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Abstract

The focus of this research study was the exploration of the phenomenon of stigmatization of obese persons by nurses. The philosophical tradition of Phenomenology based on Heidegger's view of the person guided the researchers in uncovering the meaning of stigmatization for eight chronically ill individuals with a body mass index greater than 30. Stigmatization by nurses for this group of medically obese women meant being exposed to unintentional harm, presuppositions, and reluctant care. Perceptions of stigma were manifested in shame, marginalization, and anxiety in seeking health care. Nursing care could advance positive outcomes when including non-discriminatory care related to weight in the total care needs identified for obese patients.

Keywords

Obesity, Stigma, Nursing Chronic illness, Phenomenology

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Stigmatization of Overweight Patients by Nurses

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The focus of this research study was the exploration of the phenomenon of stigmatization of obese persons by nurses. The philosophical tradition of Phenomenology based on Heidegger's view of the person guided the researchers in uncovering the meaning of stigmatization for eight chronically ill individuals with a body mass index greater than 30. Stigmatization by nurses for this group of medically obese women meant being exposed to unintentional harm, presuppositions, and reluctant care. Perceptions of stigma were manifested in shame, marginalization, and anxiety in seeking health care. Nursing care could advance positive outcomes when including non-discriminatory care related to weight in the total care needs identified for obese patients. Key Words: Obesity, Stigma, Nursing Chronic illness, Phenomenology.

According to the Centers for Disease Control and Prevention (CDC, 2009a), a person with a Body Mass Index (BMI) of 30 or greater is defined as obese. The number of persons in the United States who meet this definition of obesity has been dramatically increasing over the past 20 years. In 2008, only one state, Colorado, had an obesity prevalence rate of less than 20%. Six states, including Alabama, Mississippi, Oklahoma, South Carolina, Tennessee, and West Virginia, had obesity prevalence rates of 30% or higher (CDC, 2009b).

As the number of obese persons has risen in the United States, so have reports of discrimination against those who suffer from obesity. Puhl, Andreyeva, and Brownell (2008) found that 40% of a nationally representative sample of adults in the United States who had a BMI of 35 and above reported having experienced some type of weight-height discrimination. The data showed an overall increase in experiences of weight-height discrimination among all adults, regardless of BMI, when compared to findings from a similar research study conducted in 1995-1996. In the earlier study, ten percent of adults surveyed reported having experienced some type of weight-height discrimination. In the more recent study, 12% of adults reported having experienced such discrimination. The findings of weight-height discrimination were similar for rates of discrimination based on race. Researchers have also reported that discrimination of obese persons occurs in a variety of environments, including work, school, and health care settings (Brownell & Puhl, 2003).

There is a growing body of research to support the view that health care providers are biased in their approach to caring for obese persons. Brown (2006) in a study of nurses, found a significant bias towards obese patients. The researcher suggested that the nurses' attitudes reflected the stereotypes within our Western culture, such as an obese person is lazy, unattractive, lacks self control, and lacks motivation. The focus of this research study was to uncover the lived experience of stigmatization by nurses as perceived by obese persons.

Purpose of the Study

Nurses are often the frontline health care providers for obese persons, and the care provided by nurses may influence the attitudes of obese persons toward health care providers in general and their health care seeking or health care avoidance behaviors. The focus of this research study was the exploration of the phenomenon of stigmatization of obese persons by nurses. A better understanding of the meaning of stigmatization by nurses as perceived by obese persons may contribute to the development of nursing practices and health care environments to better meet the needs of obese persons, improve access to health care for all persons regardless of body size, and achieve more positive health outcomes.

Review of the Literature

Obesity and Stigma

Puhl and Brownell (2003) reported that the stigma of obesity has been well documented. Areas of living where stigma related to obesity are commonly seen include education, employment, and health care. In an effort to explain the origins of obesity stigmatization, Puhl and Brownell examined two possible theoretical approaches: attribution theory and social consensus theory. These authors offered the following description of attribution theory, using a psychological framework as a basis for the development of stigmatization of obese persons:

Attribution theory suggests that people attempt to search for information that determines the cause of uncertain outcomes. When approaching a person with a stigmatized condition like obesity, people search for the cause and in turn form their reaction to the obese person. Stigmas therefore are representations of society's negative perceptions about particular groups. This knowledge is used to categorize information about social groups and to form impressions and expectations of individuals. (p. 215)

In examining the basis of stigmatization of obese persons from a social consensus theory perspective, Puhl and Brownell (2003) explained that:

Social consensus theory...emphasizes the influence of perceived consensus on the expression and endorsement of bias; stigma is a function of how one perceives the stigmatizing beliefs of others...Sharing beliefs provides a means to affiliate with others, and to achieve membership, attention, emotional support, acceptance, and security in social groups. (p. 221)

Both of these theoretical approaches emphasize the influence of dominant societal perceptions on the development of stigma related to obesity. Puhl and Brownell (2003) described common societal perceptions as the belief that body weight is under the control

of the individual, obese persons are lazy, have low self-discipline, and obesity results from lack of control over impulses and behaviors. Stigmatization of obese persons may occur when individuals choose to believe or accept the dominant societal perceptions as an explanation for obesity, as illustrated by attribution theory, or individuals may stigmatize persons with obesity as a way to achieve inclusive conformity with the larger social group by accepting and acting on the larger social group's perceptions, as explained by social consensus theory.

Regardless of the theoretical basis for stigmatization of obese persons, evidence suggests that both non-obese and obese persons accept and perpetuate societal bias toward overweight and obese individuals. Wang, Brownell, and Wadden (2004) investigated the internalization of weight-related bias among overweight persons using the Implicit Associations Test (IAT). The IAT is a timed test used to examine associations between a target group and beliefs or attributes. The researchers used words that fit in to two target groups of either "fat people" or "thin people", and two groups of attributes labeled as "good" or "bad" (p. 1334). Two groups of overweight persons were studied, with a combined sample size of 107 individuals. Using the IAT, researchers found a significant association between "fat people" and "negative" (bad) qualities. The researchers reported that the participants in this study, who were all overweight, internalized the powerful negative social stigma toward overweight and obese persons. The participants associated "fat people" with the negative societal stereotypes of laziness, stupidity, and lack of worth.

In a study examining weight stigmatization and bias reduction, Puhl, Moss-Racusin, Schwartz, and Brownell (2008) administered self-reported online questionnaires to 247 females and 44 males, all of whom were overweight or obese. The online questionnaires contained four open-ended questions related to weight stigmatization, and data from these four questions were used in a qualitative analysis to describe the sample's subjective experiences of weight bias. The researchers identified that participants most frequently reported experiences of stigmatization among friends, parents, strangers, spouses, family members, and health professionals. Although most participants reported being stigmatized by others, a minority of participants expressed beliefs indicative of self-blame and internalization of societal weight-based stereotypes. Participants perceived that the most common stereotypes of overweight or obese persons were lazy, unintelligent, lack of self-discipline or will power, indulging in overeating/binges, and having poor hygiene. The majority of participants did not agree with these stereotypes, and believed that the best way to achieve stigma-reduction was through increased education on the causes of obesity, the difficulty of losing weight, and the inaccuracy of overweight and obesity stereotypes.

Puhl and Heuer (2009) completed a comprehensive review of the literature on weight-bias toward overweight and obese persons. The researchers analyzed the findings of studies published between January 2000 and May 2008, and concluded that the amount of literature on weight bias is growing and weight bias remains a persistent problem. The systematic review of the literature confirmed that weight bias is found in employment, healthcare, and education settings. Puhl and Heuer noted that recent studies have demonstrated the presence of weight bias in close interpersonal relationships with family members and romantic partners, and in the media. The researchers also found a number

of studies that reported growing disparities in hiring practices, employment wages, and education attainment of obese persons.

Stigma of Obesity and Health Care

In a qualitative phenomenological study conducted by Rogge, Greenwald, and Golden (2004), findings showed that obese persons are subject to discrimination in the health care setting. Eighteen adults, all female, shared their experiences of being obese. The researchers concluded that the obese women in the study supported, and were affected by, the social construction of obesity commonly found in western societies. Historically, obesity has been viewed as a result of self-gratification through overeating and associated with gluttony and sloth. Western health care providers are also influenced by this social construction of obesity, and may sustain the stigma and oppression associated with obesity.

Merrill and Grassley (2008) reported additional support for ongoing bias related to weight using hermeneutic phenomenological and feminist critique philosophies to analyze data of eight overweight and obese women's stories about health care provider experiences. "Struggling to fit in" was an expression of problems faced by these women in terms of the space and equipment found in physician's offices. "Not feeling quite human" was where the women were seen only as an overweight body and not as a human being and "being dismissed" was related through experiences of disrespectful and demeaning encounters with health care providers. Finally, "refusing to give up" represented their participants continued search for and need to access health care despite negative experiences.

The aversion of the health care setting by obese persons has been reported by previous researchers. Wee, McCarthy, Davis, and Phillips (2000) identified obesity as an unrecognized barrier to women in receiving routine screenings for cervical and breast cancer. Although mortality rates from breast and endometrial cancer are higher among obese women, women who are obese undergo screenings for breast and cervical cancer less often than do women who are not obese. The researchers concluded that health care providers should target obese women for cervical and breast cancer screenings, but could only speculate as to the reasons why obese women receive preventive health screenings less often than thinner females. The researchers did cite physician behavior toward obese women as one possible reason.

Drury and Louis (2002) reported a delay or avoidance in seeking health care by obese women. The researchers used a convenience sample of 216 women, of which 34.7% were considered to be obese based on a body mass index (BMI) greater than 27.5. The researchers found a direct correlation between a BMI greater than 27.5, and delay or avoidance of health care for the past twelve months ($r=.33$, $p=.01$). The most common weight-related reasons given by research participants for avoiding or delaying health care included a gain in weight since their last health care visit, getting weighed on the health care provider's scale, or knowing they would be told to lose weight.

A study by Zuzelo and Seminara (2006) concluded that nurses were sympathetic to obese patients' special needs, but felt concerned for their own personal safety when caring for obese patients. Many nurse respondents were concerned for their safety during transfers or dreaded the amount of care obese patients require. However, nurses reported

being aware of the patients' special needs and reported taking care to provide equal treatment and making efforts to avoid hurtful encounters.

The epidemic of obesity shows no signs of abating. In adults, obesity has been associated with health risks such as heart disease, diabetes, and certain types of cancers (CDC, 2009b). As a result of the growing number of obese persons and obesity-related health problems, health care providers are now treating more obese persons, and will continue to treat obese persons for many years in the future. Because of their size, obese persons often have unique health care demands that may include specialized equipment or the need for additional staff to deliver effective health care treatment (Brown, 2006; Zuzelo & Seminara, 2006). Although research has concluded that health care settings are an area where obese persons have experienced stigmatization (Puhl et al., 2008; Puhl & Heuer, 2009), little is known about the experience of being stigmatized by nurses from the obese patients' perspective. Being able to meet the unique health care demands of all patients and preserve their sense of dignity and self worth is inherent to the profession of nursing (Wainwright & Gallagher, 2008). A better understanding of the phenomenon of stigmatization of obese patients by nurses could improve the quality of their care, their access to health care, and the overall quality of their lives.

Researchers' Relationships to Stigma, Obesity and Health Care

Primary Investigator

In an effort to place ourselves in context to the research topic of obesity and stigmatization by nurses, we offer background into our life world. I have been a registered nurse for 26 years. My primary clinical experience is from neonatal and pediatric intensive care, but in the last few years I have been working in an "as needed" position for a hospice agency. For fifteen years I have been a faculty for a baccalaureate of nursing program. While conducting interviews for my dissertation on the topic of spirituality and spiritual nursing care for terminally ill patients with no religious affiliation, I was moved by a narrative shared with me by one morbidly obese participant. My research questions for that study were about experiences of having received spiritual nursing care. This participant shared with me what spiritual nursing care was, and "what it wasn't." His narrative, as well as the collective others eventually led to a theme: *Alienation*. This theme was defined by specific nursing behaviors that resulted in feelings of being alienated spiritually from the nurse. His story was about nurses who had stigmatized him based on weight!

Although I am short and have forever "watched my weight," I am not obese and have never felt the social stigma associated with this physical condition. When reading, re-reading, and writing during the data analysis process of the dissertation, the narrative of this obese participant seemed to call to me. His words, thoughts, and insight into the seemingly innocent actions of his nurses that resulted in intense feelings of spiritual hurt, motivated me to better understand the world from the perspective of overweight and obese patients, and to better understand what nurses maybe doing or not doing that results in feelings of stigma. Because I lacked this perspective and this life world understanding, I was concerned that I too may have caused an overweight or obese patient to feel stigmatized.

This study originated because of my feelings of inadequacy in caring for the spiritual, psychological, and even physical needs of overweight patients. I could only imagine that if I lacked the understanding of how my behaviors could so negatively impact my patients, perhaps others nurses lacked this knowledge and understanding also. Doing this research was my sincere wish to understand the view of another in the hopes of providing better nursing care, and to share the findings with others so that they may also provide care that is sensitive to the spiritual, as well as physical needs of overweight and obese patients.

Secondary Investigator

As the secondary investigator, my primary interest in conducting this research arose out of my life experiences as both a qualitative nurse researcher and a person who struggles with obesity. I have been a registered nurse since 1984, and I have cared for a number of obese persons over the years. Early in my career, and during my educational training, I became acutely aware of stigma associated with being an obese patient in a hospital setting. I remember only having access to one size blood pressure cuff and asking obese patients to help me hold the cuff so it would remain wrapped around their upper arm when inflated. As students, and nurses, we simply worked with what we had, and failed to consider the inaccuracy of the blood pressure readings due to an incorrect size cuff. I remember pinning two hospital gowns together to create a gown that would fit an obese patient.

However, my earliest and most vivid recollection of caring for an obese patient occurred while I was a student nurse. I remember being involved in the care of a morbidly obese female. I don't remember why this patient was hospitalized, but I remember it was for an extended period of time. I also don't remember the patient's name, but do remember that most of the staff, including the nurses, referred to this patient as "Orca" as in an Orca Whale. Two hospital beds had to be wired together to accommodate the patient, and I remember her periodic weights were obtained on an industrial platform scale located outside the rear entrance of the hospital on a loading dock. It was quite an ordeal to wire two stretchers together, push the cumbersome and unwieldy stretchers through the hospital, down a freight elevator, and out onto a loading dock. Although extremely large, the patient was able to roll off the stretchers and stand on the platform scale to be weighed. I remember the physical intensity of pushing the stretchers, but wonder now, how did the patient feel in this situation as she was rolled through the corridors of the hospital on two stretchers being gawked at by staff, visitors, and other patients?

As I have aged, my struggle with being overweight and obese has become an ever increasing burden in my life. My first recollection of being told I was "fat" occurred when I was 10 years old. I remember our family physician lecturing my mother about my weight, and demanding that she put me on a diet. My mother complied, placing me on diet. I remember eating broiled, skinless chicken breasts from home in the school cafeteria while other students ate the school lunches of pizza, hamburgers, and chocolate ice cream cups. I lost weight, but remember always thinking of myself as a "fat kid." I now look at photographs of my self from high school, and would give anything to be that size again.

My struggle with weight as an adult began in college. The combination of eating too much fast food, drinking too much alcohol, and not getting enough physical activity began to add pounds to my body. I cannot recall the number of times I have gone on diets as an adult, often losing weight and later gaining it back plus additional pounds. My excess weight has affected my health, as I now have hypertension and diabetes, and I am considered to be morbidly obese.

I have never experienced a situation where I perceived I was being stigmatized by a nurse. However, being a nurse, I work with other nurses, and I cannot recall the number of times my fellow nurses have lectured me about needing to lose weight. I am offended by this, but never say anything to them. I am well aware of my need to lose weight, especially for health reasons. However, what most of my fellow nurses don't understand is how difficult it is to lose a substantial amount of weight, and then keep it off. Most of my fellow nurses who make such comments would not be considered obese. I doubt that any of them have ever had to lose more than 10 or 15 pounds, certainly not more than 100 pounds. Who are they to give me "you should" advice? They know nothing about my struggle with food, physical activity, or body weight. I often feel they consider me lazy or lacking self-discipline, but these thoughts are not substantiated by their words or actions. Perhaps these are my fears and feelings, and I am projecting them onto others as their thoughts and feelings.

Method

Study Design

Phenomenology as used in this research study came from the philosophical tradition based on the Heideggerian view of the person. Heidegger (1996) states that phenomenology is a turning "to the things themselves" (p. 24). Leonard (1994) further describes this philosophy as focusing on the ontological question of "what it means to be a person" (p. 45). Central to phenomenology is the belief that the world is "a priori," or always already there. A person takes up meanings, language, and culture from family traditions as a non-reflective act; this process forms the person. The person is always already situated in the world. Further, a person is a being for whom things have significance and value. The things a person values are how they understand their world and themselves. There can never be a significant free or unattached experience. A person attaches meaning to his or her experiences, so each person must be considered in context. Nothing can be encountered free from the background of a person's understanding. Each person has a past, present, and future. Where a person has been determines their existence. They must be studied in relation to where they have *been* and their *expectation of being*. The focus of the future shows what is meaningful to a person.

Van Manen (1990) states that phenomenology is the study of the life world with the aim of gaining a deeper understanding of the meaning in the everyday lived experiences. Phenomenological research offers insight that brings us in more direct contact with the world. "Lived experience is the starting point and end point of phenomenological research. The aim of phenomenology is to transform lived experience into a textual expression of its essence" (p. 27). The method used for this research was Van Manen's six suggested researcher activities: a) turning to a phenomenon of serious

interest, b) investigating the phenomenon as it was “lived” not as it was conceptualized, c) reflecting on the essential themes that characterized the phenomenon, d) describing the phenomenon through writing and re-writing, e) maintaining a strong relationship with the phenomenon during research and reflection, and f) balancing the research by considering the parts and the whole. Phenomenological descriptions aim to clarify the lived experience hidden in the text. The text (transcribed interview) is the expression in language of the person’s lived experience. It is because of language that human expression is possible. This text was reflected upon by the researchers with the aim of transforming the textual expression into its essence. The essence was described to reveal the structure and meaning of the lived experience. The significance of the experience was then identified (Van Manen).

In this research study, the focus was the exploration of what stigmatization of obese persons by nurses’ means, as lived, experienced, and perceived by obese persons themselves. Going to overweight persons who have had this experience, and reflecting on the textual narratives using the method as outlined by Van Manen (1990) provided the appropriate guide to rigorously uncover the meaning and essence of this phenomenon.

Procedure and Ethical Considerations

This research study used a purposive sample of adult participants over 21 years of age. For inclusion in the study, participants were required to have a chronic illness. The researchers believed such participants would be most likely to have had ongoing interactions with nurses either in an inpatient or outpatient setting. Criteria for selection of the sample also included participants’ who (a) self-identified as having a BMI equal to or greater than 30 or at least 30 pounds overweight, (b) reported having experienced stigmatization from nurses related to their weight, and (c) were willing and able to share their experiences of stigma.

Upon approval by the University Institutional Review Board (IRB), recruitment of participants began through recruitment announcements which were placed in local organizations’ newsletters, Craigslist, National Association to Advance Fat Acceptance (NAAFA) website, and posted as flyers in the waiting rooms at a local area hospital. This allowed participants to self-identify for possible inclusion in the study. One participant was recruited by response to newsletters, one in response to Craigslist posting, and six were in response to NAAFA website posting.

Participation in the study was voluntary, and informed consent was obtained from all participants prior to interviews. Consent forms were provided in writing to participants. They included information related to the purpose of the study, a description of the interview being recorded and core interview questions, benefits and risks, contact information of the primary investigator and her immediate supervisor, and assurance of confidentiality. For participants who were interviewed face to face, the consent was reviewed allowing time for any questions or concerns to be asked and discussed with the researcher. No participants expressed concerns related to the consent process. For participants that were interviewed via phone, the consent was emailed first and reviewed with the participant by the researcher prior to the interview for identification of possible concerns or misunderstanding of the research purpose. The following guiding questions were asked during each interview: (a) What is the meaning of stigma or of having been

stigmatized? (b) Would you share any experiences of being stigmatized by nurses that you think may be related to your weight? (c) What impact do you feel this experience has had on your health care, or willingness to seek healthcare? (d) What could the nurses have done differently, or how would you have liked to see the nurse behave towards you when you were there for health care?

Two interviews were conducted at an office location which was private and convenient for the researcher and the participants, and six interviews were conducted via phone at a time convenient to participant. The interviews were audio-taped and lasted from one to one and a half hours. Immediately following each interview, the researcher wrote anecdotal notes. These included relevant facts about the interview, the setting, and the participant's condition or demeanor, as well as the researcher's impressions. As soon as possible after the interview, transcriptions of the interview audiotapes were typed and reviewed by the researchers. Data collection continued until saturation was reached when researchers felt no new themes had emerged. A total of eight participants were interviewed during data collection.

Participants were given pseudonyms to allow for the presentation of their statements that ensured confidentiality. All of the eight participants were women. Participants ranged in age from 30 to 60, with most participants being in their 40's. Participants were currently married, divorced, or single. Most participants lived with a spouse or significant other and children. Three participants lived alone. The participants lived in various regions of the United States. Three were from the southern region (Louisiana and Texas), two were from the Midwest, and three were from the west coast (California). Diagnoses of chronic illness for participants included hypertension, diabetes, arthritis, heart failure, sleep apnea, asthma, and depression. Diabetes was the most common chronic disease. All but one participant had more than one diagnosis. The BMI scores of participants ranged from 45 to 60.

Data Analysis

Data analysis for this study was conducted using recommendations by Van Manen (1990). Data management was assisted by the use of a computerized word processing program, but no data analysis software program was used.

The following steps were used during data analysis. Both researchers read and reviewed the transcribed tapes to ensure accuracy of wording and authentic representation of the participant's experience. After accuracy was ensured, transcripts were read and re-read several times to begin the dwelling process as described by Van Manen (1990). Phenomenological reflection allowed the researchers to grasp the meaning of stigma for these obese participants. This process was conducted on each interview individually and then across cases. Additionally, data displays which included the use of concept mapping and tables allowed the researchers to organize textual data and draw conclusions. Both the primary and secondary researcher read all transcripts, coded all transcripts, and created data displays individually. Once this phase of reflection, writing, and re-writing had been conducted; the researchers together used reflection and analysis to go deeper into a shared meaning of the data.

The researchers used Van Manen's (1990) six research activities to guide the phenomenological process (p. 30-31):

Activity one: The researchers turned to a phenomenon of serious interest during proposal development, grant, and the IRB application process using literature review and peer discussions to guide the formulation of the phenomenological question based on questions generated from this exposure to literature and peer input. The researchers identified assumptions and pre-understanding of the phenomenon of stigma and obesity through discussion with community members and co-workers of all weights.

Activity two: The researchers investigated the phenomenon as it was “lived,” not as it was conceptualized. This required the researchers re-learn ways to look at the world and to seek wisdom from understanding the nature of a person’s lived experience.

Activity three: The researchers reflected on the essential themes that characterized the phenomenon. They first read each text word by word, phrase by phrase, giving equal weight to all data. Text words or phrases that stood out as being the most relevant or valued in relation to the research questions were identified by each researcher individually. What Miles and Huberman (1994) refer to as data reduction further facilitated this process. Data reduction is the analytic process of focusing and abstraction of themes within the text. Thematic analysis is the process of uncovering themes that are embedded in the text (Van Manen, 1990). Three approaches were used:

- a. Sentences that captured the text as a whole were recorded.
- b. Sentences or phrases that were essential or especially revealing of the phenomenon were noted, and a detailed reading was done in which every sentence was examined to discover what it revealed about the phenomenon.
- c. From this analysis, patterns were uncovered and named.

Activity four: The phenomenon was described through writing and re-writing. The researchers engaged in reflecting on essential themes and phenomenological writing simultaneously. The writing and concept mapping of essential themes allowed the researchers to make explicit the essential structure of stigmatization of obesity, while staying sensitive to the voices of the participants. Additionally, data displays of concept maps were used to allow the researchers to organize textual data and draw conclusions. Miles and Huberman (1994) state that data displays “make complicated things understandable by showing how component parts fit together” (p. 90).

Activity five: The researchers maintained a strong relationship with the phenomenon during research and reflection. During this time the researchers stayed focused on the question and did not wander away from the fundamental question.

Activity six: The research was balanced by considering the parts and the whole; movement back and forth between these two helped clarify the overall picture. This allowed for a clear understanding of how the parts contributed to the total structure. A master copy of the transcript was left intact, while themes were identified with text to support them. This was a continuous process of movement between the parts and the whole to discover meaning (Van Manen, 1990).

Additionally, measures were undertaken through the data collection and data analysis phases to ensure rigor and minimize bias. During the interview, descriptive validity (Maxwell, 1992) was assured through careful questioning of participants about any unclear aspect. Summarization and reflection of participants’ narratives were used to verify accuracy with the participant.

Participants were sent information requesting a member check. Members were asked to verify whether the collective results “ring true” or if they could “hear” themselves in the results in terms of their lived experience of stigmatization. They were asked to provide feedback on the “rightness” of themes for them or on any themes that they felt misrepresented their experiences. Members responded that the findings did indeed represent their experience of being stigmatized. Comments included those like Bella’s who said, “[The findings] absolutely ring true for me. I am simultaneously thrilled to realize I am not the only one who has been treated this way, and sad that it is so widespread.”

Researchers sought to maintain interpretive and theoretical validity during the data analysis process. One strategy to facilitate interpretive validity (Maxwell, 1992) was the use of participants’ own words and language. In addition, peer review by the co-investigator, who was knowledgeable in the use of phenomenology, was used to establish interpretive validity. Theoretical validity, as described by Maxwell, relates to construct validity, and it includes the validity of concepts applied to the study and their relationships. This validity rests with the persuasiveness of the arguments that support the interpretation of the findings.

An audit trail was maintained throughout the study. This audit trail included audiotaped interviews, their transcripts, and checking for consistency of wording between the recorded interview and the transcription. Memoing was done as part of the audit trail. Memos were kept for all phases of analysis; these memos included references about how themes were chosen, the researchers’ thoughts on themes, and alternative speculations. Memos were used to help with writing, re-writing, and as a guide for the researchers about where their analysis had been and where the analysis was going.

Field notes were taken during and immediately following interviews. These notes were aimed at capturing the context of the interview, including setting and participant observations (for face-to-face interviews), as well as the researcher’s immediate impressions. As the researchers read, reflected on, and analyzed texts, the primary researcher’s impressions and thoughts were considered to add texture and context to the whole of the participant experience. These notes also provided one mechanism to aid in identification of possible bias of the primary researcher, who conducted the interviews. Putting forth those impressions in a written and verbal format allowed access to the secondary researcher of those impressions. Instead of a “bracketing” of assumptions, the researcher was considered as part of the world and came to the study with a worldview; therefore, it was important that the researcher was aware of personal bias and values in an effort to approach the study in an unbiased manner as possible (Munhall, 1998). To be completely unbiased was of course impossible, but the attempt was made to make explicit the researcher background and impressions and thoughts at the time of the interview and through out the analysis process with the intentions of increasing trustworthiness of the findings.

Results

Van Manen (1990) suggests themes may be used as a means to systematically present the essential aspects of a study. Findings from these overweight patients who had experienced stigmatization by nurses are presented as themes supported with quotes,

which reflect their lived experiences. In phenomenology, giving voice to the silent “taken-for-grantedness” in participants’ experiences is done through reflection and writing. Phenomenological writing is composed of pattern discovery (themes) supported by specific quotes to allow the reader to access the experience. The attempt is to make evident the ineffable experiences of the participants’ life world (Van Manen, 1990)

Stigmatization by nurses for this group of overweight (overweight is the term preferred by participants and is used in exchange for the medical term obese) women meant being exposed to *unintentional harm*, *presuppositions*, and *reluctant care*. Perceptions of stigma were manifested in *shame*, *marginalization*, and *anxiety in seeking health care*. The following represents the core of what it meant to this group of overweight women to experienced stigmatization by nurses.

Theme One: Unintentional Harm

Participants experienced *unintentional harm* when nurses communicated with them, or about them, either verbally or nonverbally in a way that was hurtful to them spiritually, emotionally, or psychologically. Nurses spoke, or gave the impression non-verbally, of their negative response to participants’ overweight status.

Some of the verbal comments made by nurses were incredible and almost unbelievable to hear. Several of the participants became tearful as they told their stories. The stories were difficult for them to tell and difficult for the researcher to hear. Nurses either had no idea of the impact, or were unconcerned about the impact, their verbal comments made on the lives of these patients. Bella shared an experience that was deeply hurtful to her when being admitted to a hospital after sustaining several broken ribs and a leg. Bella commented:

And when I got to my room, they did all the excruciatingly painful maneuvers to get me into bed. And then a nurse stood in the door, she didn’t even come in, and stepped back out in the hall and said, “you got a weight on her?” and somebody said, “no” and she (the nurse) hollers down the hall, “Get the cow canvas!”

Alice had a similar experience when undergoing surgery:

And as they are rolling me down..... the nurses.... are pushing my stretcher and are calling for people. And, um, the CRNA specifically says, um, “We have a big one we need to roll over!” And I remember that. They thought I wouldn’t, but I did, and that made me mad.....Yelling down the hall, yelling down the hall! And so here’s all these people around me and now they’re gonna see me naked. Then I was embarrassed..... I was mad at the CRNA who said that.

For Gail, verbal comments caused *unintentional harm* when nurses tried to obtain intravenous access when she was admitted to a hospital for dehydration. She said: “They couldn’t get it in the crook of my arm and they made a comment that if I wasn’t so fat their needles would work... but they just couldn’t feel my veins.”

Unintentional harm was also conveyed by non verbal communication. Participants said that the way nurses touched or looked at them conveyed stigma. Some participants perceived this as “unwillingness” by the nurse to touch their body when checking vital signs, performing intravenous procedures or hygiene care. There were many references from the participants about “looks” or the way they felt nurses were “seeing” them.

Bella shared this statement, “And she would just look at me with *ewh*, like a something smelled face! I often get [that look] from skinny people.” And “It was this nursing supervisor in particular, who came in my room, probably every other day or so... and she would wrinkle up her nose as if there was a smell in the room, when she talked to me.” Alice said, “I think they look at me differently.... Because I don’t look like normal or what ever their perception of normal would be.” Claire said, “I just got this feeling like they were looking at me, like uh, you know, You are a horrible person, What are you doing?” This occurred when she went to a physician’s office and had re-gained weight that she had previously lost.

Other participants told of experiences of stigma where they felt the nurses were reluctant to touch them when providing care. Claire shared an encounter where she experienced unintentional harm when a nurse stigmatized her during a routine vital sign check. Claire commented:

I remember at one point there was, one of them was taking my vitals, taking my blood pressure, and she was apparently having trouble finding the pulse in my wrist. And she was just barely touching me like she couldn’t stand to even be near me. And she kept telling me, “I can’t find your pulse.” And so I put my fingers on my wrist and say, “It’s there, right there.” So she would reach out and just barely touch me and say, “No, I can’t find it.”

Theme Two: Presuppositions

Presuppositions were any assumptions that nurses made about the participant based on their appearance or weight. All participants talked about the “assumptions” made by nurses about them based on their weight. When asked what they would like a nurse to do differently, the number one response was they would like for nurses to not make assumptions about them or their behaviors. Some of the things they experienced included nurses assuming they had diabetes when they did not, assuming they did not exercise, and assuming their illnesses were related to their weight. Haley shared an experience she had in an emergency department:

This nurse came into my cubicle. I had never seen her before, never talked to her, she’d never seen me. And I happened to be holding a cup with something in it. And what was in it was some diet Coke. And she looked at me and with out asking me anything she said “You shouldn’t be drinking that – you’re diabetic!”

Gail shared a similar story about a medication she was taking:

I took a drug to induce ovulation... metformin. It is typically used for people that have diabetes.... I had already told three different people and they had written it down, that I took the drug and what it was for; that it was prescribed by the fertility doctor that was overseeing me in that hospital visit. They still ordered a blood sugar test because they thought that I didn't know what it was for!

Several participants talked about their illnesses being attributed to their weight, or that because they were overweight they were assumed to be "unhealthy." Haley said, "So the assumption immediately is that this person was going to drop dead on the spot, that they are unhealthy is not necessarily accurate." Claire said, "I just don't believe my sinus infection has anything to do with the fact that I'm fat!" and "everything that hurts below the waist has got to be weight. My knees can't hurt because I hit them on the steering wheel during a car accident."

Other assumptions included that they didn't exercise, that they were unclean, or even that they were not smart. "And they didn't ask me in the first place what my exercise habits were to begin with." (Gail) "It is the assumption that fat people aren't clean. A lot of fat people are not stupid. If nurses were willing to be open... and that is a hard, hard, one. It is so ingrained that it's a taboo to be fat." (Haley)

Theme Three: Reluctant Care

This group of overweight patients felt stigmatized when they perceived the care they received as being given reluctantly. They were made to feel as if they were "whining," that nurses had to make special accommodations or take extra effort to care for them, and that their illness was an inconvenience to the nurse. Bella said, "I felt they were very impatient with me on more than one occasion. And I am not a complainer, I'm not a whiner." Ellen said, "People are sometimes degraded when they're obese by health care providers. It's like I don't want to pick you up. I don't want to have to roll you. I don't want to have to turn you." Ellen continued with an experience where she was hospitalized for several days and requested a shower. Ellen commented:

It was well, "we don't want you to get in the shower because you might fall and we have to pick you up and we might hurt our backs." I'm like – I need a shower! But it was like. "we don't have to turn you, we don't want to have to pick you up off the floor after a shower." Basically, we don't want to do anything that is going to expose us to your excess weight!

Three themes were related to how being stigmatized by nurses was manifested in the lives, thoughts, and feelings of the participants. The three themes of *shame*, *marginalization* and *anxiety in seeking health care* were an outcome of the stigma. The participants told about their lived response to perceived stigma and how this affected their health care.

Theme Four: Shame

Shame was expressed by the participants in a variety of ways. Some said simply that they were “ashamed,” “embarrassed,” or “humiliated.” However, many of them used words of shame that expressed intense feelings of trauma. They felt “angry,” “degraded,” “defensive,” “mortified,” and often expressed “self-hatred,” including being “sorry for being large” or that they were a “horrible person” and that their weight was “my fault.”

Nurses contributed to these feelings of shame by exhibiting the same stigmatizing behaviors as seen in society in general. Alice said:

I remember the first time going in [to the hospital for surgery] and hearing them call for more help. And I remember, thinking, “I’m sorry, that I’m big. That you have to do that.” I felt so bad for them.

The second time Alice went in for surgery, one nurse called out loudly for help moving Alice from the stretcher to the operating table. This time Alice “was embarrassed to see the number of people that came in” to move her. She said, “I felt ashamed after that. I was shamed that I knew what was gonna happen – because they take all your clothes off and then they flip you over – I was so embarrassed.”

Claire also had a similar experience when being transferred after surgery. She said, “I was ready to crawl out of my skin I was so embarrassed and ashamed of my body at that moment. It was a mortifying experience.”

Bella described her experience when the nurse called for “the cow canvas” as “humiliating.” She said, “I was horrified when she called for the cow canvas. I thought I would die.” Nurses caring for Fiona on a regular basis at her primary care physician’s office made her feel as if “you’re a horrible person,” when she went in for visits and had gained back weight previously lost.

Nurses’ had a profound effect on these participants’ perceptions of nursing care, their bodies, and their worth in general. Fiona said, “I was just getting the feeling from them that I was worthless, somehow.” Nurses’ should be aware of the feelings of intense shame and self-hate that their verbal statements and non-verbal attitudes can convey to overweight patients.

Theme Five: Marginalization

Marginalization was a result of the stigma experienced by the participants from nurses. The theme emerged as a pattern of expression of feeling being seen as different. These participants felt that they were different and not “wanted” or even “undeserving” of nurses’ care and attention. Even experiences of receiving basic care contributed to participants’ feelings of being marginalized. Simple procedures such as having their weight or blood pressure taken, getting into a hospital gown, or having an intravenous catheter inserted had to be adapted because of participants’ size. Nurses’ behavior and attitude toward doing basic care and common procedures reinforced differences and resulted in feelings of *marginalization*.

Donna actually bought her own hospital gowns to bring with her to doctor visits. She said, “I just buy my own hospital gowns at this point!” She also said, “I typically

have to remind nurses to use the large blood pressure cuff. The use of the appropriate size cuff is very important.” If a smaller size blood pressure cuff is used, the blood pressure reading will be inaccurate. Donna also wished “doctors’ offices had armless chairs in the waiting rooms. Gail had similar experiences with blood pressure monitoring:

They never know what size to use on my arm. It’s always either too small or they’ll use the thigh cuff. I ask them to use the adult large cuff and they don’t a lot of time. They don’t like that I’m requesting a specific size.

Being weighed was an ongoing problem. Participants experienced problems with scales that were inaccurate, scales that could not meet their weight requirements, and nurses who pointed out the “difference” between the participants and other “normal” sized patients. Alice told how nurses would say, “We have to go get the big scale. Well, why say the ‘big scale?’ How about let’s just say we’re gonna go get a scale.” Or “I have to go get a big girl gown.” Her point was that all patients needed to be weighed and to have a gown. It was insensitive and marginalizing for the nurses to consistently point out that the participant needed a “special” gown or scale.

Additionally, *marginalization* was described as the participant feeling “ostracized” or even questioning their care. Gail said, “I question whether or not I’m getting the same quality of health care as somebody who is not fat, because they don’t see me as deserving the same quality of health care.”

Theme Six: Anxiety in Seeking Health Care

The final theme that resulted from stigmatization of overweight patients by nurses was *anxiety in seeking health care*. Not surprisingly, the participants were very anxious when they needed to be seen in a physician’s office or if they had to be admitted to a hospital for a more serious illness event. Ellen said:

I try to stay away from hospitals! It definitely does make you less likely to seek health care. I mean there is no question about that because if you’re gonna be sick and then you’re gonna be treated like crap when you get there.

Donna has a degenerating muscle condition and said, “It was extremely stressful and extremely frightening to go out of my comfort zone knowing I was going to have to see medical providers. I waited a long time to seek treatment.” Clair only went in when “I had to go.” She would “talk to friends or family” and “just avoided going to see them unless I had to.”

Especially anxiety provoking was when the participants needed to see a new health care provider. Gail said:

It’s a big deal. I avoid it [seeing any new health care providers]. My husband and I just moved about 4 hours from where we lived for 10 years and I still see the allergy doctor four hours away to avoid starting over with a new doctor.

Past stigmatization creates an environment of anxiety even when the participants were visiting a health care provider they had seen before. Gail said:

Even a doctor that I know, if he's just been to some training on weight loss, it may be the day he decides to talk to me about it. Or he may have a new nurse, and all these things play out in my mind.

These findings represent the collective voice of eight overweight women who have experienced being stigmatized by nurses. Their voices, now heard, add knowledge to our definition of stigma and to the knowledge of care of the overweight patient.

Discussion

It is important to remember that the primary findings of this research are that due to their perceptions of being stigmatized by nurses the participants felt their self worth and health care were affected. Themes that emerged in this study from participant experiences support the findings of previous researchers who have found nurses have the same bias towards obese patients that our society has towards obese people (Brown, 2006; Puhl & Heuer, 2009; Rogge et al., 2004). The participants' perceptions of *presuppositions* made by nurses included the following: obese persons were unhealthy, "not smart," sedentary, and unclean. All sorts of illnesses were attributed to their weight – even illness that had no link to their weight or had an overt alternative explanation. These assumptions echoed previous research findings and the attribution theory components, in that the participants had impressions and expectations formed about them based on their appearance (Merrill & Grassley, 2008; Puhl & Brownell, 2003; Wang et al., 2004).

In addition, participants in this study reported this bias as harmful and resulting in what they felt was care reluctantly or grudgingly provided to them. The hurt experienced by participants was of an existential and spiritual nature. It was difficult for them to relate the hurtful comments, looks, and touches they had overheard or that had been spoken directly to them. Merrill and Grassley (2008) found a related theme when interviewing women about their experiences with health care providers, that their participants felt they were treated as "not quite human."

Harvey (1999) explains unintentional harm as one component of civil oppression. This is psychological harm imposed on the socially undesirable by the socially desirable. Because participants had the socially undesirable trait of obesity, it was seen to be perfectly acceptable for their nurses to say hurtful things or behave in a hurtful manner towards them. In these narratives the nurses were perhaps behaving in a way that would not have occurred to them to behave to another person. Could the nurses' behavior be because the obese patient is "deserving" of this care based on our society's view that obesity is sinful and caused by the individual? This could be part of the phenomenon whereby society attributes the overweight with being responsible for their condition and therefore deserving of disregard of common courtesy (Rogge et al., 2004).

The reluctant care provided by some nurses was rationalized by the nurse's telling the patient that their weight or their care could be physically harmful to the nurse. This is

similar to the findings of Zuzelo and Seminara (2006), who found that nurses were concerned about their personal safety when caring for obese patients.

Additionally, the findings of *shame* and *marginalization* may be compared to Puhl et al. (2008) who reported participants internalized and identified beliefs of self-blame for their obesity. Again, Merrill and Grassley (2008) identified participants “struggled to fit in” to the space and equipment provided at clinics and offices of health care providers. However, no studies reported specifically about nursing care where patients felt marginalized due to the frequent designation as “different” either as a result of nurses pointing out the need to use special “big” equipment, procedures, and gowns. It went so far with one of the participants in this study, that she felt the need to bring her own hospital gowns with her to office visits or to hospital admissions! The act of receiving even the most basic of care, such as having vital signs or weight taken, often resulted in feelings of stigma. Nursing has as a fundamental goal the provision of non-judgmental holistic care to all patients regardless of size (Fowler, 2008). In order to fulfill this professional charge nurses must ensure that all patients feel included and are not marginalized by comments and behaviors that cause them to feel singled out as different.

Finally, this sample of overweight patients also clearly reflected previous researchers’ findings that obese patients may delay or avoid health care due to fear of being stigmatized (Drury & Louis, 2002; Merrill & Grassley, 2008; Wee et al., 2000). The participants in this study went out of their way to maintain contact with health care providers who were “fat accepting,” even traveling great distances. But even that did not alleviate their anxiety, as a new nurse may have taken the place of the nurse they were familiar with from past visits. Health care concerns that required visiting a new provider or hospital was the most anxiety provoking, often resulting in the participant going in “on the defensive.” A behavior not favorable to creating a therapeutic nurse-patient relationship!

Limitation of the study

Factors that may have limited this study include the ability of participants to articulate their experiences of stigma. Several of the interviews were conducted via the phone. This did allow for a geographically diverse group of participants, but may have impacted their ability to be “open” and relate to the researcher. Conversely, it allowed for a measure of anonymity and allowed the participant to express hurtful and deeply personal findings in the safety of being unseen. The researchers’ previous knowledge, assumptions, and experiences may have influenced their ability to find meaning from collected data. Both researchers have experience in qualitative methodology and health care, and data were viewed from within the context of their experiences. The findings from this study were produced by the researchers’ use of interpretive phenomenology; other approaches may have yielded different results. Finally, the sample was a homogenous group of well-educated females, and findings are not necessarily generalizable to all overweight people.

Conclusions

This study was conducted to understand the lived experience of stigmatization from the voices of overweight patients. The findings are relevant for the body of knowledge of nursing related to care of the growing portion of our population who are overweight. Consciousness raising related to the provision of nursing care for overweight patients needs to be done among nurses, as the participants in this study reported having experienced adverse consequences in relation to being stigmatized. In addition, programs of nursing education should examine curricula for inclusion of weight appropriate care at all levels of education and classes should not be limited only to the study of health risks, but should include teachings of care of the overweight patient from an individual, human-to-human perspective.

Finally, funding for continued research into the effects of stigma for overweight patients, as with all marginalized persons, should be considered since this segment of the population continues to escalate. As this segment of the population increases, research funding needs to keep pace with changing needs of our changing population.

The experience of stigmatization of overweight patients by nurses was revealed with the themes identified through phenomenological reflection: (a) *unintentional harm*, (b) *presuppositions*, (c) *reluctant care*, (d) *shame*, (e) *marginalization*, and (f) *anxiety in seeking health care*. Much of what was discovered is supported by the conceptual literature; however, within nursing research differences can be found. This study supports the premise that when overweight patients are stigmatized by their nurses based on weight, it negatively impacts their current health care and future access to health care.

In general, this study reveals how caring, or the lack of caring, by nurses is perceived and interpreted by patients. In this study, the patients were all overweight and felt stigmatized by a nurse because of their body size. The stigmatizing or non-caring behaviors of nurses were conveyed to patients through verbal and non-verbal actions. The actions of nurses form the basis of the nurse-patient relationship, which ideally should be transformational and healing. Perhaps Watson (2007) best described this type of nurse-patient relationship by writing,

The nurse seeks to recognize, accurately detect, and connect with...another through genuine presencing and being centered in the caring moment; actions, words, behaviors, cognition, body language, feelings, intuition, thought, senses, the energy field, and so on, all contribute to transpersonal caring connection. The nurse's ability to connect with another at this transpersonal spirit-to-spirit level is translated via movements, gestures, facial expressions, procedures, information, touch, sound, verbal expressions and other scientific, technical, aesthetic, and human means of communication, into nursing human art/acts or intentional caring-healing modalities. (p. 7)

Although this study focused on the meaning of stigmatization of overweight patients by nurses, hopefully the knowledge gained will be utilized to improve nursing care of not only overweight patients, but all patients nurses may encounter. Perhaps nurses can reflect upon and learn from the experiences and perceptions of the overweight

patients in this study, and move toward a model of practice in which they provide non-judgmental, transformational, and healing nursing care. It is the sincere hope of the researchers that nurses may hear the voices of these participants and realize how their words, actions, and gestures can be destructive and hurtful devices or how instead, they can use the same encounters as therapeutic tools in the nurse-patient relationship.

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