shameful decent, and transform the ugly secret into a matter of pride,' as private issues enter the arena of public discussion (Bauman, 2000, p69). Such visual media can be a rich source of public health information (Visawanath *et al*, 2010, Debarr *et al*, 2009) or conversely a source of disinformation that causes distress to women who are unable to meet the requirements of the ideal body portrayed in cultural images (Bordo, 2003) particularly with the rise in reality television that portray deficient bodies (Skeggs and Wood, 2011). In these cases resistance to the discourse may be demonstrated.

Sue's story may or may not fall into Bauman's 'sensitive, difficult matters' category (Bauman, 2000, p61) but she demonstrates resistance as she takes her children into the public arena to face and address the dominant victim-blaming discourse. However, resistance and power may take many forms. Foucault's conceptualisation of power is that of a dispersed force, localised within everyday life and social interactions and exercised from many different points, rather than a force that is exterior or centrally located (Foucault, 1990). It is therefore within everyday life and exchanges that resistance can be mounted,

with points of confrontation numerous and unstable. For instance Kara, when explaining why she refused to attend a gym for exercise said '*... if anyone's going to control me it's going to be me, not anybody else, you know.*'

Conversely, Sue's attempt at resistance in theorising that food additives may be causing her overweight, whilst appearing to be assertive, relies on a medical/scientific model which places her as a victim and in a position of vulnerability.

It is tempting to hope that women will use resistance mechanisms to break free from oppressive cultural constraints. However, Bordo warns against 'romanticizing the degree of cultural challenge that is occurring, and thus diverting focus from continued patterns of exclusion, subordination, normalization' (Bordo, 2003 p295). She points to the disordered eating, compulsive exercising, and use of image-altering surgery of modern women to suggest that, even where cultural resistance is attempted, it is within a social context so is vulnerable to the prevailing cultural norms (Bordo, 2003). As Ellison (2007) points out, resistance can be shaped by cultural norms, not only against them. This may be why women participate in mutual surveillance and regulation through slimming clubs, and why 'perfection codes' within current health discourses determine positive and negative possibilities for aspects of the body and its behaviours, even authorising professionals to incorporate these knowledge categories into their professional practice (Evans *et al*, 2008). This can include teachers, health professionals and slimming club leaders, who may justify contemporary concern with an attractive appearance by reframing it as health.

The term 'health' is often used in the sense of a self-evident good but it could be argued that it has become defined by a discourse that reflects the interests of commerce, industry and government as much as, or even more than, the people whose health may be affected by their policies. Klein (2010) notes how much political repression and social control is exercised in the name of health. When I began this study I had intended to ask why women have so much difficulty in maintaining a healthy weight. I changed it to ask why women have so much difficulty in maintaining a weight they feel comfortable with, because in my initial reading it became apparent that health is an ideological position rather

than a fixed concept, and how contested and value-laden the term is. It can change to suit political ideology, economic circumstances and prevailing fashion, as shown in the literature review when it was noted that the already contentious measurement tool for weight – the BMI – was revised downwards, thus pathologising overnight those whose weight-range was previously considered to be in the normal range (Campos *et al*, 2005, Orbach, 2006). In addition, reports of pharmaceutical company funding and other financial benefits to the weight-loss industry and even to the WHO International Obesity Task Force challenge the concept of an objectively established healthy weight (Moynihan, 2006, Saguy & Riley, 2005).

Comfort, pleasure and pain

Whilst there was much to say about control and loss of control, it was notable that none of the participants in my study spoke or wrote about food as representative of pleasure or enjoyment in their lives, except in the context of childhood treats – past pleasure that could no longer be accessed in adulthood. The temptation of snack foods such as sweets, chocolates, cakes and biscuits appears to be rooted in childhood experience, with these used as comfort and reward – even, as one participant describes, as a reward for being brave at the dentist. Jen talked about her childhood home in which sweets, biscuits and cakes were plentiful and unrestricted. Even now, her mother advises her to reduce her weight because she is worried about her, yet will turn up with chocolate treats for her. Jen said, *'It's her way of saying I love you, really.'* She has maintained her eating patterns from childhood.

All the participants described their childhood and the food they ate as children, using vivid imagery to illustrate their points. A common factor was the effect of having parents who had experienced the war and post-war years of the 1940s and 1950s. Jen's mother loved to give her children the sweets and treats that she was unable to have during food rationing. Likewise two participants referred to parents who refused to allow any food wastage because of their own experiences of food shortage in the Second World War. Ann remembers sitting for several hours with a roast dinner when she was a child, unable to leave the table until she had finished her food. Sue remembered a meal of mince and potatoes dripping down the wall when she was a child, describing her father's

anger when she was unable to eat the meal he had worked so hard to provide. Her mother, tired of the argument, had thrown the plate across the room.

Sue also referred to her childhood when she speculated that her problem may be that she's *'never grown out of nursery food.'* There are similarities in my own experience, noted in reflections in my research journal – I reward myself with food in the same way that I was rewarded with treats as a child. I also comfort-eat with foods I enjoyed as a child. There may also be an element of this in Sue's identification of her problem. Participants may associate the sweet treats they enjoyed as children, with comfort and reward. Puhl & Schwartz (2003) found that adult eating patterns are influenced by memories of childhood food rules, with binge eating and dietary restraint significantly related to memories of parents using food to control childhood behaviour.

Bruner suggests that the 'psychic reality' of an individual may resist change as 'formal structures may get laid down early ... and persist stubbornly in spite of changed conditions' (Bruner, 1987 p.31). Jen recognised this when she compared herself to people who were not overweight as children. *'Somebody that has struggled with different mental attitudes as a child or has had food given to them as rewards or treats and it's been a big part of their family life, are more likely to have more mess to unscramble to get back to where they need to be.'*

Berlant argues that an important cause of obesity is the use of food as self-medication to help people deal with the exhaustion of everyday life, and that the process of eating provides 'an interruption of being good, conscious, and intentional that feels like a relief' (Berlant, 2010, p26). She points out that eating as a form of self-care can be a 'controllable, reliable pleasure' (p34) a response to feeling overwhelmed, but can also be part of membership of a community that offers comfort and personal belonging – a positive aspect of control. This could be relevant to the participants' memories of eating in childhood and family meals and to the stresses and difficulties they talked about when referring to their daily lives.

They could be, as Berlant (2010) points out, eating as a reprieve from the exhaustion of daily striving. Jen pointed out that her mother *'remembers rationing very, very clearly and things like sweets and that were a real treat and*

a special reward to her ... never had any kind of funds really ... that's why she bestowed great amounts, vast amounts ... She went on to talk about her own busy life, bringing up a family whilst running a business that requires her to begin work in the early hours and continue until she collects the children from school and prepares the family meal. Lizzie's family had little money and her mother had to work full-time in a job she disliked. However, *'she would come home every Saturday night with a bag full of bread and cakes and sweets – 'we all tucked in ... we loved all of that.'*

This reflects Berlant's point that, even where there is knowledge of an unhealthy diet food can be a stress-reliever, particularly in households which struggle financially. Within such cultures children may take on the stress that parents have and look for comfort in the same places (Berlant, 2010). In this sense eating can be ballast against the exhaustion of building and continually developing the life that individuals want. This does accord with the findings from Warin's research that mothers associate their large bodies with the positive, loving and nurturing aspects of their care-giving roles (Warin *et al* 2008). The mothering role is very likely to take priority over the desire for slenderness, showing the contradictions inherent in managing femininity and balancing care responsibilities with the requirement to be attractive. However, the rise of the 'yummy mummy' phenomenon suggests an increasing expectation that motherhood is no longer an escape from the body project and mothers are expected to work hard at being slender and glamorous as well as good mothers. The fertile, nurturing body of the mother may attract disapproval if it fails to subject itself to the disciplinary practices of diet and exercise.

It was interesting to note how little pleasure and enjoyment was present in the narratives about participants' adult lives. These seemed to show mostly unhappiness and negative emotions. When women deny themselves pleasure from food they may experience the reverse of pleasure – unhappiness and guilt. Four of the participants described mental health problems that they had experienced in the past. These included panic attacks, stress and depression. Ross (1994) interviewed 2020 adults aged 18-90 in the USA to find out whether the depression associated with overweight was caused by the overweight itself or with dieting to fit norms of appearance. She found that being overweight has no direct effect on depression in any social group except the well-educated.

However she found the combination of dieting and the effects of worse physical health to explain the negative effects of overweight on depression. More recently a meta-analysis confirmed a reciprocal link between depression and obesity. Obesity was found to increase the risk of depression, whilst depression was found to be predictive of developing obesity (Luppino *et al*, 2010).

All the participants talked about negative emotions and issues that they had experienced or continue to experience, in relation to their weight. These are shown in Table 4:

	Negative emotions and issues
Kara	Unhappiness, grief
Ann	Addiction, obsession
Sue	Misery, feeling like a victim
Lizzie	Cross, stressed
Jen	Stress, unhappiness, anxiety, depression

Table 4: Negative emotions and issues

Sue described her husband’s redundancy, which happened shortly after Sue’s father died and left her money. The family were unable to qualify for benefits because of the legacy – instead it was used for living expenses.’ Sue said *‘I’ve been in absolute misery and feeling like a victim for ... the last ten years.’* Although Sue did not mention clinical depression the depth of her negative feelings were clear – these may have linked to comfort-eating and increasing weight.

Kara’s overeating and weight gain *‘is an evidence of a deep-seated and underlying unhappiness that I need to tackle.’* She talked about Catholic guilt. For her, eating may give an immediate comfort but its longer-term effects are the reverse. Jen became ill. She gained weight and her boyfriend *‘moved into the spare bedroom because he couldn’t bear how fat I’d become.’* She then developed anxiety after having a baby. Lizzie talked about losing weight as a teenager, taking GCSEs when she was *‘very stressed, for various other things like my first boyfriend, falling in love and things like that ...’* and believing that friends were more attractive than her because they had boyfriends.

Participants also described using food to deal with negative emotions. Ann described her loneliness when she first left home, '*I did used to comfort-eat.*' Jen said '*... oh that was a bad day. Let's eat something nice.*' Lizzie described '*stuff(ing) in bread and cheese*' whilst tired and cross, preparing dinner after a day at work. In my reflective journal I wrote about the comfort foods I remember from my childhood and the links with my beloved grandmother and grandfather, particularly from the years when we lived in the same house. The insight that came from this writing was the realisation that, as a young student nurse I would compulsively eat the same comfort food at times when I had to deal with distressing issues.

Grief can be dealt with in different ways, mediated by cultural, social and familial factors. Kara, in her autobiographical writing, demonstrated the link between eating and extreme emotions when she wrote, '*I eat for comfort. I eat to appease my guilt. I eat to deal with my workload. I eat and eat and eat and wish to forget.*' Her choice of words reflects the experience of one of Shay's research participants. Kara overate, mourning the loss of her family and the death of her baby. The veteran speaking of the death of his comrade said, 'And I cried and I cried and I cried ... and I stopped crying. And I probably didn't cry again for twenty years. I turned. I had no feelings. I wanted to hurt. I wanted to hurt. And I wanted to hurt' (Shay, 1994 p96). Whilst as Shay noted, warriors from the Vietnam War responded to their trauma and grief in much the same way as warriors from the Trojan War in 1200BC, by 'berserking' (Shay, 1994 p77), other responses to grief may include mental or physical illness. Johnston points out that women 'eat to avoid letting ourselves feel, until our awareness of those feelings is pushed so far back that we lose touch with them,' and 'build dams to stop the natural flow'(Johnston, 1996, p54).

Eating for comfort may be one reason for disordered eating but the participants' narratives reflected theory in linking a range of emotions and desires with the notion of comfort. Orbach argues that compulsive eating is linked to a wish to be fat and that this desire must be addressed if the compulsive eater's relationship with food is to be addressed (Orbach, 2006). In her therapy practice she uses exercises which allow women to see a new and different meaning in

their fat – these include feeling comfortable by being protected, desexualised and not having to compete. Jen reflected this when she said, *'I don't have to be too good if I'm overweight,'* and *'I'm not expected to be an important businesswoman if I'm fat.'* Chernin writes about the first time she ate compulsively, at the age of seventeen, when she was living and studying abroad. She describes running through Berlin, 'from bakery to bakery, eating as I ran ... and then I am crying ...' (Chernin, 1981, p7). In her case the feeling she squashed down with food was her longing for a life of scholarship that was denied to the mother she loved and admired.

Embodiment and alienation

The term embodiment is used here to denote a way of being and knowing, recognising the link between bodies and minds, culture and society and, as Bendelow and Williams (1998) assert, the ambiguity of body and mind positioning across the nature/culture divide that resists biological reductionism. This acknowledges the specific constraints applying to the gendered body. As noted in the previous section, the experience of embodiment may not be pleasurable for women, despite the potential for enjoyment in the body's appearance when diet programmes are successful. Their focus may be more on strength of will and control of the body and its appetites. Women who resist the contradictory cultural demands of femininity may arouse negativity in others and experience alienation as a result. One mechanism used when others are found wanting is that of stigma. There were many examples of both stigma and fear of negative judgement in the participants' narratives. Puhl and Heuer (2010) point out that stigma and weight discrimination is pervasive and increasing. They describe it as a social justice and public health issue. In North America the prevalence has increased so much over the last decade that it is now noted as comparable to the prevalence of racial discrimination (Puhl *et al* 2008). Stigma is pervasive even amongst professionals whom one might expect to be non-judgemental. Participants reported experiencing stigma from a school-teacher, live-in partner, friends, colleagues and families. Jen experienced alienation through stigma from her father, from a partner and from members of an internet dating agency - she found that many men who were members had specific requirements about the women they were hoping to meet:

'It's shocking, it is disgusting. The number of blokes that are on there saying, oh, I am a laid-back person, I'm not interested in your looks, I'm only interested in your personality, so long as you're not bigger than a size 10. And they are very, very specific, these guys ... on these internet sites. You must not be bigger than a – I cannot find people bigger than this attractive, so, no offence but, if you're, if you're fat, don't bother contacting me. And they're very blatant about it and it's not one or two, it's the majority.' (Jen)

Ann wrote about her sensitivity to the negative judgements of others in her autobiographical narrative. *'Seeing people I have not seen for a while and really not wanting to go, for even though they wouldn't be rude enough to say outright, I know they would be thinking, "Goodness, she's put on weight."* She was anxious about going to restaurants. *'I would worry that the seats were big enough.'* She was also upset by a comment made by a member of staff she was working with. *'He said to me, "You're not fat," I remember the feeling of relief and the thought "Goodness, he doesn't think I am fat" and then he said, "You are just big boned." I thought over that comment so many times, for months and months afterwards.'*

Kara felt she was undermined by her future mother-in-law from the time she first met the man who would become her husband. Kara felt that her mother-in-law criticised her indirectly through the comments she made about others, and this triggered the beginning of a problem with food. Kara also remembered a comment made by a stranger when she attended a slimming club in London. *'She said, oh, she said, you have got a really African shape, haven't you? ... I think she meant my big bottom ...'* In her autobiographical narrative she wrote, *'I no longer understand my body.'* Ten years ago she was *'a size 12, weighing between 60 and 62 kilos.'* Now, ten years later, there is concern about her appearance *'I am a size 16/18 weighing 85 kilos'* and *'a no-commitments relationship with my lover who makes jokes about my size.'* She also writes, *'I catch glimpses of myself in shop windows and think, oh my heavens, is that really me? I am so big!'*

Sue did not mention stigma directly in her interview, but wrote an autobiographical account of her experience of competing in a swimming race as a child.

'I was going to come last. I was a hefty girl; the initial dive would probably finish me off ... I was going to be humiliated, the laughing stock of the afternoon.' (Sue)

Even the former Practice Nurse I interviewed referred to a game she and her friends would play in which they silently allocated points to overweight people they see, with higher points reflecting higher degrees of overweight. Later, the friend claiming the most points would have coffee bought for them. It is perhaps surprising that a health professional (albeit a retired one) would feel comfortable to discuss this. However it could equally demonstrate 'the big story' in terms of how acceptable it is within UK culture to stigmatise overweight people, and sets a societal context in which the fears, concerns and experiences of women can be viewed even more clearly. In this context it can be seen that large women may be sensitive to negative judgements of others, particularly when they have experienced this from people close to them, so that stigma is often anticipated and feared. Goffman notes that stigma has a negative effect on identity and his theory of spoiled identities outlines the role of society in this (Goffman, 1963).

Schwartz *et al* (2003) reported weight bias of health professionals, even those specialising in obesity. Others have found implicit anti-fat bias in health professionals who specialise in obesity treatment (Teachman & Brownell, 2001). In general, stigma is commonly reported by people who are overweight and obese (Puhl and Latner, 2007, Brochu & Morrison, 2007) and is found in media reporting of obesity (Evans *et al* 2008). Stunkard *et al* (1998) even found evidence of weight-related stigma from medieval times.

Gard and Wright (2005) argue that social expectations of women are responsible for the negative reactions that fat women arouse in others. Women are expected to be meek and small, that is, slender (Chernin, 1985). Their physicality is restrained. When they are big and powerful they may be challenging men. Bordo points out that evidence in the form of a big woman's appearance shows that she has given in to desire and thus broken the rules. This irritates others, particularly when those others have been trying hard to deny themselves so that they can follow the rules and fit in. Their response is to stigmatise and try to humiliate big women (Bordo, 1993). Combining health and

beauty discourses provides a powerful, inflexible system of control – if women resist it they may pay a high price in alienation and stigmatisation.

However, the consequences of stigma may be the opposite of that intended. It has been reported that discrimination against overweight people is commonly thought to be helpful in providing a stimulus for individuals to lose weight. However, the converse may be true, with an iatrogenic effect of stigma reported (Guttman & Salmon, 2004, Puhl & Heuer, 2010) and morbidity and mortality increased by stigmatisation (Bayer, 2008).

People who are stigmatised may focus on the perceived deficiencies of others in an attempt to divert attention away from themselves. Some of the participants positioned themselves favourably, stressing that others are far worse. For instance Lizzie said that she and her sister were '*... not fat like some of the things you see around now.*' Ann talked about the woman in the bakery eating four cakes '*in an obsessive way*', and (from field notes), Sue left her interview, twirled around and told me that she's 'tall and a big girl, but not like some of those women you see ... wobbling everywhere and huge'. This may have been a defence mechanism – if they have to join in the game, at least they can position themselves powerfully in relation to others. However it could also represent stigma as so pervasive that victims can readily become perpetrators. Orbach (2006) notes the pressure on women to rank themselves in order to compete with others, describing the competition as 'extremely fierce and painful' (Orbach, 2006 p86) and so much an accepted part of culture that it is even institutionalised in the form of beauty contests. This is echoed by Jen as previously noted, who talked about competitive auditions with other girls at stage school and how much success depended on appearance and slenderness. She referred to herself as competitive and said '*... so long as I'm fat and overweight people don't expect too much of me ...*' This suggests overweight as a reprieve from striving to compete. It announces to others that the overweight woman is removed from the competition, the rules and the judgemental gaze of others.

Relationships with other women described in the data are complex. Kara described her experience of visiting a school friend who was anorexic, '*on death's door,*' and currently remains very thin. Despite the poor health that her

friend continues to suffer as a result of the anorexia, Kara noted that *'Even seeing her go through that, you still don't stop worrying about your weight.'*

It is notable that the participants and I referred to dress sizes rather than kilos or pounds when talking about our overweight, even whilst we idealised the aim of health rather than slenderness. This suggests that appearance is more important than we are willing to admit. Lizzie said, *'I've got to a point where I thought I want to be fit and active, and then followed it with, 'I don't look too bad. I would not go up another dress size ... I'm not prepared to go up to an 18. I wouldn't contemplate it so that will shock me enough.'* If the priority is appearance, the focus on health will not seem relevant to these women and health education strategies will need to take account of this. In addition, the lay woman's view of health may be quite different from that of the health professional. The relationship between women's embodied experience and its link to their nurturing role and responsibilities towards their families was shown in the work of Warin *et al* (2008). In a study of mothers who recorded BMIs in the obese clinical category, she found that none of her participants identified themselves as obese and were horrified to find that they were in this category. She concluded that the relational identities of the women – their constructed identities, particularly in their role as mothers, worked against the promotion of individual behaviour changes to address their obesity.

Health alters according to the value judgements and even political stance of the observer. For instance, within the current neo-liberal political climate health is seen increasingly as an issue of personal responsibility, with senior politicians stating unequivocally in the forewords of public health policy papers that individuals are responsible for their weight control and their food and drink intake (DoH, 2008, DoH, 2011) as discussed in chapter two.

The concept of health is also used repressively when it is substituted for terms such as 'beautiful' or 'glamorous', which can be seen in magazines and other popular literature, particularly those which have 'health' in their titles. MetzI and Kirkland (2010) point out that reframing sexist or cultural narcissism as health enables these views to be presented unchallenged. 'The fat, the flaccid, the forlorn are unhealthy, the logic goes, not because of illness or disease, but because they refuse to wear, fetishize, or aspire to the glossy trappings of the

health of others' (Metzl and Kirkland, 2010, p3). Health and beauty discourses become a formidable controlling force when combined.

Pressures on women to conform to approved patterns of behaviour and physical appearance, and the body disciplines required to achieve these, may be considerable. Lizzie said that as a teenager she disliked the shape of her stomach, comparing it unfavourably with that of Twiggy. Her concern upon discovering her body to be that of an adult woman rather than the 1960s fashion of the body shape associated with a slender, boyish model reflects the importance of physical appearance to young women, whose bodies represent the social capital they need to ensure social acceptance (Frost, 2005). This is common in studies with women. When the body does not meet the fashion, the solution is that of diet and exercise. As Bartky states:

'Dieting disciplines the body's hungers; appetite must be monitored at all times and governed by an iron will. Since the innocent need of the organism for food will not be denied, the body becomes one's enemy, an alien being intent on thwarting the disciplinary project' (Bartky, 1990 p66).

When the body becomes the enemy, individuals may go to extraordinary and damaging lengths to subdue its desires, thus alienating themselves even further from their bodies.

Bordo (2003) and Orbach (2006) have both identified conditions such as anorexia nervosa as the extreme of a continuum on which all women are potentially located when they are unwilling or unable to meet the requirements of femininity, depending on their level of vulnerability to society's construction of femininity. If this is the case then disturbances of body image and disordered relations to food may not be pathological conditions but they can reflect the distress caused by cultural demands such as the contradictory expectations of women. These can include the requirement to have a slender, glamorous body whilst fulfilling a traditional female role. This was expressed by participants, who spoke about the difficulty of denying themselves food whilst trying to feed a family. Lizzie said '*I wouldn't be overweight if I wasn't in charge of the kitchen*'. In many ways, things are not as they seem and women who for many years discharge their gendered family duties admirably may suddenly or gradually

become aware of the limitations, challenges and injustice of their roles - 'social reality is revealed as *deceptive*' (Bartky, 1990 p17).

Cultural pressures include the requirement to 'fit in' with social groups, to compete successfully with other women, and to manage a maternal nurturing role, whilst maintaining a slender, attractive appearance – some women will resist this. The potential for resistance and its effectiveness will vary hugely amongst individuals, depending upon factors such as age, ethnicity, social class and sexuality. Failure to comply – that is, to manage femininity in the ways approved by others, may alienate women. The 'rewards of compliance' (Bartky, 1988) include a secure sense of identity which may be hard to relinquish. Rather, women are aware that the media images reflecting the prevailing view of feminine perfection are valued by people important to them, for instance, employers, friends and lovers (Bordo, 2003). Compliance may therefore secure the identity that is valued.

This is not a new issue. Chernin (1985) cites Betty Friedan who in 1963 wrote of the problem with no name, when she explored the issue of women's lack of identity, their feelings of emptiness because of their stunted personal development and growth – a situation perpetuated by what she called 'the feminine mystique'. Chernin notes that since then younger women have written in positive terms about their own generation's access to universities and institutions that were denied to the generation of women before them. However, she warns that even whilst Naomi Wolf described her experiences at university, working on scholarly tasks related to the writing of women's history there were contemporaries on the same campus with eating disorders, 'involving themselves in behaviour that threatens their social adjustment, their most intimate relationships, their struggle for self-development, and in a significant number of cases even their lives' (Chernin, 1985 p30).

Conclusion

This chapter revealed patterns and threads identifying common concerns and experiences within three overarching themes, which would not have been elicited from the individual stories alone. Issues of control were apparent - women resisted controlling medical/scientific models, adopting strategies and behaviours that allowed them to take control of their own lives. However in

some cases they used the same models to explain their lack of responsibility for their overweight.

The importance of childhood experiences and memories was related to comfort, although the narratives largely featured pain which was worsened by stigmatisation. The women's experience of femininity was that being overweight 'broke the rules' and equated with being unattractive, although at times they used the same rules to position themselves favourably compared to others. Alienation was the price they paid for ignoring the rules of femininity. The struggle to manage appropriate femininity was shown across the narratives but was particularly evident from the thematic analysis.

Next, relational analysis of the narratives turns from the relationship of the narrative accounts to societal issues, and focuses on the smaller story. It highlights the performance of the narratives and the relationship of the narrators to the interviewer, to themselves and to other characters within their narratives.

Chapter Six

Relational Analysis

In this chapter the findings are presented from the analytic lens of relational analysis which shows performance reflexivity and identity claims. This lens enables an examination of the way each participant positioned herself; in relation to me and in relation to others within the narrative. This also required me to examine my own positioning in order to clarify my interpretations. This section complements the thematic analysis of content by looking more closely at the ways in which each participant told her story; the performance and representation between the experience itself and the narrative (Bamberg, 1997). Such analysis includes the way in which language is employed, and an examination of identity claims.

‘Interpretation requires close analysis of how narrators position audiences (and, reciprocally, how the audience positions the narrator). Identities are constituted through such performative actions’ (Riessman, 2001).

The relational analysis with each participant will be presented; using the analytic questions described in the methodology chapter, and will be summed up at the end of the section.

Relational analysis Jen

In what kind of story does the narrator place themselves?

Jen constructs a narrative which shows her as someone who narrowly missed success. In her story she is a trained performer who missed what she defined as success in that sphere, because ‘*I wasn’t the skinny stick-insect a lot of them were. Or the fact that I thought I was overweight although perhaps in hindsight I wasn’t. It would have stopped me going to certain auditions, I wouldn’t have bothered trying out for certain parts because of that – I think.*’ Although now a successful businesswoman, she said ‘*I’m not expected to be an important businesswoman if I’m fat ... I don’t have to be too good if I’m overweight, and I suspect ... there may be a little element of that in there,*’ despite describing herself as ‘*quite a competitive person*’.

How do they position themselves in relation to the audience?

Jen was witty and amusing. She also remarked on something I had told her before the interview, that I had lost weight through attending Slimming World. She noted that it was easier for people like me to lose weight because I was not overweight as a child. In this Jen has positioned herself as someone who cannot help being overweight. Additionally she has developed a theory which supports this by asserting that people whose weight problem appeared for the first time in adulthood can lose weight easily, unlike herself.

How does the audience position themselves in relation to the narrator?

I was entertained by Jen, who was amusing and used dramatic effect in telling her story. I was interested that she had trained and worked with people who are now celebrities. I felt slightly guilty about having reached a target weight, when Jen told me she thought she was unable to do the same because she was overweight in childhood.

How does the narrator position other characters in relation to themselves?

Jen positioned her mother as a person who was determined to give her children the sweets and treats that she herself was unable to have in her wartime childhood. She gave several examples of her mother's tendency to overfeed her family, pointing out that her mother, in common with many ladies after the menopause, *'get a bit tubby ... I think that's a totally different issue to, to seeing a girl of 18, 19 walking down the road, absolutely enormous.'* Jen's father was positioned as someone who made critical comments. She said *'my dad used to refer to me as his "barrelina", because of the way I looked in a, in a leotard.'* She described an incident which upset her teenage daughter. *'... somebody's patted her on the tummy and gone "oh, getting a bit podgy there" ... that was my father did that.'* Using direct reported speech of her father gives credibility (Riessman, 2008) and is perhaps used by Jen to emphasise and convince me of her father's upsetting comments.

She also described other girls in her youth as competitors, as she went to a stage school and students competed with peers at auditions. Jen saw herself as someone who always came second. She referred to herself in the third person when describing how others were a threat to her younger self. For instance, the

dance teacher's cane which she would *'whip past your ear'*, and at school *'you were told you had to get in the salad queue it's because they considered you too fat.'*

How does the narrator perform her story (identity creation)?

Jen's identity claims are linked strongly with her family. Her mother, father and siblings are described at the beginning of her narrative, and appear again at different points throughout. Her mother, who is now eighty, still works in Jen's business. Jen saw herself as overweight from an early age and casts her mother as active agent in this. *'Always cakes, biscuits, sweets in the house.'* Jen described her child self as *'...this monstrous thing in this blue leotard ...'* However, she went to a residential stage school at the age of ten, and described how her life at school, up to the age of nineteen, confirmed her belief that her body was not good enough.

When describing those teenage years, Jen talked about the competition *'... there were always ... the girls that got the boys ...'* and about her lack of insight into the way she looked at that time, *'So um looking back at the photographs I think, God I wish, I wish I looked like that and knew that I was okay then.'* During her narrative, Jen used the personal pronoun, 'I' when describing the photographs that showed her how good she looked at that time and again referred to herself in the third person when explaining *'there were always girls who looked better in their leotard than you did.'* This positioned her as not alone in her feeling that other girls may have looked better. She introduced the subject of diets as a passive recipient. *'And then the diets really, then they started, proper,'* changing to agentive to show how she rose to the challenge. *'Cabbage soup, that was memorable. I done Lighter Life. I wanted to kill everybody in my wake when I was doing Lighter Life ... Atkins worked very well for me.'*

Relational analysis Lizzie

In what kind of story does the narrator place themselves?

Lizzie's story is one of rags to riches and respectability. She stressed how poor her family were, with her mother forced by circumstances to take a job beneath her abilities. Lizzie grew up in the 1960s, sharing a flat with girlfriends, trying fad diets and trying to emulate the body shape of Twiggy. *'Um, I always thought my*

stomach was huge ... I always wanted it to be flat 'cause Twiggy arrived when I was about sixteen, seventeen ...'

She constructed a positive moral identity, using the concept of health to do this. She talked about when she married and became very interested in nutrition, feeling responsibility for *'the life and diet'* of her husband and herself, researching, providing and cooking healthy food for her family, even whilst she was working. She had children, then a freelance writing job and was a busy working mother. She is now retired, with adult children who have left home.

How do they position themselves in relation to the audience?

Lizzie narrated her story confidently and coherently from childhood to the present day. This interview was conducted in Lizzie's house, at her request. She hosted a delicious, attractively arranged lunch and used references to the food as an example of the healthy foods she and her husband ate, perhaps setting up an entitlement to talk about and demonstrate knowledge of a healthy diet and lifestyle.

Lizzie told me about a son who was a bit chubby for a while but soon lost the weight when he started exercising. Much later, after looking at the story I wrote from her transcript, she told me that the son who was overweight had developed an eating disorder, which resolved after he went to university. Sharing sensitive information about children is difficult. However there may also be times when participants 'wield silence,' using it for their own purposes (Bell, 2006). This could be because some issues are too painful to discuss, or because they destabilise an identity that has been developed.

How does the audience position themselves in relation to the narrator?

I felt like a member of an audience, watching an actor play a pre-rehearsed part within a production, perhaps because I was a guest in Lizzie's house. As Goffman stated, '... we spend more of our time not engaged in giving information but in giving shows.' (Goffman, 1974 pp.508-509) People perform narratives. I was interested to note how different it felt to interview someone in their own home and how it helped to equalise the power relationship between the interviewer and the interviewee.

How does the narrator position other characters in relation to themselves?

Lizzie talked about her mother, who worked hard, in a job beneath her abilities, and who brought home on a Saturday night *'a bag full of bread and cakes and a bag full of sweets and we all tucked in.'* Lizzie noted that, after all the Saturday night sweets she had as a child, *'... I can see why poor old mum was doing that because, uh, she wasn't there all Saturday.'* She also mentioned her sister. *'I have an older sister who has weight problems...'* *'She eats chips, pies and rubbish and is diabetic (laughs)'* *'So we're not very similar, really, no.'*

In terms of comparisons with others, Lizzie is not unhappy with the way she looks, *'Catch sight of myself in a mirror, you know, in a shop window and there's some woman coming up looking dreadful, who's probably my age, I think oh, not bad for an oldie, so I don't have those kind of hang-ups.'*

Some characters are framed negatively in order to demonstrate Lizzie's points of view in the narrative. For instance, Lizzie's sister, described above; her niece, who doesn't control portion sizes and who gave up smoking, only to start again four months later as she had gained a little weight. Also, unnamed friends and acquaintances who diet, *'I'd hate to be a diet bore, actually, a real obsessive. I mean, you do meet those. They're really good...'*

How does the narrator perform her story (identity creation)?

In Lizzie's performance she has little responsibility for her overweight, pointing out that she had remained the same weight since 1994 so she had *'got maintenance off ...'* but had never *'... got it down to a level I should be maintaining.'* She compared the food of her childhood *'convenience food, probably of the worst kind ... good food cost too much I think'* with the healthy food she and her family eat now. *'I make crumbles but we have a sprinkle on the top – a dusting of the crumble.'* She talked about her developing interest in food and nutrition, taking the role of food-provider seriously when she married. Lizzie performed the role of a sensible, moderate person who is well-informed about nutrition and makes healthy lifestyle choices for herself and her family. She gave many examples of this, in terms of exercising, *'I do quite a lot of exercise compared to some of my friends ...'* and eating healthily. *'I believe in*

home cooking.' She also referred to the food she served for lunch as an example of the healthy recipes she used when preparing family meals.

There are times within the narrative when she slips from this role and talks about overeating. Anger features in these accounts, with the word 'cross' used in each.

'Some days I got in and I was so kind of cross at the thought that I'd done a day's work and I had to come home and do another one that I would cut, almost deliberately, a big chunk of bread and cheese, stuff that in, while I'm preparing it. It's like, almost like, this is my reward. But it wasn't a reward because it didn't make me feel better.'

'I am very hungry and very tired and very cross because I'd like it to appear like magic and I've got to cook it'

'my – little treat if you like is um, is grazing in the evening and it, it's never after supper. Sometimes I sit there at supper and I think, I don't really want this and I think, my God, how much must I have eaten ... and then I get cross'.

Relational analysis Kara

In what kind of story does the narrator place themselves?

Kara's narrative had rhetorical force as a story of tragedy. She married young, had her confidence destroyed by a malicious mother-in-law, was betrayed by her husband, lost a baby through stillbirth, and a subsequent pregnancy through miscarriage. She finally left her family for a lover, who has since revealed himself as often unkind and not a good provider. She feels guilt for leaving her family, has gained a lot of weight and eats for comfort.

How do they position themselves in relation to the audience?

Kara provided what started as a coherent, temporally ordered story, beginning with brief details of her mother and father, her birth, childhood and education, expanding her account as she reached details of her early career, marriage, children and husband's infidelity. She then exclaimed that she had forgotten to tell me something, skipping back several years then returned to her former narrative, talked about an identity crisis she experienced after the birth of her

next baby, never being good enough for her mother-in-law, and getting '*a bit strange*' about her weight. It was then she told me about the stillbirth of her baby, followed by the miscarriage of a subsequent pregnancy, how she left her family – something she now regrets. Narrators have agentic choice in how they construct their story. One choice is to step outside of the flow of events (Bamberg, 1997). Kara may have used this to delay talking about the painful issues of the loss of her baby and the infidelity in her marriage.

How does the audience position themselves in relation to the narrator?

I felt sad for Kara, particularly in relation to the tragic loss of her baby and subsequent pregnancy, and the ways in which her life had become so challenging. I could empathise with the way she dealt with distress (by overeating). I wondered why she felt such guilt for her actions when it was her husband who had an affair after the third baby was born. She said, '*I turned my back on my marriage and my family*' but described what her husband did as a '*fling*'. I felt that Kara was perpetuating a double-standard of behaviour in which women are punished for failing to conform to the dominant patriarchal culture.

How does the narrator position other characters in relation to themselves?

Kara's mother was vividly portrayed as a very beautiful and slim woman although that is a mother she never knew as, in Kara's lifetime, her mother was '*very large*' and Kara was afraid of developing the same health problems that she saw as weight-related. Kara's father is a key social actor, positioned as the first tragedy of her life. He '*desperately wanted a son*' and instead had three daughters. '*None of us ever managed to be a boy*' and '*Boy, have we tried to be boys ... so I think that goes very deep into our psyche of failure.*' The focus on Kara's early life may be a form of accounting for what happened later.

She remembers comparing herself with other girls at adolescence, then, years later, experiencing the criticism and '*snide comments*' of her mother-in-law with regard to her weight and fashion choices. She also presented the story of a childhood friend who was anorexic and was left with '*a legacy of bad health problems.*' However, Kara noted that '*even seeing her go through that, you don't stop worrying about your weight.*' This friend featured in the first of two distressing incidents that Kara omitted from an otherwise temporally ordered

narrative, and returned to later, suggesting the experience and health problems of the friend may have significance for the way in which Kara sees herself.

Kara said she had discovered her husband was having an affair and that before then her weight had *'really, really gone up'* after having a baby. Kara met her current partner and her marriage ended. She said she had *'fictionalised an escape in my head and it, you know, doesn't match up to the reality ...'* as she described the disappointing aspects of her current partner and their relationship.

How does the narrator perform her story (identity creation)?

Kara's identity claim is that of a victim in much of this story. From being born as a daughter when her father desperately wanted a son; to being a reviled daughter-in-law, a betrayed wife and bereaved mother. The moral or cautionary tale which is an important function of narrative (Gibbs, 2007) features here. By the end of Kara's story she has left her family for a lover and found, *'all that glitters is not gold ... he's not always a kind person.'* She describes feeling guilty, is unhappy in her job, she is overweight, *'It's not the body I used to have,'* and she is afraid of weight-related heart problems (which her mother has). However, there is a positive conclusion. At the end of her story, Kara briefly outlines positive aspects of her life and family and tells me that a *'good future'* is within reach. This suggests redemption and hope.

Relational analysis Sue

In what kind of story does the narrator place themselves?

Sue is from a family who had little money. Her father worked in three jobs to provide for them and to buy the *'two-up, two-down terraced house with a tin bath and outside loo ... there were weeks when mum's purse was absolutely empty days before the housekeeping money appeared.'* Traditional values were stressed. *'My parents, both born in 1933, had grown from five-year-olds to teenagers during the war years and knew the paucity of the war-time diet. They provided the best they could during the limitations at the time.'*

She described many reasons for her overweight, including her build, her genes, and reacting to additives in food; she likes to eat all the wrong things but is no longer *'able to get away with it'* as she cannot exercise now because of a bad

back. Low willpower, together with *'peculiar eating habits ... many diets encompass foods I won't eat'* and *'misery'* were also presented as reasons for overweight. Sue also positions herself as someone with an interest in genetics and the science of nutrition, who is irritated by the UK authorities allowing additives in food. She believes that these additives have the effect of causing a small percentage of the population (who are sensitive to them) to become overweight. In this Sue has created a story that resists the master cultural narrative which blames overweight people for their lack of self-control.

How do they position themselves in relation to the audience?

Sue organised her narrative around the reasons why she felt she was overweight. She was interested in my research, looked at some of the materials I had collected and used comments from them to lead a discussion of causes of obesity. Sue was animated as she talked about her theories. She told me that she had appeared on a national television programme to talk about this. She thus constructs her identity as knowledgeable and free-thinking, which has the effect of grounding her powerlessness in a position of authority.

How does the audience position themselves in relation to the narrator?

I interviewed Sue in my house, at her request, and provided lunch as I knew she was coming to me from another appointment and wouldn't have had time to eat. Initially I wasn't sure whether Sue really believed in the theories she was talking about but it soon became clear that she did, even to the point that she had written to a national newspaper about them. She brought the press cutting to show me. I was interested in her ideas and keen to develop an understanding of how she would like to be understood.

How does the narrator position other characters in relation to themselves?

Sue talked about other women of her family. *'... there's large women on both sides.'* She spent some time showing me photographs of her children when they were younger, to demonstrate their difference in size. She believes that they had broadly similar food intake and exercise patterns, yet one child was fourteen stone in weight – *'always had my shape,'* whereas the other, *'has always had my mother's shape, thin and wiry, like her father.'*

How does the narrator perform her story (identity creation)?

Sue began her narrative by establishing an entitlement to speak authoritatively about reasons for the weight she is not happy with. She does this initially by talking about the big women in her family. She positions herself as helpless in the face of the powers that shape her. One of the powers is nature – the *'large women on both sides'*, her *'size sixteen'* frame, and *'but I do think, I do think, as I say, it's a genetic thing. Part of it is the genes you were given predisposes you to a certain shape.'*

Another power is contained within the food itself. *'... I do believe there are certain things in, in food and drink, modern food and drink ... that maybe some people react to and others don't. Um I mean you you, there's there's so much in everything now, any processed food is, you know, has got all sorts of stuff in it ... You don't even know what's in the water.'* Sue's concern extends to a theory of the effects additives may have on the weight of some people. *'You know, there's so much, so much artificial stuff in what we consume. If just one per cent of the population reacts to something it's not going to be obvious until somebody actually studies it. You know, it's not going to be an obvious, um. A one per cent spread across a whole population, you know, oh she's fat, she isn't, they're eating the same thing. It's like my girls ...'* Sue went on to talk about her children and her belief that one was thin and the other much bigger, despite similar food intake and exercise patterns.

Finally, another power was revealed as 'misery'. As the interview was coming to an end I asked if there was anything Sue would like to add. She said, *'Well only I suppose that state of mind has an effect as well'*. I replied *'Oh.'* She then continued, *'I've been in absolute misery and feeling like a victim for – the last ten years. Worrying about what I'm stuffing in my gob and what effect it's gonna have ten years down the line is one of the last things on my mind, you know?'* She went on to talk about her husband's redundancy, financial issues and a painful back problem and that her *'expectations get less and less every year'*. In her story Sue is now positioned as a survivor who is making the best of things in the face of health and financial difficulties.

Relational analysis Ann

In what kind of story does the narrator place themselves?

Ann's story is from the narrative genre of redemption - one of overcoming early challenges, in which personal growth comes from hardship and loss (McAdams, 2006) and salvation through a mentor, who turned her life around and ensured she had a better future. Her childhood was marred by the divorce of her parents and her mother's subsequent change of lifestyle. She talked about her good fortune in having been offered a management post in London by a senior colleague. Without this, she feels she *'could have been stuck (in her home town) with, you know, three or four kids – being a chav.'* McAdams (2006) notes that lucky encounters with mentors who influenced them are often a key feature of life history and part of what is referred to as the narrator's personal myth.

How do they position themselves in relation to the audience?

Ann and I have a prior relationship so this was very much an 'acquaintance interview'. Whilst I had expected that this would help her to be relaxed and chatty during the interview, Ann did initially surprise me with the formality of her approach. She established issues of confidentiality prior to the interview. Ann's story, from childhood to the present day, was narrated fairly coherently although it was not temporally ordered throughout. She also revealed things that she had never told me before.

How does the audience position themselves in relation to the narrator?

As someone who knew Ann well I had not expected to be surprised by so much of her story. However, there was much of it that I did not recognise, even when she spoke of events that occurred when we were much younger. If I had spoken about the same events from my own memories, an audience of people who didn't know us would not guess that we had shared those events. This was a powerful reminder that in narrative research truths are multiple, stories are performed by narrators to define who they are and that people become the autobiographical narratives that they tell (Bruner, 1987). Despite this I empathised with many aspects of Ann's narrative. I identify the redemptive elements in my own narrative; I have mentors who provided turning points in my life, and I recognise from my own story the obsessive, disordered eating that

Ann talks about. Orbach (1993) writes of compulsive eating, anorexia and bulimia as metaphors of our age and a continuing obsession with the body as the price we pay for being permitted to have a role outside the home. For Ann and me, our problems with disordered eating began when we left home.

How does the narrator position other characters in relation to themselves?

Ann identified people she recognises as sharing her problem of food obsession. She spoke about a woman she saw eating cakes in a bakery during a time she used to go to work close by. '... *She was quite, very thin and I knew as soon as she finished eating them she was going to go and make herself throw up because she was eating them in an obsessive way, and I recognised what she was doing.*' She also talked about her niece and a friend's son who she believes are '*obsessed with food and I recognise their obsession because I recognise traits in myself*'. Ann also expresses concern about how others see her, despite her compulsion to over-eat as the following excerpt from her interview transcript shows:

A: You know, and it's like when I go to a buffet. I've got to be stood right next to the buffet and I'm never the first up there because I try and, you know, I don't want people thinking oh she's fat, she's going to be first up there. I try and be second or third and look sort of casually and eat as I'm going along so when I come off the end my plate doesn't look as – too full. You know, and help-yourself places.

I: I'm like that too

A: I know, I know. And I might, that's where I admire Tom (Ann's husband) because Tom will just go up and take what's left. I just think, 'God, I wish I could do that.

How does the narrator perform her story (identity creation)?

Ann has positioned herself as helpless in the face of an obsession with eating. '*I feel I can relate to alcoholics, drug addicts ... whilst I would never claim that food is as bad as drugs or alcohol, the feeling of a need to stuff my face, is as great as their addiction is to them.*' Whilst thinking about when her compulsive eating got worse, Ann said, '*When did it get worse? I don't know, and you go,*

you go through the things that you go through as a young adult, you know. Will I ever meet a partner? Will I – oh, my goodness, having children must be horrendous, and having this thing about childbirth, and what happens if I never get married, and if I'm on my own all my life, and almost feeling that some part of you is not quite right.' These memories were set within a time of transition in which Ann was socially isolated and living away from home as a young adult in her first management post - the time in which she identified her eating problem as beginning.

Summary

This chapter has examined the ways in which participants positioned themselves in relation to others and created identities, through performing desirable selves in their narratives. Relational analysis has highlighted how desired identities can be situated in interaction and performed to an audience, not only in the ways participants position themselves but also in the refining of performance in narrative. In this performance other characters may be placed to add a particular emphasis, as Lizzie did when she claimed identity as a healthy person with an interest in nutrition, pointing out that she had a responsibility for her family's diet. Other characters may be used to add weight to a theory as Ann did when claiming to be obsessed with food and adding that she recognised other people, including a relative, with her problem as they shared common traits. Participants may also construct a positive identity in relation to others, establishing their claim by positioning others in opposition as Lizzie did when talking about acquaintances that were 'diet bores'. Sue used a scientific model to construct a theory of obesity for which external forces were responsible.

The relational analysis challenged me to focus on my own role as 'audience', looking at the extent to which I influenced the participants' performances. Stories are part of interpretive communities which require actors – both speakers and listeners – to be sensitive to the culture and politics of the setting (Squire, 2008). I was alert to the enactment of the preferred self – the 'who ... when and why' of the production of narrative (Riessman, 2008 p105) just as much as the words themselves. Identities are situated and enacted in social interaction and Goffman (1963) shows the ways in which social actors perform

their desired self to save face in difficult situations, thus managing spoiled identities. For instance, in Sue's interview she performed a physical act – turning around on her toes – prior to asking me to corroborate that, although a 'big girl' she was not 'like some of those women you see ... wobbling everywhere and huge.' As researcher I was being asked to affirm the identity that Sue had created for herself – as a big but not huge woman. This is a role that could only be played by an interactive audience.

Jen asked me about the weight I had lost through the slimming club I had attended. She also asked me directly whether I had been overweight as a child. I replied that I had not been overweight until beginning nursing training. She then explained her theory that people like herself, who were overweight as children, found it much harder to lose weight and maintain weight loss as adults, than did people who were average-sized children. Our interaction was thus used by Jen to validate a theory that minimised her own responsibility for her overweight.

Performance was even more evident in Lizzie's interview. Lizzie had invited me to her house for the interview. She hosted a lunch, pointing out that this was the nutritious and low-fat form of diet that she and her husband usually ate. As we began the interview her husband came in and she introduced us. As he left, with his low-fat fish pate and salad she told me he eats healthy, low-fat food now, unlike the unhealthy diet he had when they first married. We both laughed as she told me that he used to eat 'masses of meat' and never had yoghurt as he didn't like it, but now eats fish, salads, yoghurt and muesli. This tied in with a main theme in her narrative in which she talked about her sense of responsibility for ensuring that her family ate healthy and nutritious food and that losing weight was about making small, healthy changes which she considered she had already made.

Reflecting on my field notes whilst transcribing Lizzie's interview, I realised that she may have asked to have the interview at her house rather than mine to aid her performance. She set the scene, including the use of food as props, for a performance in which she played the part of a knowledgeable woman who carries out duties of homemaker and family carer in a responsible manner. This is the identity that she performs. It can be seen that there is dissonance

between this identity and Lizzie's unhappiness with her inability to lose and maintain a weight she feels happy with. It is this dissonance that could be used to prompt her to reconstruct her identity in a way that would enable her to achieve her goals.

Frank (2010) drew attention to the ways in which people use models of identity from their culture in order to support the construction of narrative identity, just as Ann borrowed the identity of the addict to explain her compulsive eating, and Sue constructed an identity of survivor buffeted by external powers that threaten to overwhelm her. There is therefore potential for participants to address their problems by borrowing from other cultural models and other stories to reconstruct their identities. This offers an opportunity for health education.

Findings from the three analytic lenses will be discussed and concluded in the following chapter.

Chapter Seven

Discussion and conclusion

The research questions addressed were as follows:

When women repeatedly attempt throughout their lives to lose weight and maintain a body weight they are happy with, i) what is the meaning of their experience, and ii) what are the implications for health education?

Research findings showed the personal circumstances of participants, the cultures in which they live and work and the complexity of their relationships. They also afforded some insight into the social inheritance of participants through their stories of childhood, and to the meaning participants gave to events and experiences in their lives. The meanings of their experiences are personal to them; however, an examination of how narrative is performed can assist interpretation, as discussed in the methodology chapter. Identities are situated and carried out in social interactions (Bamberg, 1997; Riessman, 2001). I was aware that in the interviews the participants were not revealing an inner self to me; they were performing identities that could be quite different if performed to others or in relation to a different topic.

The story of each participant was unique. However, in examining the meaning of the women's experiences of weight loss and maintenance of a desired weight there were unanticipated commonalities and differences between participants. Emphasis on physical appearance and the ways in which participants compare themselves with others, particularly in the relationships they have with other women, was noted in the women's narratives. This appears to have precedence over health issues, and a health education approach using a medical model was often resisted in favour of strategies which enabled them to remain in control of their own lives. Interestingly these strategies sometimes used a medical model for authority, which demonstrates its power and its value to those seeking to justify their behaviour.

Comfort and pleasure, embodiment and alienation and the importance of control, both in the steps taken to establish self-control and those taken to avoid control by others, have been revealed as meaningful issues. It is notable how

little pleasure appeared in the narratives, except in relation to childhood memories. Pain and negative emotions featured largely and this was extended by the participants' fear of negative judgements and stigmatisation by others through a controlling beauty discourse. This, the data suggests, appeared to threaten their feminine identity and worked to highlight the cultural pressures they face to carry out their gendered roles whilst maintaining a slender, glamorous body. The price paid for transgression is alienation and stigmatisation. This reflects the literature reviewed which discussed disciplinary power on the bodies of women - currently imposed through social attitudes and supposedly voluntary mutual surveillance and regulation of Scott's (2010) reinventive institutions. The embodied experience of these women is largely an unhappy one and is further threatened by the increasing reframing of beauty as health, creating further pressures in their management of appropriate femininity. However, resistance appeared to provide some comfort, with food and over-eating used as a form of self-care and a way of placing themselves outside of the game, thus avoiding competition with other women.

There is relevance in the way overweight and obesity is framed by the participants. None of the women I interviewed, including the practice nurse, proposed fatness as an acceptable form of body diversity, as does the Association for the Advancement of Fat Acceptance. They all expressed dissatisfaction with their body size and made attempts to lose weight, ostensibly to be healthier, but were unable to maintain a size and weight that they could be happy with. Despite this emphasis on health, none of them sought medical help to reduce their weight, possibly because the structure of local primary care services discouraged this. Rather, they used commercial organisations, treatments and preparations, and measured the outcomes in terms of size and appearance rather than health. This could be symptomatic of the current fashion for slenderness and the ubiquity of digitally altered images which promote views of feminine perfection that are largely unattainable (Bordo, 1993). It is argued that even the prevailing medical standard of ideal weight is influenced by fashion (Orbach, 2006). It thus becomes less likely that women's views of a successful outcome will be one that is achievable, particularly given the constantly moving target suggested by the downward revision of the ideal weight charts.

In addition, the data seem to demonstrate that individuals are increasingly expected to take responsibility for their own health and prevention of conditions that are deemed to be caused by lack of self-control, such as obesity. An example of this is where Lizzie states that her sister is obese, diabetic and eats rubbish. This is compounded by a more insidious form of social control, performative regulation, in which people carry out monitoring and surveillance on each other, in the guise of a self-improvement activity (Scott, 2010).

Slimming groups may be considered as one example of this. If individuals comply, the standard they aim to achieve will be set by others, according to the prevailing fashion. However, compliance may be just another facet of control. Berlant (2010) argues that sovereignty – the notion that we have individual, personal control over our actions and decisions – is fantasy. Furthermore, the actions that we might point to in order to demonstrate our sovereignty, for instance, eating five fruit and vegetable portions a day are merely measures of our compliance, promoted to us or experienced by us as choice. Women are traditionally expected to be compliant more than men. It is possible that these actions that demonstrate compliance give an illusion of self-control and choice.

Despite their apparent rejection of the medical model the participants' views of fatness reflect the dominant medical discourse, which resituates debates over body size from a political arena into a medical one in which medical authority is used to establish credibility and discredit opponents. When a solution is situated somewhere between these two extremes, credibility struggles will prevent a solution if integrative perspectives require the two sides to work together (Saguy & Riley, 2005). For instance, BMI is used as a measure of obesity by medical authorities, despite criticism of its validity by academics who question the premise of an obesity epidemic. Changing the ways in which obesity is measured would require the agreement of medical authorities and academics, working together for a compromise. It would ultimately require a measure of capitulation – with a potential loss of credibility – from the medical authorities which are the existing guardians of the dominant discourse.

There are several implications for health education, the first being plausibility of the messages given. From the individual's perspective health education messages may be seen as contradictory and constantly changing (Fuller *et al* 2003). This is an important issue for public health which has been seen to have

several highly-publicised turnarounds in areas of public health over the past two decades. For instance, the upward revision of so-called safe daily alcohol units for women from 14 units weekly in 1987 to 21 units in 1995 (RCP, 2011) the discovery that dietary fats are not unhealthy *per se*, indeed that some have significant health benefits, and that higher consumption of eggs, far from raising blood cholesterol dangerously, is not associated with increased risk of coronary heart disease or stroke (Rong, 2013). When guardians of the dominant discourse relinquish or relax their claim to authority, new knowledge can fill the gap that is left. However, it is rare that claims to authority are relaxed, perhaps because as Bauman warns, structures once broken down are always succeeded by new structures just as rigidly imposed. 'No mould was broken without being replaced with another' (Bauman, 2000 p7).

Public health targets policy and institutional structures rather than individuals. It uses epidemiological approaches to assess population health and determine the interventions which could have the greatest impact in terms of improved population health. In the prevailing neo-liberal political context, this is translated into instructions to individuals who must take responsibility for their own health and their own actions, and who are blamed for diseases that are deemed to be caused by lack of control and behaviour restraint, for instance obesity, alcoholism, smoking, drug addiction and related disorders.

Body projects

The ways in which women see their bodies and their construction of self is also relevant to their experience of overweight and their attempts to maintain a weight they are happy with. The situated nature of the way in which the participants see their bodies is important but is not integrated into fatness discourse. As Warin *et al* (2008) argue, women tell their stories about bodies that incorporate histories and meaning that cannot be reduced to biological reasoning. It is notable that in our stories the participants and I talked happily about childhood and the food we ate at that time but none of us talked or wrote expressing pleasure about food we eat now, except to use it as an example of something we should have denied ourselves.

Bauman (2000) uses the Jane Fonda phenomenon of the 1980s to demonstrate what people seek – an object lesson or example rather than an authority. They

look at other people, seeking an example which they can use to identify their own problems and work out ways of overcoming them. This appears to be the form of control the participants chose, rather than medical control. Whereas authority leaders act as 'translators between individual good and collective good', exemplars offer themselves, in the way that Fonda did when she pointed out that she was responsible for creating the shapely, youthful, desirable body that made her work-out book so successful. Bauman believes that with Fonda's stress on self-development through hard work, she invokes '... the memory of a very pre-postmodern ... instinct of workmanship.' In other words, her body is only as good as the time and effort that she puts into it; only she is responsible for its success. The reverse is also clear: 'you owe your body thought and care, and if you neglect that duty you should feel guilty and ashamed. Imperfections of your body are *your* guilt and *your* shame' (Bauman, 2000, pp 66&67). Bartky (1990) argues that as modern industrial society changes, so do the forms of domination that women are subject to. Requirements of chastity and a life based mainly in the home have been replaced by a normative femininity based on women's appearance. Coupled with the growing power of image in an increasingly visual media-oriented society, and the increasing use of digitally enhanced images of women (Bordo, 2003) women's lives are now regimented around continuous, exhaustive beauty routines throughout their life-cycle. Women have become obliged to monitor, check and police themselves; as Bartky argues, 'This self-surveillance is a form of obedience to patriarchy' (Bartky, 1990 p80) but women do this to themselves.

It could be argued that this is reinforced by the current emphasis on individual responsibility. Surveillance and regulation now appear benign and voluntary although institutions such as slimming groups are as strictly controlling as those they replaced. It is also argued that they naturalise an obesity discourse that ignores lived, gendered experience in a world that represents big people as offensively stereotyped (Aphramor, 2005). Health education may have success in changing some individuals' behaviour some of the time but with many individuals the message is either ignored or contested (Lupton, 1995).

This may be because women do not recognise themselves as a target; Lizzie demonstrated this when she said that she didn't feel she had an issue; she was not a fat woman although she identified herself as overweight and she had

made healthy changes to her diet; or because like the mothers in Warin's study, large body size is seen as a positive aspect of a nurturing maternal role, symbolic of safety and security for their children (Warin *et al*, 2008). It may also be that the public health messages are ignored, resisted or subverted by developing theories for which there is little or no evidence – as Sue did, in developing the theories that firstly, her genes have determined her size and secondly, food additives may be responsible for obesity. Ann presented herself as a woman in the grip of an obsession similar to that experienced by drug addicts, and Jen was clear that her mother's overfeeding in her childhood and her dual responsibilities of looking after a family and running a business, had left her with an overweight problem that she had little chance now of addressing successfully. The simple energy-deficit solution of 'eat less, exercise more' appears to be inadequate to address complex and situated, gendered issues.

The identities that women construct are relevant for health education and currently do not appear to be taken into account when strategies to target overweight and obesity are developed. Narratives are people's creations; there is scope to help individuals reconstruct their stories by supplying counter-narratives, to borrow from and work into their own stories (McAdams, 2006). An example of this would be the successful health education campaign by the (former) Health Education Authority in the 1980s to persuade Asian immigrant communities to increase their uptake of childhood immunisation. Simply translating into Asian languages the message that immunisation was important had not succeeded in increasing rates. The new campaign rewrote the information as an offer to Asian adults, to 'give your children something you never had,' featuring a well-known sporting figure, the cricketer Imran Khan, as the poster image. Instead of a potentially risky and worrying parental responsibility the immunisation became a gift parents could give to their children.

In the areas in which health education or public health could perhaps make a difference, such as influencing healthy public policy, advising on health-related regulation and societal infrastructure, there is currently little evidence of effective input. For instance the new 'social marketing' approach should be using market strategy to promote health (Winnett, 1995). However it failed to engage with what was arguably the United Kingdom's health promotion

opportunity of this century – the London 2012 Olympic Games – to promote health. Instead, the games promoted high saturated fat, high sugar convenience foods and alcoholic drinks, justified by the food industry's philosophy that no food or drink is inherently bad but that it is an individual responsibility to exercise moderation in intake. This supports a public view that authoritative institutions – guardians of the dominant discourse – are ambivalent about health or that they chop and change, constantly revising public health messages about what is healthy and what is not. Also, the increasing role of the food industry in public health and policy partnerships provides commercial pressure to shift responsibility for health from public institutions to individuals, whether or not those individuals have sufficient awareness or knowledge to understand the implications of the choices they make.

Furthermore, recognition of gender and gender roles in relation to health behaviour is lacking in public health messages and they do not challenge the dominant gender discourse of female attractiveness. Gendered construction of overweight and obesity by participants of this study, and reflected in the literature review, provides insight into the importance of targeting health interventions appropriately. The participants do not present themselves as the targets of health education. They resist the controlling medical discourse and are helped in this stance by fat-acceptance activists and researchers who show evidence which conflicts with the anti-obesity researchers' findings of danger in overweight and obesity (Saguy & Riley, 2005). Appealing to people's sense of personal responsibility cannot work if they do not see it as relevant to themselves.

There is little recognition of other factors in overweight, which may be experienced as positive, for instance the maternal nature of bodies, and the protection that overweight may confer. This may include a withdrawal from competition in a society in which women are increasingly expected to be clever, successful, glamorous and slender. One of the participants, Jen, pointed out that she didn't feel she had to be an important businesswoman when she was overweight. Medical collusion with the discourse of female attractiveness may reinforce these norms and make them harder to challenge.

Alternative approaches for health education

Despite the lack of evidence of long-term success in weight-loss programmes there is little information about alternatives such as the Health At Every Size Approach (HAES) which could be useful in providing an alternative to commercial slimming clubs for large women who want to explore fitness and health with women like themselves but are not convinced that weight loss is necessary or possible. The 'Health At Every Size' approach has been successful in the United States in providing a setting in which women who might not wish to expose themselves to situations in which there may be pressure to diet, can meet to explore health and related activities such as exercise groups without standing out or being stigmatised (Aphramor, 2010). The literature reviewed shows beneficial effects of this approach on eating behaviours (Provencher, 2009).

The participants did talk about the importance of health to them, particularly those who had relatives whose health had been threatened through obesity. The value of the HAES approach to women whose motivation in losing weight is to be healthy is that it has the potential to break the link between health and slenderness. When women have spent many years gaining, losing and then regaining weight it is unsurprising that they would doubt their ability to lose weight successfully. Health education measures that strengthen the association between health and slenderness may simply be ignored by women who have given up attempts to reshape their bodies in order to look like the unrealistic media images they see.

Alternative approaches have also been described by Orbach (2006). She wrote about the resolution of her own compulsive eating issues with the help of a women's self-help group, before going on to become a therapist and help other women with the same issues. Women's groups which have consciousness-raising as an aim rather than weight-loss can explore body insecurity through looking at broader issues such as the place of women in society. This avoids the regulation and surveillance function of slimming groups. It also rejects the public health regulation of women's bodies which is achieved by promoting health as a moral imperative (Lupton, 1995).

Reflection on the research

In this section I reflect on the research in this thesis, including its strengths and limitations, its contribution to the field and areas for further study.

The literature reviewed in this study has revealed that obesity science, despite constructing an obesity epidemic with measurements of the extent of the problem and the likelihood of its increase, fails to explain why some people become and remain obese, despite repeated dieting. The response to the obesity threat continues to be health education advice from medical authorities that individuals should eat a healthy, balanced diet that contains less calories than they expend and exercise regularly (the energy deficit formula) despite evidence that demonstrates this approach is not working and that the issues are clearly more complex (Mann, 2007, Aphramor, 2010). In addition, evidence that suggests the health threat of overweight and obesity may have been inflated (Flegal, K, 2013, 2005, Angeras, 2012, Curtis *et al* 2005) has not informed current health policy. Although stigmatising obese individuals has been found to be counter-productive (Guttman & Salmon, 2004, Puhl & Heur, 2010) an individualised behaviour change approach to health education continues to be adopted. This has strong moral overtones as it appears to blame obese individuals, suggesting they fail to lose weight because of their gluttony and sloth.

At the same time normative femininity is becoming centred increasingly on women's appearance and women may live much of their lives feeling that their bodies fall short of the current fashionable standard. Women's relationship to their bodies is being reconstructed by exposure to constant visual images of female bodies that are consistently smoothed, shaped, sharpened, elongated, that is digitally altered to a point that is unattainable for a real person. The increasing power of the image is emphasised in the literature (Orbach, 1993, Bordo, 2003, Gard & Wright, 2005, Evans & Rich *et al*, 2008) and formed part of the evidence presented to a cross-party parliamentary inquiry (APPG & YMCA, 2012).

This background troubles the dominant health discourses around overweight and obesity amongst women. From a simple 'body as machine' model that suggests a body can simply re-size in response to an energy deficiency

formula, the complex and multilayered approach of Bordo (2003) and Orbach (2006,1993) highlights a continuum of disordered relations with food and eating that represent dieting at one point and conditions such as anorexia nervosa and bulimia at its opposite. This is counter to the current positioning of such eating disorders as bulimia and anorexia nervosa as distinct and pathological, which suggests the less extreme positions are normal.

The study has elicited, interpreted and re-presented the narratives of five women who have repeatedly and unsuccessfully dieted to lose weight and maintain that weight loss, and has examined the meanings of their experiences and the implications of the findings for health education.

Strengths and limitations of the research

Some have noted limitations of using narrative research. Atkinson & Silverman (1997) argue that it can reify the interior self, presenting subjective truth as an authentic voice, replacing systematic, disciplined analysis. However the research presented here demonstrated the significance of narrative for eliciting women's stories without the boundaries that my questions would have imposed. In addition a real strength and contribution of this research might be seen to be the different analytical approaches used. This moves beyond a singular approach to allow for aspects such as looking to the wider social picture, examining counter-narrative through identity creation and positioning, and the context as well as the content of narrative production. Counter-narrative opposes dominant and hegemonic narrative so can be used as a strategy to avoid complicity with the master narrative (Bamberg, 2007).

Whilst five participants could be seen as a small number, this is common to narrative approaches, particularly with the collection of in-depth data. In this study I have shown how these in-depth stories can be deconstructed, examined and reconstructed in different ways to add important detail to discourses about women's lives. Furthermore this has been with a group who are highlighted as an important part of this issue but have up to now been relatively ignored in the research.

Implications of the findings

The findings re-presented in chapters four, five and six show the complexity of participants' lives. This study has focused on one aspect of these lives – that which relates to weight-loss and weight-management experience. However, important and fascinating details of the participants' broader culture and childhoods have emerged. Despite the current lack of priority weight loss issues appear to have for the participants it is notable how much of their lives have been taken up with the issue of their weight. The impact this has had on other aspects of their lives is also notable, for instance the way they feel about the most appropriate ways to feed their children, and the effects of remembered stigma or fear of negative judgement on their social confidence. This also features strongly across the narratives, including participants' willingness to stigmatise others, reflecting the literature which shows stigma related to overweight and obesity as widespread, pervasive and counter-productive in changing behaviour.

This willingness to stigmatise may also be an aspect of Scott's performative regulation, the social control examined in chapter 2, in which members of the reinventive institution monitor themselves and each other in the interests of self-improvement (Scott, 2010). Evans *et al* (2008) point out the ways in which young people carry out this surveillance and regulation under the guise of health. People participate in regular surveillance in the interests of health and self-improvement.

The findings show that health education in its current form does not appear to be seen as relevant to the participants of this study. They all gave reasons why they could not adopt eating plans that would enable them to lose weight. These ranged from unhappiness and comfort-eating, lack of time to plan healthy meals and exercise through to compulsive eating. Another reason was clearing plates and eating left-over food even when not hungry – this may be associated with the childhood experience of being forced to eat unwanted food to avoid waste. Literature suggests that food rules remembered from childhood have a negative effect on adult eating behaviours (Puhl & Schwartz, 2003). Other complex historical influences may also have contributed to the development of women's

current identities and would need to be addressed accordingly in health education provision.

Furthermore, reflecting Warin's (2008) study, participants didn't position themselves as obese. They positioned themselves as busy mothers, workers, women with responsibilities and problems that took higher priority than their overweight. In short, they have developed counter-narratives that could make them unlikely to recognise themselves as a targeted group in health education. As Lupton (1995) argues, if the group targeted do not recognise themselves in the discourse used they will not respond in the way expected, particularly if there are opposing influences such as media or counter-acting personal experiences. In addition the tendency previously noted for participants to speak negatively of others larger than themselves may reflect a difficulty in judging their own weight status.

Kreuter & Holt (2001) call for tailored, individualized health education messages to improve engagement. However the data shows that individualist approaches have not helped the women in my study. The reductionist approach based on individual behaviour modification techniques advocated by current policy fails to take account of the gendered, situated nature of women's identities and personal histories. Even the social marketing approach adopted by public health perpetuates the dominant health discourse of energy-deficit weight-loss messages that appear to assign blame by targeting individual behaviour change in those considered to be at risk. These do not match the experiences described by the participants in terms of the lives they actually live.

Women are bombarded with images of unrealistic and unattainable body images. Bordo (2003) argues that, despite theory about cultural resistance and agency, women still feel powerless to resist the images and the messages they convey. They may disassociate from their goal and give up trying to attain a healthy weight because the body they are striving for is not achievable and they cannot compete with the digitally enhanced images they see. Frost (2005) notes identity damage as one consequence of failure to achieve the desired female body – slender, physically fit and attractive. Others may include eating disorders and invasive medical procedures such as cosmetic surgery and bariatric surgery. There are many discourses that impact on the construction of self,

such as the dominant social messages about gender and appearance – these compete with health education messages. The extent to which people can resist these may depend on, as Foucault noted, their social context (Bathmaker, 2010). Health education approaches that challenge the master-narratives of gender and attractiveness may have more chance of success than those which blame the individual for causing their own overweight.

Also, narratives are social creations which are used to shape individuals' life stories. If women are to transform themselves and change their stories they will need counter-narratives as a resource with which to repair their identities, either by adopting new storylines or as McAdams (2006) suggests, borrowing parts of the stories of others. The counter-narratives participants constructed included those that resisted the master-narrative, for instance prioritising career and work over slenderness – no time for dieting and exercise – and those that borrowed from master-narratives. The latter included denial of responsibility for overweight because of obsessive eating experienced as an addiction, and obesity as a response to pollutants in food. These both used biomedical discourse, thus drawing from a master-narrative to support their assertions. However, Bamberg (1997) argued that using master-narratives does not mean automatic complicity – master-narratives give direction and guidance for daily life and individual agency is used to resist hegemonic power in a variety of ways, which may include small, subversive acts in everyday interaction.

Contribution of the research

There is a scarcity of research into the weight loss and weight maintenance experience of middle-aged women and of women who are not pathologised as suffering from eating disorders such as anorexia nervosa or bulimia. Bordo (2003) points out that clinicians are keen to draw a very sharp dividing line between these eating disorders for which they can investigate pathological causes, and disordered eating such as bingeing/purging, together with body-image difficulties. Research around women and overweight is thus focused largely on young women and eating disorders. Doubt has also been raised on whether BMI, the tool used for determining overweight and obesity is a useful measure. It is not a proxy for health. BMI has been shown to be subject to revision, whether for the prevailing fashion (Orbach, 2006) or for the financial

advantage of firms which benefit from the creation of an obesity epidemic (Moynihan, 2006).

This study contributes to the literature the experiences of women who are not pathologised as suffering from eating disorders and who have not sought medical help but who nonetheless have tried repeatedly and unsuccessfully to lose weight and maintain a weight they are happy with. The embodied experience of these women is often that of alienation, reflecting their struggle to manage what is seen as proper femininity. They are regulated by themselves and others, through the surveillance of slimming clubs and their social networks. They in turn participate in the surveillance and regulation of others. This is shown by their drive to diet and exercise and their experiences of stigma as both victims and perpetrators. The study also explores the implications of the findings for the changing, developing field of health education/health promotion, now largely subsumed into public health, which itself is currently moving from health authority to local authority settings. It finds complex reasons for overweight and obesity in the participants that are not addressed by behaviour change interventions. Health education measures that fail to take account of cultural and societal factors are unlikely to be successful. These factors include meeting the expectations of others and competition with others, including attempts to achieve contrived and unrealistic body images; the challenge of gendered roles; and the immediate relief of eating for comfort and self-care.

These findings trouble the dominant discourse that emphasises individual responsibility for overweight and obesity. Current obesity discourse in education, culture and society, reflecting government policy, assigns at best responsibility and at worst blame – with corresponding stigma – to individuals and their behaviour for causing overweight and obesity, despite lack of evidence that behaviour change interventions work in achieving government goals (Cabinet Office, 2011). The findings of this study suggest that women may resist taking individual responsibility for their weight, whilst at the same time seeking individual control over their lives. Whilst this appears to be contradictory it positions the women as powerful, representing a rational way for stigmatised people to respond to discourse that threatens their sense of self and to manage, as Goffman (1963) points out, a 'spoiled identity'. Approaches which reflect the connection of body, self and society and recognise the

challenge of managing appropriate femininity may be a more realistic goal for health education and health promotion.

The study also contributes to research methodology in using analytic methods in a combination which I propose has increased the breadth and depth of these findings. Alternative approaches to examining the causes and effects of overweight and obesity is one of the affordances of the re-storying form of analysis. The complexity of each participant's account included influences from childhood, past and current lifestyles and the priorities they gave to different aspects of their lives – these priorities may not accord with those of health professionals. Thematic analysis revealed the contradictions inherent in the management of femininity and the common pressures faced by women who struggle with gendered roles and the expectations of others. Relational analysis enhanced the re-storied narratives of the women and extended the findings of the thematic analysis. Storytelling is embodied and situated, involving factors such as attention to setting, positioning of characters and audience, and the means of communication used. Reported speech, even re-storied, neglects important aspects of the process that relates to performance, for instance choice of setting, use of the audience in demonstrating a point, and attention to physical factors. Relational analysis addressed these points, exposing contradictions between the desired self in the performance and relationships with other characters within the narrative, and revealing insights from collaboration with the audience. It also afforded the opportunity to change focus from the 'big story' of women's experiences in the context of society and culture, to a closer examination of how their story was performed and the ways in which they used narratives to create identities.

The last word

This research study has challenged and changed my ideas and perspectives about overweight and obesity in women. The narrative method I have followed has enabled me to develop new research skills and to develop a deeper understanding of the value of alternative approaches.

In particular, including an 'acquaintance interview' was a valuable learning experience. Initially I was concerned about issues relating to the effects of a close relationship on interviews and interpretation and the need for rigorous

reflexivity to address this, and on the dangers of future effects on the relationship. Reflecting on this experience now, the lesson I learned is to see less clearly. Before the interview I remembered past events which seemed clear and unequivocal. After the interview it was necessary to revisit those events and reflect on differences and contradictions between my memories and those of my participant. I concluded that the clarity of each of our memories was influenced and shaped by our current impressions, values and judgements, and that this would be likely to hold true for other participants. Seeing less clearly meant that I saw a broader field with more scope for interpretation and insights.

Whilst working as a health professional I was accustomed to working within a positivist medical paradigm and, whilst not unquestioningly accepting a biomedical model to explain differences in body size and eating practices, I have spent some twenty years attempting to make the energy-deficit formula approach to weight loss work for me. I have now seen the unsuccessful attempts my participants have made, sometimes at great personal cost, to do the same. This approach has clearly not worked in the long-term for any of us. The solution of reducing calories consumed and expending more energy in the form of exercise appears to be simple. However it fails to take account of cultural and societal influences that position and control women and the forms of resistance that may be developed in response to them. These have the power to undermine health strategies. The opportunity and challenge for health education and health promotion will be to take account of these broader cultural and societal aspects whilst addressing women's health, from the new public health local authority setting.

Appendix 1i: Sample of transcript

(with colour-coded segments as early stage of thematic analysis)

L: ... and seconds for puddings, mum made fantastic puddings, lemon meringue pies that high (*holds hand up about six inches from table*) and apple crumble. I make crumbles but we have a sprinkle on the top, you know very - a dusting of the crumble. We used to have it this thick ...

(*holds up finger and thumb about an inch apart – joint laughter*)

I: Yeah

L: ... you know, and we used to fight over the cream, the cream from the top of full-cream milk ... so it was all that kind of thing. A lot of tinned food because she didn't have time, certainly didn't have a freezer. I remember a time when we didn't have a fridge, so um convenience food, probably of the worst kind. I dunno, I don't suppose tins are as bad as we tend to think they are, except if you're allergic to the lining of the tin or something, the food was pretty reasonably fresh. I don't recall a lot of fresh food, um, time and money. There was often, this was before supermarkets, you'd have to go down the road and bring home a bagful of stuff but there was this feeling that um good food cost too much I think. I would always say to my children before they left home, eat loads of fruit and veg, loads of veg; you know you could make a meal out of veg and beans and eggs. It wouldn't cost you a lot and so much better for you. Anyway, I got really interested in food. I wasn't – no, when I did my – I went to grammar school aged ten, and did my GCSEs age fourteen and fifteen and the second lot I was very stressed, for various other things like my first boyfriend, falling in love and things like that so I went down (*laughs*). My normal weight was ten and a half stone; I don't know if you call that odd, I'm in my teens. I went down to nine stone something, just barely nine...

I: Ooh!

L: Which looked great but it did make me look ill. That was stress; it all came on again and I don't really - I had sandwiches and fruit and crisps for lunch. I don't - there was no big deal about it. But when I got to, um, you know, girlfriends were better-looking than me, were going out with boys, then you start thinking, mm I could be a better shape. Um, I always thought my stomach was huge. I have a round stomach, I mean I have a shape that my stomach – it had a shape to it. I always wanted it to be flat 'cause Twiggy arrived when I was about sixteen, seventeen, that's probably when I first ... so it's all about body image then, isn't it? So I was never going to be Twiggy. I like my food too much, I wasn't going to do a great deal about it. When I left home I was twenty, twenty one and there was always a fad diet going on, so we did the grapefruit diet that made us pee all night. We did the um, um, I think I said earlier, the fibre one, what one was that? When we were talking earlier I think I came out with the name; can't remember now. The high-fibre book – every recipe went straight through you so if you weren't coeliac when you started you would be when you finished...

KEY

Health

Strategies for control

Social inheritance

Body shape/size

Stress/vulnerability

1ii: Example of coding and links to themes

Code	Definition	Example	Links to theme
Motherly instincts	Parenting experiences	<i>I absolutely refuse to force her to eat anything</i>	Comfort, pleasure and pain
Discrimination	Anti-fat bias, name-calling, judgemental behaviour	<i>If you're fat, don't bother contacting me You're just big-boned My lover ... makes jokes about my size</i>	Embodiment and alienation
Control strategies	Weight loss regimes Avoiding health professionals Theories of external factors causing overweight	<i>I did Atkins, South Beach, Lighter Life The Asthma Nurse nags me ... eventually she got me Part of it is the genes If I wasn't in charge of the kitchen I would not be overweight</i>	Control and out of control
Good girl	Compliance with demands of others/fitting in	<i>I've never grown out of nursery food Shift of identity ... I felt I needed to look professional ... needed to sharpen up So even at the age of ten ... if I had chocolate ... I felt terrible about it ... guilty</i>	Comfort, pleasure and pain
Social inheritance	Cultural/family influences	<i>A lot of that stems from childhood and being made to eat As I grew up ... we were quite poor Food could not be wasted I felt like I'd lost both of them (following parents' divorce)</i>	Control and being out of control
Other women Stigma	Relationships with others	<i>We weren't fat like some of the things you see around now Country mouse comes to town</i>	Embodiment and alienation

Appendix 2



GRADUATE SCHOOL OF EDUCATION

CONSENT FORM

I have been fully informed about the aims and purposes of the project.

I understand that:

there is no compulsion for me to participate in this research project and, if I do choose to participate, I may at any stage withdraw my participation

I have the right to refuse permission for the publication of any information about me

any information which I give will be used solely for the purposes of this research project, which may include publications

If applicable, the information, which I give, may be shared between any of the other researcher(s) participating in this project in an anonymised form

all information I give will be treated as confidential

the researcher(s) will make every effort to preserve my anonymity

.....

(Signature of participant)

.....

(Date)

.....

(Printed name of participant)

One copy of this form will be kept by the participant; a second copy will be kept by the researcher(s)

Contact phone number of researcher(s):.....

If you have any concerns about the project that you would like to discuss, please contact:

.....

OR

.....

Data Protection Act: The University of Exeter is a data collector and is registered with the Office of the Data Protection Commissioner as required to do under the Data Protection Act 1998. The information you provide will be used for research purposes and will be processed in accordance with the University's registration and current data protection legislation. Data will be confidential to the researcher(s) and will not be disclosed to any unauthorised third parties without further agreement by the participant. Reports based on the data will be in anonymised form.

Appendix 3

Certificate of ethical research approval

Certificate of ethical research approval

Your student no: 580041209

Title of your project: Women and weight loss: an investigation of repeated, unsuccessful attempts by women throughout their lives, to achieve and/or maintain weight loss.

Brief description of your research project:

Overweight and obesity in western societies has increased rapidly in recent years, despite measures taken to reduce the levels. This is a public health problem as obesity is linked to chronic ill-health, disabilities, impaired quality of life and emotional/psychological harm. Attempts to tackle this problem have included written and verbal health education information on healthy eating and exercise, and the development of a national exercise prescription scheme. These have been unsuccessful in reducing the prevalence of obesity and overweight.

My project will use narrative inquiry to develop and analyse case studies of five women who have attempted, unsuccessfully, to lose weight or maintain weight loss throughout their lives. I will examine the participants' attempts to lose weight and maintain that weight loss, whilst exploring i) their perceptions of the factors they believe influence their weight gain and loss, and ii) the implications for health education.

Give details of the participants in this research (giving ages of any children and/or young people involved):

Five women will be purposively selected in order to meet the following criteria:

- i) To be adults over the age of eighteen who currently have a perception of themselves as overweight, and
- ii) Have attempted more than three times during their life to lose weight, but have been unsuccessful in either/or achieving or maintaining weight loss.

This will be a non-clinical, opportunistic sample, with participants recruited from women's groups and workplaces.

Give details (with special reference to any children or those with special needs) regarding the ethical issues of:

- a) **informed consent:** Where children in schools are involved this includes both headteachers and parents). An example of the consent form(s) must accompany this document. a blank consent form can be downloaded from the GSE student access on-line documents:

I will give participants clear information about the purpose of my research, the way in which it will be conducted and the measures I will take to protect their dignity and privacy. I will also discuss dissemination of the thesis and the possibility of data being included in future publications. I will ask them to sign a consent form if they agree to participate, after considering the information given.

- b) **anonymity and confidentiality**

Give details of the methods to be used for data collection and analysis and how you would ensure they do not cause any harm, detriment or unreasonable stress:

I will conduct two open interviews with each of the five participants, using audio recordings and notes. Interviews will be of one-hour duration. Photographs and documents may also be used to supplement the women's stories and they will be asked if they wish to develop artefacts (for instance, drawings, journal entries or autobiographical accounts of their experiences) to bring to the second interview. Photographs may be chosen by the women to show and remember themselves at different points in their lives; for instance, at their wedding or when their children were young. Documents may include diet plans and ideal weight charts used over the years.

I will respect individual, cultural and role differences, including age, disability, education, ethnicity, language, national origin, race, religion, sexual orientation, marital or family status and socio-economic status. In particular, I recognize the sensitivity of this topic. Participants will be treated with respect and I will maintain their dignity.

I will also ensure that confidentiality is maintained. Data will be anonymised, with pseudonyms assigned to each participant. I will store data records, including transcripts, audio recordings, photographs and artefacts, securely.

Give details of any other ethical issues which may arise from this project (e.g. secure storage of videos/recorded interviews/photos/completed questionnaires or special arrangements made for participants with special needs etc.):

Data will include transcripts, audio recordings, photographs and personal documents as well as artefacts (likely to be autobiographical accounts). These will be stored safely and securely.

Give details of any exceptional factors, which may raise ethical issues (e.g. potential political or ideological conflicts which may pose danger or harm to participants):

None known. However, details of organisations and helpful groups will be available for participants who wish to access them. These will include local primary care services, and groups such as 'Anybody.org' which promote size acceptance and fight size discrimination.

*This form should now be printed out, signed by you on the first page and sent to your supervisor to sign. Your supervisor will forward this document to the School's **Research Support Office** for the Chair of the School's Ethics Committee to countersign. A unique approval reference will be added and this certificate will be returned to you to be included at the back of your dissertation/thesis.*

N.B. You should not start the fieldwork part of the project until you have the signature of your supervisor

This project has been approved for the period: 10 Dec 2010 **until:** 31 July 2011

By (above mentioned supervisor's signature): Haya L **date:** 6-12-10

N.B. To Supervisor: Please ensure that ethical issues are addressed annually in your report and if any changes in the research occur a further form is completed.

GSE unique approval reference: 210/11/17

Signed: Sarah J. [Signature] **date:** 8-12-10
Chair of the School's Ethics Committee

Chair of the School's Ethics Committee
updated: July 2010

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