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Packer, Jaclyn, Ph.D.

City University of New York, 1990

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**BARRIERS TO HEALTH CARE UTILIZATION:
THE EFFECT OF THE MEDICAL STIGMA OF "OBESITY" ON WOMEN**

by

JACLYN PACKER

**A dissertation submitted to the Graduate Faculty in
Psychology in partial fulfillment of the requirements for
the degree of Doctor of Philosophy, The City University
of New York.**

1990

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

BARRIERS TO HEALTH CARE UTILIZATION: THE EFFECT OF THE MEDICAL STIGMA OF "OBESITY" ON WOMEN

by

Jaclyn Packer

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Both qualitative and quantitative methods of data collection were used to determine whether, among those who are more than 30% above medical standards for appropriate weight, weight level and attribution of responsibility for weight affect physician utilization. A questionnaire, administered to 118 female participants, ages 19 to 70, 58 from Weight Watchers (a diet group) and 60 from the National Association to Advance Fat Acceptance (NAAFA) (a human rights group), found that the former were much more likely to believe that they were personally responsible for their weight. Those in Weight Watchers were more likely to have had their current physician for a greater amount of time while those in NAAFA were likely to have seen a greater number of different physicians. Those who weighed more had significantly less positive attitudes toward physicians and indicated more weight-related and non-weight-related reasons for having avoided physicians in the past.

Twenty of the 118 participants were chosen for in-depth interviews. Seven women from each of the two groups were chosen, matching on background characteristics, particularly weight and age. Six of the largest women, all from NAAFA, were chosen for interviews as well. Almost all the women interviewed expressed negative feelings about having their weight discussed by a physician and did not believe that physicians are likely to be of much help to people in losing

weight. Most reported having avoided needed physician visits because of weight-related reasons including not wanting to discuss their weight with a physician, having their medical needs ignored because of their weight, or being treated disrespectfully. The largest women reported having had more difficult interactions with physicians regarding their weight. Despite the similarity in feeling between participants in the two groups, the NAAFA participants reported being much more angry about the treatment they've received by physicians, and only the NAAFA participants reported having severed relationships with physicians because of weight issues. While weight level clearly has a negative effect on physician utilization, believing one is not responsible for being fat leads to greater conflict with physicians and more active avoidance.

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Introduction

People who are stigmatized encounter situations in their daily lives in which they must interact with people who think of them as different from others, and who consequently may exhibit prejudice toward them and act in a discriminatory manner. Stigmatized individuals may be looked at in a disparaging light, particularly when the stigma is seen as self-induced and voluntary. Many people see obesity as a condition that fat¹ individuals cause and that fat people are capable of changing. Recent evidence shows that many people's fatness is caused by genetic or biological factors, such as low metabolic rate, and that once a person is fat, they are unlikely to be successful with dieting. Despite these findings, the belief persists that obesity is caused by the person's behavior, and that by exerting a certain amount of control over food the person could change the situation. This belief appears to be strong even among physicians, who ought to be familiar with the emerging biomedical evidence to the contrary. Because of research data correlating obesity with certain medical problems, weight loss has been accepted by many as being within the purview of physicians' practice. Unfortunately, physicians are influenced by our culture's strong negative reaction to fat individuals.

Statement of the Research Issue

Because fat people are stigmatized, and are believed to be at fault for causing their obese condition, physicians may resent that fat patients do not seem to help themselves and may believe that most medical symptoms are a result of the patient's obesity. Consequently, they may treat fat patients in a disparaging manner, may tend to attribute the person's symptoms to their weight, and may not directly treat the symptoms, but instead focus on weight loss in preference to employing preventive medicine, leading to less effective treatment. Since patients tend to make use of health services when they feel they are liked and respected by health care providers, physicians' negative attitudes toward fat patients may cause fat people to underutilize their services which may ultimately lead to poorer health. In addition, stigmatizing aspects of the office

visit, such as undressing or getting weighed may cause discomfort and embarrassment and may contribute to underutilization. It is likely that those who weigh more, and are therefore more stigmatized, will be even more likely to delay or avoid physician visits.

Fat individuals have varying attributional philosophies about their weight, and how they think about it can have profound effects on their social interactions, particularly in situations where a great deal of attention is paid to their weight. In addition to the effect of weight level, it is likely that the attributional philosophy of people who are fat will affect their attitudes toward and relationships with physicians, who typically see obesity as a medical issue. If a fat person's relationships with physicians are stressful and uncomfortable, it is likely to result in lower physician utilization; this is most likely to occur for people whose philosophy differs greatly from their physicians'. If a fat person's attributional philosophy consists of the belief that they are neither responsible for cause nor cure of their condition, their views are likely to clash with that of their physician, and they are likely to react especially negatively to physicians' behavior toward them. Fat people who believe they are responsible for the cause and cure of their condition will be more likely to have a philosophy about weight that is in agreement with their physicians'. They will be more likely not to react in a strong negative manner to the office visit and to the physician's behavior, and may tend to feel that the physician's behavior is justified and appropriate; less conflict should be expected to ensue in the interaction. Consequently, these individuals should be more likely to utilize medical services, while those who do not believe that being fat is a result of their behavior and do not feel they must change will be less likely to choose to interact with physicians.

In addition, people are more likely to take preventive measures regarding their health when they believe positive results will be achievable; those who feel their physicians will not improve their health should be less likely to visit them. Those whose attributional philosophy about weight differs greatly from their physician's would be less likely to believe that seeking help from a physician would result in an improved health status, therefore those individuals would be less likely to make use of physician services.

Statistics on Obesity in the United States

Because there is no uniform method of measuring and reporting obesity statistics, figures tend to vary substantially from one report to another, and many of the numbers are not directly comparable. Reported here are statistics collected by the National Center for Health Statistics from the second National Health and Nutrition Examination Survey (NHANES), conducted from 1976 to 1980, and from the National Health Interview Survey of Health Promotion and Disease Prevention (NHIS) which was conducted in 1985. The former is based on actual physical examinations (height, weight and skinfold measures), and the latter from self-reported height and weight data. While most studies report obesity statistics based on "ideal" or "desirable" weights (usually 20% above these weights merits a determination of obesity), NHANES presents the number of people above the 85th and 95th percentile for the standard of people 20 - 29 years of age; that is, they chose this particular age group as the standard, and then counted the number of people in each age group who exceeded the figures of 20 - 29 year olds at each of these arbitrary cut-points. NHANES refers to people above the 85th percentile as "overweight", and above the 95th percentile as "severely overweight." According to NHANES statistics for the United States for the years 1976-1980, 24% of men and 27% of women ages 20-74 years old are overweight, and 8% of men and 11% of women are severely overweight. The percent of people overweight increases steadily with age (although for men it decreases slightly after age 55), and is greater for blacks versus whites (especially for women). These data are problematic, because the cutoff percentiles are chosen arbitrarily, and because NHANES presumes that any weight gain after age 29 is only fat and is therefore unnecessary (Abraham, Carroll, Najjar, & Fulwood, 1983). The presumption that maintenance of the same weight from age 29 reflects good health and lower mortality has been disputed by Andres, Elahi, Tobin, Muller and Brent (1985) who make the case that, based on mortality data, it is healthier for individuals to gain weight as they age, and they suggest a set of ideal weights that increase by as much as 53 pounds from age 25 to age 65.

Data provided by NHIS are somewhat more useful. Although these data use self-reported height and weight information (which is not necessarily accurate and which would not take into account the ratio of lean tissue to fat), the data are presented as percentages of "desirable" weight, and are therefore more comparable to statistics used in most health reports and surveys where there was either no actual physical examination or where only height and weight was measured. Statistics are presented as percentages over desirable weights based on tables prepared by the Metropolitan Life Insurance Company. Note that like NHANES, these data also assume the same desirable weights for people of all adult ages. According to NHIS, 26% of men and 22% of women are at least 20% over desirable weight. Twelve percent of men and 14% of women are at least 30% above desirable weight.

Stigma of Obesity

There is abundant evidence that fat people are stigmatized, both by the general public and by health care workers. Goffman (1963) defines a stigma as a deeply discrediting attribute one possesses, which results in a spoiled identity. According to Goffman (1963) people tend to avoid, discriminate against and reject individuals who are stigmatized. Stigma often leads to impression engulfment, that is, the person can only be dealt with in terms of his/her deviant mark (Jones et al., 1984). When stigmatized people interact with others it often leads to affective, cognitive and behavioral consequences (Jones et al., 1984). Goffman (1963) discussed three types of stigmas: tribal stigmas of race, nation and religion; abominations of the body; and blemishes of individual character. Fatness might be included in either the category of blemishes of character or abominations of the body. One major difference between obesity and other character blemishes is that obesity is visible, while other character blemishes can be hidden, thereby making possessor's of the latter "discreditable" but not necessarily "discredited". A major difference between obesity and other "abominations of the body" is that possessors of the latter are usually not held responsible for their physical condition, while fat people generally are (Allon,

1982; Cahnman, 1968; Maddox, Back & Leiderman, 1968). Fat individuals have more in common with those who have characterological stigmas (DeJong, 1980).

Interactions between stigmatized and non-stigmatized persons are uncomfortable and anxiety-provoking for both. Because one's stigma is seen as a master status (Goffman, 1963), fatness is often the exclusive focal point of interaction between fat people and those of normative weight (Allon, 1982). Jones et al. (1984) refer to six dimensions which influence people's reactions to those who are stigmatized -- concealability, course, disruptiveness, aesthetic qualities, origin and peril. Concealability, considered to be one of the most important dimensions, is usually not possible for fat people, and therefore makes them especially vulnerable to negative responses from others. As a result of the nonconcealability of the condition, there is great pressure on fat individuals to change the course of their stigma by losing weight. While probably not terribly disruptive in social interactions, fatness is considered extremely unaesthetic. Less attractive people tend to be treated in a more negative manner than those who are more attractive. In regard to origin, fat individuals tend to be seen as responsible for causing their stigma. Obesity may cause some degree of peril in others who are reminded that they too can gain weight. However, peril is probably not a very important dimension of obesity, in the same sense as, for instance, someone believed to have a contagious disease. It is the nonconcealable, unaesthetic qualities, as well as blame for origin and responsibility for course that make fat people the victims of so much negative affect by others.

General Attitudes toward Fat People.

Fat people are judged negatively by others (Allon, 1973; Cahnman, 1968; DeJong, 1980; Hiller, 1981), even by very young children (Richardson, Hastorf, Goodman & Dornbusch, 1961; Staffieri, 1967) and by other fat people (Allon, 1973; Harris, 1982; Maddox, Back & Leiderman, 1968; Rand & Stunkard, 1978). They are believed to be responsible for their stigma, which is seen as immoral -- a "kind of immorality which invites retribution" (Maddox, Back & Leiderman, 1968, p. 288). Negative attitudes toward fat individuals are exacerbated by the public's belief in the person's responsibility for causing their condition (DeJong, 1980). Cahnman

(1968), as a participant observer, studied fat children who attended obesity clinics, and concluded that the stigma fat people face may be worse than that of persons with other stigmatizing conditions, because a "moral factor" is introduced, by which fat individuals are held responsible for their condition, and are seen as being able to control their fate. It is believed that fat people deserve their stigma and should feel mortified and ashamed (Allon, 1973). Harris and Smith (1982) found that substantial numbers of adults believe that fat people can easily achieve a normal weight simply by eating less. According to DeJong (1980), the "naive assumption" that fat people are responsible for causing their condition evokes derogation. However, fat individuals perceived as "doing something" about their weight (dieting) are seen more positively (DeJong, 1980). People are upset at seeing others suffer; yet they feel much less disturbed if the person suffering is seen as deserving it. People want to believe they live in a just world (Lerner, 1970), where people deserve the negative outcomes they get, and that suffering happens only to bad people. Attaching responsibility to an outcome provides individuals with the security that they can avoid a similar state (Lerner, 1970). People are tempted to believe that stigmatized individuals deserve their fate and are somehow responsible for their condition.

Negative attitudes toward obesity are not universal, but are culturally determined, as evidenced by societies in which fatness is a highly valued attribute (Allon, 1973; Beller, 1977; Cahnman, 1968; Dwyer, Feldman & Mayer, 1970; Powdermaker, 1960; Ritenbaugh, 1982).

Attitudes Toward Fat Women

Attitudes toward fat women are much more negative than toward fat men, because appearance is more critical for women (Allon, 1982; Chrisler, 1989; Dwyer, Feldman & Mayer, 1970; McCaulay, Mintz, & Glenn, 1988; Millman, 1980; Wadden & Stunkard, 1985; Wooley, Wooley & Dyrenforth, 1979). Women (fat or normative weight) are much more dissatisfied with their bodies than are men (Allon, 1982; Klesges, 1984; McCaulay, Mintz, & Glenn, 1988), are more likely to be dieting than men (Klesges, 1984; Zegman, 1983) and are consequently at greater risk for eating disorders (Chrisler, 1989; Silberstein, Mishkind, Striegel-Moore, Timko & Rodin, 1989; Wooley & Wooley, 1984). Moore, Stunkard and Srole (1962) found that women are

much more likely to be downwardly mobile if they are fat, while finding no clear relationship for fat men. Although health problems related to obesity appear to affect men much more than women, it is overwhelmingly women who are treated for obesity by the medical profession (Ernsberger, 1984; Fullarton & Pasick, 1978; Maddox, Anderson, & Bogdonoff, 1966; Zegman, 1983), and health care professional literature often focuses on overweight women rather than men (McBride, 1982). Diet pills are prescribed more often to women than men, while physicians are more likely to advise fat men to exercise (Zegman, 1983).

Effects of Attitudes on Self-Esteem and Body Image

The literature on the effect that being fat has on one's self-esteem and body image is mixed. Allon (1973), Leon and Roth (1977), Rand and Stunkard (1978), Stunkard and Mendelson (1967), and Zegman (1983) have shown evidence that being stigmatized because of body size causes many fat people to develop a negative body image. Because their weight receives so much negative attention, many fat people also have been shown to develop low self-esteem (Allon, 1982; Cushman, 1968; Leon, 1982; Sallade, 1973). Belief by others that fat individuals deserve to feel ashamed affects many fat people, who internalize many of the same notions (Allon, 1973). Many fat people begin to believe that other's negative behavior toward them is just. Their sense of shame or guilt prevents them from protesting the negative treatment they receive; they generally lack the type of in-group support that other stigmatized individuals receive such as those who experience prejudice because of their race (Cahnman, 1968).

On the other hand, in an extensive literature review of the effect of obesity on body image and self-esteem, Jarvie, Lahey, Graziano and Framer (1983) found little evidence for pathology in self-esteem, psychological functioning or body image among fat people. However, the authors note that most studies do not take into consideration age of onset or degree of overweight which may prove to be important factors in the development of problems in these areas. Harris and Smith (1983) found that fat and normative weight people had similar self-concept ratings.

Much of the literature on obesity draws a distinction between individuals fat from childhood or adolescence versus those who are not (Bray, 1973); the latter may be more likely to

have become fat through lifestyle changes, rather than genetic/biological influences (Smith & Fremouw, 1987), seem to be more likely to achieve permanent weight loss (Wooley & Wooley, 1984; Smith & Fremouw, 1987) and tend to have a better self-image (Allon, 1982; Stunkard & Mendelson, 1967; Tenzer, 1989) and body image (Zegman, 1983) because they have been spared much of the negative feelings toward them, having not been fat/stigmatized during adolescence, a critical time in the establishment of one's self-image. Some of the damage to the self-esteem of people fat from childhood is caused by their own parents (Tenzer, 1989). Despite the findings about obesity affecting self-esteem more in those who are fat from a young age, Crocker and Major (1989) found that internalization of negative attitudes may be more likely for those people who are stigmatized *later* in life. Many of the findings supporting lower self-esteem in those fat from a young age come from observing clinical populations; the findings might be different if research was conducted on the general population (Jarvie, Lahey, Graziano, & Framer, 1983).

The literature comparing the general psychological health of fat people and those of normative weight has found few differences (Jarvie, Lahey, Graziano, & Framer, 1983; McReynolds, 1982; Wadden & Stunkard, 1985). Klesges (1984) found that global measures of self-consciousness and depression did not discriminate between normative weight and fat individuals, but that similar measures specifically related to weight did show higher depression and self-consciousness levels. While the evidence is weak for general self-concept to be affected by appearance, for measures specifically addressing appearance, unattractive people may have poorer self-concepts (Berscheid, & Walster, 1974).

Negative Attitudes of Physicians Toward Fat People.

Studies have consistently demonstrated that medical professionals have negative attitudes toward fat people. Physicians' attitudes toward fat individuals appear to be shaped by our culture's negative attitude toward obesity, rather than solid medical evidence regarding causes of obesity and a link between obesity and health (Allon, 1973; Maddox & Liederman,

1969; Mann, 1971). Criticism about the presumed causal link between obesity and poor health will be discussed in a later section.

Most members of the medical profession subscribe to the same naive theory of obesity that the general public does -- that fat people are responsible (Chrisler, 1989; DeJong, 1980) and can easily change their condition (DeJong, 1980). Physicians are socialized to see patients as "the enemy", particularly those who are seen as responsible for inducing their illness (Mizrahi, 1986). Physicians refer to fat patients in a pejorative manner and prefer not to work with them (Mizrahi, 1986). They believe that people don't lose weight because they are uncooperative and gluttonous (Stunkard & McLaren-Hume, 1959), out of control (Chrisler, 1989) or not using willpower (Tenzer, 1989). Fat patients are often blamed and criticized by physicians (McBride, 1982; Tenzer, 1989). According to Maddox and Liederman (1969), physicians tend to dislike fat people and believe they are weak-willed, ugly and awkward, and lack control; these attitudes develop as a result of informal experience and middle-class values rather than from any formal training or scientific research. Younger physicians react even more negatively than older physicians (Maddox & Liederman, 1969).

Patients who are believed to be suffering the consequences of self-abuse are seen as less worthy of medical care than those who are not seen as having caused their problem. The former are seen as morally inferior to "innocent" victims. Not having to deal with such undesirable patients is seen as a badge of social privilege (Mizrahi, 1986). Obesity receives punitive behavior from physicians because it has a poor likelihood of cure and is seen as volitional (Maddox, Back & Liederman, 1968). Alcoholism is responded to in a similar way to obesity by the medical profession. According to Murphy (1980), physicians have generally been unsuccessful in treating alcoholism, yet the medical profession continues to define alcoholism as a medical problem. "The medical profession, reproached for this failure, has in turn reproached patients for not seeking its aid and collaborating in the treatment it offers" (p. 418).

People are less likely to help others when they believe the other person is responsible for being in his/her situation, than when the person is not held responsible (Ickes & Kidd, 1976).

Intentional need does not inspire help (Fiske & Taylor, 1984, Ickes & Kidd, 1976). A person who is seen as needing help as a result of not expending effort regarding their situation elicits anger from others who then decline to help (Weiner, Perry, & Magnusson, 1988). Those stigmas seen as controllable and unstable elicit little pity and help-giving (Weiner, Perry, & Magnusson, 1988). It is likely that physicians would be more willing to work with a patient on improving his/her health if they don't feel that the patient intentionally damaged his/her health and if they do not see the person's condition as controllable.

Medical professionals (including physicians, nurses, psychologists and social workers) asked to rank pictures of children with physical and cosmetic disabilities, rated the fat child as the least likeable (Goodman, Richardson, Dornbusch & Hastorf, 1963). In response to an open-ended questionnaire asking about patient conditions that arouse feelings of discomfort, reluctance or dislike (Klein, Najman, Kohrman & Munro, 1982), 34% of physicians listed obesity. Only psychiatric conditions (57%), alcoholism (56%) and drug addiction (42%) were listed more often. Presumably, a closed-ended question listing these characteristics would have produced even higher percentages. The authors speculate that strong negative attitudes toward certain types of patients cause physicians "psychic stress", as evidenced by the considerable anger reflected in the unsolicited comments physicians made to elaborate their responses to the questionnaire. The authors conclude that obesity, and many of the other conditions named by physicians, challenge important components of the protestant ethic. The fact that obesity and other conditions have a low probability of cure challenges a strong faith in science's ability to solve problems. In addition, the protestant ethic stresses achievement, hard work, an obligation to make efforts to improve one's situation and an emphasis on self-denial and self-discipline. If one assumes obesity to be a self-induced and controllable problem, the condition challenges these values. The authors believe that the protestant ethic may be especially strong in physicians because their backgrounds and schooling typically reinforce these values.

Even medical students who had not yet worked with fat patients were found to have negative attitudes toward them; after working with them, their negative attitudes did not change.

Students felt that extremely obese patients were significantly more ugly, more depressed, weaker and worthless than non-obese patients (Blumberg & Mellis, 1985).

These negative attitudes by health professionals almost certainly interfere with the kind of medical treatment fat individuals receive (Maiman, Wang, Becker, Finlay & Simonson, 1979). Using an experimental design, Breytspreek, McGee, Conger, Whatley and Moore (1977) demonstrated that male and female medical students formed different impressions of a fat female patient compared to one of normative weight (both of whom they observed on videotape), and assessed her treatment outcome differently. The fat woman was seen as significantly more defensive, nervous, depressed, emotional, and less likeable, competent, straightforward, attractive and seductive. She was also seen as less educated. On the other hand, she was seen as more sincere and warm. The medical students had a stronger desire to help the fat woman, yet at the same time saw her as less likely to benefit from help. Medical students evaluating interviews between physicians and women patients with vague complaints felt that fat women patients were depressed and nervous, and gave recommendations that the women seek psychotherapeutic help (Allon, 1979). Harris & Furukawa (1986) surveyed elderly people and found that those who were above normative weight did not perceive physicians as discriminating against fat patients. The authors caution, however, that this may be a reflection of the decreased emphasis on attractiveness for those who are older.

Cozens (1982) suggests that health professionals' negative feelings toward fat patients may impair their ability to establish an effective relationship with them. If they assume that the patient's size is a result of laziness and lack of willpower, the professional may feel it is not worth his/her effort to help the patient. This sentiment is echoed by Popkess-Vawter (1982) who states that health care professionals often are insensitive to the needs of fat individuals, and that "an attitude of disgust surrounds this so-called therapeutic environment, and the obese patient is subconsciously, if not overtly, treated as a weak person who lacks 'willpower'" (p. 234).

According to Hahn (1988), "although many non-disabled observers are reluctant to openly acknowledge their aversion to persons with disabilities, there is a strong possibility that

both the prevalent emphasis on disabled people's functional limitations and the pervasive features of an unaccommodating environment disguise widespread feelings of bias or prejudice" (p. 40). Similarly, barriers to adequate health care for fat people and the emphasis on fat individuals ruining their own health may be a reflection of physicians' prejudice about obesity. Medical professionals may not be consciously aware that their actions are preventing fat patients from getting the same level of health care as those who are normative weight.

In spite of abundant evidence that fat people, on average, eat no more than those of normative weight (Huenemann, 1972; Maxfield & Konishi, 1966; Rose & Mayer, 1968; Willmuth, 1986; Wooley & Wooley, 1979), many physicians refuse to believe that their patients are being truthful about the amount of food they are eating, leading Bailey (1981) to make a plea to physicians to "take time to listen to us and believe we are telling you the truth" (p. 227). Physicians express dismay over fat patients who do not see the connection between their "gluttony" and their obesity. They use this as justification for the contempt they feel for their fat patients. For instance, the following quote by a physician illustrates the way in which he completely discredits patients' statements regarding their food intake:

[This] denial of responsibility can reach quasi-delusional proportions. The perception that the body functions entirely in accordance with its own rules, which have no physiologic basis, and that its functioning is altogether unconnected with any activity of the self (notably eating and exercise) can be unshakable. (Altshul, 1981, p. 543)

Similarly:

Many of us are familiar with the way obese people underestimate their food intake. Physicians who set a high store by integrity and truthful dealings are often shocked and repelled by this behavior. . . [resulting in a] punitive attitude [by the physician]. (Stunkard & Reader, 1958, p. 82)

Although there have been numerous studies of physician attitudes toward obese people, none has studied the *actual* behavior of physicians toward their patients to establish whether they do, in fact, act differently toward them. However, studies do exist which show that physicians who hold negative attitudes toward a group are more likely to provide poor treatment, or no treatment at all to members of the group (Breytspraak, McGee, Conger, Whatley & Moore, 1977; Klein, Najman, Kohman & Munro, 1982; Mizrahi, 1986), and this differential treatment

occurs in an environment that reinforces this behavior (Link, 1983). Not only has physician behavior toward fat patients not been studied, but fat patients themselves have rarely been studied at all in this context. While fat patients are considered in the discussion section of many of the physician attitude studies, and are presumed to be negatively affected by physicians' attitudes toward them, few have studied fat patients' attitudes toward their physicians, or their reports of their experiences with physicians. The current study will address this gap in the literature.

Relationship Between Obesity and Health

While there has been much medical literature linking fatness with health problems, much of this research has been questioned in the last decade (Bennett & Gurin, 1982; Ernsberger & Haskew, 1987). The widespread belief among physicians that even moderate obesity causes illness is partly based on poorly-interpreted statistical data and is fueled by a culture that finds obesity repugnant. Numerous biomedical researchers conclude that the relationship between obesity and poor health is a complicated one, and that a causal relationship cannot be established based on available evidence. Many agree that there is no relationship at all between poor health and moderate degrees of obesity; at higher levels of obesity, certain illnesses show up in greater numbers in this population, but are not necessarily *caused* by obesity. Much of the data commonly referred to in the medical field are based on insurance data which have been critiqued repeatedly because these data are not representative of the population (Ernsberger & Haskew, 1987; Fitzgerald, 1981; Fullarton & Pasick, 1978; Mann, 1974) and are biased against fat people who have to pay a higher premium than others for life insurance and are therefore more likely to buy insurance at a time they feel it will pay off. Most studies of cardiovascular disease and mortality rates that do not use insurance data (e.g., Seven Country Study, smaller industrial studies) show little or no relationship of fatness to heart disease or premature death (Ernsberger & Haskew, 1987). Several studies even show mild overweight to be associated with an *improved* mortality rate. Obesity is rarely an independent risk factor in disease (Fullarton & Pasick, 1978). There is

little convincing evidence that when fat people with chronic illnesses lose weight their health is improved (Mann, 1974). Furthermore, there are many diseases which fat people get less frequently than the rest of the population (e.g., cancer, infectious diseases, osteoporosis), and other diseases for which they have a much more favorable prognosis (e.g., cardiovascular disease, diabetes) (Ernsberger & Haskew, 1987).

A perseverance effect occurs when individuals persist in stubbornly believing old information they have, even in the face of evidence to the contrary (Fiske & Taylor, 1984). Despite much evidence to the contrary, physicians tend to believe in a strong relationship between fatness and health problems. Fitzgerald (1981), commenting on the equivocal evidence for a strong connection between obesity and health, says that "in view of the conflicting data, the patent cultural biases under which we labor, and the possible harmful effects of therapy, it seems best that physicians examine the problems of obesity with the same keen skepticism and science they apply to other unsettled issues. To treat disease in the obese is obviously good. To treat simple obesity as a disease may be another matter entirely" (p. 228).

The Role of Stigma in Causing Poor Health.

Health and Dieting

Many fat people diet in an attempt to change their stigmatized status. The diet industry earns an estimated \$33 billion dollars a year (Beck, 1990). More than two-thirds of women who perceive themselves as overweight to any degree are trying to lose weight (Dawson, 1988). The choice of study populations used in research on the medical effects of obesity has been criticized, because most studies use fat people who have dieted all of their lives and dieting itself can cause many medical problems. One explanation for the correlation between obesity and poor health is the ill effects on health of losing and gaining weight repeatedly through dieting (Allon, 1982; Bennett & Gurin, 1982; Ernsberger, 1982; Smith & Fremouw, 1987). Some negative health effects of dieting include: reduction of muscle, particularly heart muscle (Ernsberger, 1982); lack of energy causing decreased physical activity (Bennett & Gurin, 1982); rapid regain of weight after dieting causing hardening of arteries (Ernsberger, 1982); diets

causing increased salt retention leading to high blood pressure (Ernsberger, 1982); heart rhythm problems and sudden death from certain popular diets (Bennett & Gurin, 1982); eventual greater weight gain than loss from repeated dieting (Bennett & Gurin, 1982). In addition, dieting has been found to contribute to eating disorders (Polivy & Herman, 1985; Willmuth, 1986).

Stress, Stigma and Health

Research indicates that there may be a relationship between stress and illness (Kanner, Coyne, Schaefer, & Lazarus, 1981; Rodin & Salovey, 1989; Taylor, 1990). Stein, Keller, and Schleifer (1985) review evidence showing a link between stress and activity of the central nervous system. There is increasing evidence that the autonomic reaction to stress is related to the development of heart disease, particularly if the stress is of long duration (Adler, 1989). Stress has been found to alter the body's immune function.

Several researchers have hypothesized that the impact of constant emotional stress resulting from being stigmatized may be the cause of some of the ill health found among fat people (Allon, 1982; Fitzgerald, 1981; Seidell, Bakx, Deurenberg, Burema, Hautvast, & Huygen, 1986; Smith & Fremouw, 1987; Wooley & Wooley, 1979). Everyday "hassles" and "uplifts" appear to be more highly correlated with psychological stress than are stressful life events (Kanner, Coyne, Schaefer, & Lazarus, 1981). Hassles are defined as everyday demands of the environment that are irritating, frustrating and distressing, while uplifts include activities such as relaxing or spending time with one's family. One of the items included in the Hassles Scale (Kanner, Coyne, Schaefer, & Lazarus, 1981) is prejudice and discrimination by others. However, it has been difficult to establish definitively whether day-to-day stress does in fact cause ill health (Taylor, 1990).

One study which does lend support to the theory that stress from stigma causes ill health, focused on a U.S. community that had an extremely high incidence of obesity (Stout, Morrow, Brandt & Wolf, 1964). It is likely that in this community, compared to other U.S. communities, people were not stigmatized or were much less stigmatized because of their weight due to the high incidence of obesity. The researchers found that in this community there was a lower

incidence of heart attacks than among average slender Americans. Those who eventually moved from this community to other areas later had an incidence of heart attacks equivalent to average U.S. figures. Wadden and Stunkard (1985) state that "the suffering associated with the psychological complications of obesity probably exceeds that associated with its physical complications" (p. 15). The National Institutes of Health Consensus Development Panel on the Health Implications of Obesity concluded that the psychological burden of being fat "may be the greatest adverse effect of obesity" (National Institutes of Health, 1985, p. 1074).

Other Explanations for Poorer Health Among People Who are Fat

Other possible explanations for the correlation between obesity and poor health include: the inherent health risks of some medical treatments for obesity such as diet pills or surgery (Ernsberger, 1984; Fitzgerald, 1981; Wooley & Wooley, 1979); lack of exercise among fat individuals because of the harassment and ridicule they are subjected to (Ernsberger, 1982; Packer, 1989; Wadden & Stunkard, 1985); reluctance to engage in other health-promoting behaviors when one is fat (Ernsberger, 1982; Ernsberger & Haskew, 1987); and a feeling of desperation which leads people to smoke cigarettes in order to reduce caloric intake (Popkess-Vawter, 1982) and to try other extremely unhealthy weight loss methods (Mann, 1971), many of which are advocated by physicians (Bruch, 1970; Ernsberger & Haskew, 1987). In addition, some medical conditions may be causes of obesity rather than effects. For example, there is some evidence that a hormone, amylin, may be responsible for causing both diabetes and obesity ("Does Obesity Cause Diabetes", 1989). Another example is arthritis that causes lessened physical activity which may lead to weight gain.

Considering the negative attitudes exhibited by medical professionals, it should not be surprising that the effects of stigmatization have rarely been considered by them in addressing the negative health effects of obesity. That obesity should be seen as the cause of illness was inevitable, according to Mann (1974), and "may be seen to be a just reward, at least by some thin moralizers addicted to the ascetic work ethic that many Western societies prize" (p. 178).

It has been suggested that, rather than advocate weight loss to individuals for whom success is unlikely, psychological support should be offered instead to help overcome the impact of society's negative attitudes toward fat people (Smith & Fremouw, 1987). It is likely that improved attitudes on the part of health professionals would result in better health care for fat people, and those more positive attitudes may help fat patients feel better about themselves, which may lead to lower daily levels of stress and a consequent improvement in health.

Physician Attitudes Regarding Weight and Weight Loss

Physicians' Belief in a Strong Link Between Obesity and Health

In February 1985, The National Institutes of Health (NIH) gathered together a panel of people working in the field of obesity, in order to come to some consensus about what the health implications of obesity are (National Institutes of Health, 1985). The conference statement reported that being 20% or more above desirable weight is an established health hazard, and listed health conditions which tend to show up in greater numbers among fat people. The report recommends weight reduction for those 20% or more above desirable weight and also for those less than 20% overweight who have certain physical conditions. These recommendations were made even while the report acknowledges the flaws in using insurance data to determine desirable weight, the problems in the way that obesity is defined, and the fact that psychological suffering is the worst effect that obesity has on people. Conspicuously absent from the report are recommendations for how individuals can effectively lose weight.

The NIH panel's recommendation is evidence to the strong belief among medical practitioners that even low levels of obesity lead to poor health. Although there is much evidence to the contrary in regard to low to moderate levels of obesity, the NIH panel voted for recommendations that fell squarely on the side of a strong obesity/health link.

Despite the questionable findings about obesity and health, physicians still blame health problems on weight and prescribe weight loss to their patients (Tenzer, 1989) as part of their medical treatment. The practice of physicians discussing weight loss with their patients is widely

accepted, considered part of appropriate medical care and thought to be useful to the patient. The U.S. Preventive Services Task Force recently concluded that physicians should take an active role in encouraging patients to change unhealthy behavior, and to counsel patients on nutrition; however this suggestion was met with caution by health psychologists who suggest that physicians may achieve very little in these areas through the use of brief intervention strategies (Moses, 1989). One strategy used by many physicians is that of attempting to frighten a patient into losing weight by pointing out all the health consequences. For instance, Vener, Krupka and Gerard (1982) advocate the use of threatening messages by physicians for some fat children, who the authors believe will be helped by this method: "The use of threats such as 'overweight children become fat grown-ups with more heart attacks' is effective with some children." (p. 1108). Using fear to promote healthy behaviors has proved unsuccessful, because it tends to undermine people's beliefs about their self-efficacy to control health threats. Frightening people does not necessarily make them act (Bandura, 1986).

Evidence that physicians tend to see fatness as a medical problem and to prescribe weight loss to their patients is provided by data from the 1985 National Ambulatory Medical Care Survey (NAMCS) of the National Center for Health Statistics, analyzed by Packer (1988), which compared patients diagnosed as obese with the presenting symptom of the patient. While 67% of the patients diagnosed as obese (specifically: "Obesity and other Hyperalimentation") had come to the physician with symptoms directly relevant to this diagnosis (specifically: "Weight Gain"; "Diet and Nutritional Counseling"; and "Abnormal Appetite"), fully 33% of the patients whom a physician diagnosed as obese had made an office visit because of other concerns, the largest category being the need for a general medical examination. Seventy-six percent of people diagnosed as obese were given or referred for diet therapy, compared to 7% of those who were not diagnosed as obese. The majority (66%) of those who did not come to see their physician for an obesity complaint were given or referred for diet counseling.

Physician Interventions for Weight Loss

One might question whether the issue of weight and weight loss should be considered to be within the province of the general practitioner. Most studies of weight loss programs, many of which are medically supervised, show tremendously high recidivism rates (Foreyt, Goodrich, & Gotts, 1981; Stunkard & McLaren-Hume, 1959). When participants are followed for several years after their initial weight loss, many studies show that as high as 95 to 99 percent of persons who lose weight gain it all back (Bray, 1979; Stunkard & McLaren-Hume, 1959). It has been argued that this enormously high recidivism figure may be the result of basing long-term success rates on people who are in treatment, rather than those in the general population (Krantz, Grunberg, & Baum, 1985). One study (Schacter, 1982) has shown a much greater success rate among those in the "general" population who are not in weight loss programs. However the author studied two populations among whom it would be unlikely to find many fat individuals to begin with (Columbia University graduate psychology students, faculty and staff; and residents of a seaside resort town). Schacter's low rates of obesity in his population compared to wider population studies have been critiqued by Jeffery and Wing (1983). Further critique of Schacter (1982) was made by Cohen et al. (1989). Schacter had made a parallel argument for both the cure of obesity and the cure of smoking, providing data from the same populations for both; Cohen et al. examined data from a large number of studies on smoke cessation and found that people who attempt to quit smoking on their own rather than by attending a formal program are no more likely to be successful quitters, and, in fact, seem even less likely to quit. Presumably, similar findings would obtain for obesity.

Many people who do succeed in losing weight eventually gain back even more weight than they lose. This effect may be the result of the dieter's basal metabolic rate slowing down in an attempt to function daily on sub-normal amounts of calories (Apfelbaum, Bostjarron, & Lacatis, 1971; Bennett & Gurin, 1982; Smith & Fremouw, 1987; Zegman, 1983). It is believed that repeated regaining of weight ("yo-yo dieting") is more dangerous medically than is maintaining a steady, albeit high, weight level (Allon, 1982). In addition to studies of food intake, cited earlier,

that have consistently shown that fat people eat no more than those of normative weight, many studies comparing the exercise rates of fat and normative weight people also show no differences, although findings have not been as consistent (Geleibter, 1982) -- approximately half have shown fat individuals to be less physically active, while the other half have found no differences. The former studies may have been unduly influenced by fat people's feelings of self-consciousness or embarrassment in being watched during sports and other exercise activities (Allon, 1982).

Recent studies show obesity to have a strong genetic component (Ravussin et al., 1988; Roberts, Savage, Coward, Chew, & Lucas, 1988; Stunkard, Sorensen & Hanis, 1986). Many researchers in this field acknowledge that for a fat person to lose weight and keep it off, he/she must be vigilant about every calorie of intake, and must undereat for the rest of his/her life (Nisbett, 1972), which may lead to emotional stress, obsessive preoccupation with food, overresponsiveness to food cues and resentment at having to spend intense energy to maintain an acceptable body size that others achieve without effort. Others have stated that no effective treatment for obesity exists (Wooley & Wooley, 1979; Zegman, 1983). Wooley & Wooley (1982) have stated that "except for a minority of extreme cases, there is no such 'disease' as obesity; treatments have failed because there is nothing to 'cure'; they are dangerous because they are bred out of desperation and ignorance" (p. 68).

Most physicians do not expect fat patients to be successful at losing weight (Maddox, Anderson & Bogdonoff, 1966; Maddox & Liederman, 1969; Rothert et al., 1984) and tend to believe that weight loss management efforts overseen by physicians are not likely to bring success (Maddox & Liederman, 1969), yet they continue to prescribe diets and medication, and admonish their patients for being fat. There is no medical intervention that produces a higher success rate for weight loss than any other methods commonly available (with the possible exception of surgery, which is dangerous and very often life-threatening -- Ernsberger, 1984; Smith & Fremouw, 1987; Vener, Krupka, & Gerard, 1982), and some research indicates that physicians have even less success (Stunkard & McLaren-Hume, 1959). In addition, when

physicians oversee the weight loss attempts of patients, they often prescribe diet pills (Stewart & Brook, 1983), which have repeatedly been shown to be ineffective in the long run, and are potentially quite harmful (Stewart & Brook, 1983; Vener, Krupka, & Gerard, 1982).

Amphetamines can cause addiction and may contribute to high blood pressure and heart disease (Fitzgerald, 1981). One study found that 75% of physicians surveyed gave fat patients diet pills; 43% gave them to those only "slightly" overweight (D'Amelio, 1976). Another study found that 32% of physicians give diet pills to a majority of their fat patients (Lasagna, 1973). Interestingly, D'Amelio (1976) reports that only 11% of physicians advised fat patients to get more exercise, which is believed by many to be the only effective method for permanent weight loss (Bennett & Gurin, 1982; Mann, 1971). According to an article on the American Society of Bariatric Physicians Conference ("Executive Director Address", 1989), many bariatric physicians are still prescribing diet pills to their patients. However, a publication put out by the Department of Health and Human Services (1989) states that amphetamines are used much less frequently now for treating obesity because of their addictiveness and their adverse effects on the heart and the central nervous system. On the other hand, one billion over-the-counter diet pills (phenylpropanolamine) were sold in 1983 (Dawson, 1988). A recent article (Silverstone, 1987) presents the point of view that while diet pills have fallen out of favor in recent years, they are still a helpful adjunct for weight loss, and the author suggests that stimulants are appropriate for lethargic patients. He admits that once the drugs are stopped, patients will usually gain their weight back, and suggests that if this occurs, drug treatment continuation over a long period of time is warranted. Similarly, Munro (1987) feels that "it may well be that the price that has to be paid for effective drug treatment of obesity is life-long [pharmaco]therapy" (p. 15).

Social Factors and the Perception of Obesity

There is some evidence that social factors strongly influence which people physicians tend to treat for obesity, and that it is not simply a matter of a person being a particular percentage overweight. Using NAMCS data, Packer (1988) looked at obesity diagnoses given by physicians, broken down by demographic characteristics. Although only 27% of patients studied are in the

age range 25-44 years, this is the category with the largest number of people diagnosed as obese (46%). Twenty-eight percent of those diagnosed as obese were in the 45 - 64 category and 9% were those over 65. This is in contrast to statistics from NHANES showing that individuals tend to gain weight as they get older and that there is more obesity in the higher age ranges, especially among women. According to data from NHIS, the numbers are about the same at all age ranges.

While 61% of office visits were made by women, 83% of obesity diagnoses were made for females. Although there were less than two times as many women than men in the 25-64 year old categories, women were diagnosed as obese more than 4 times as often. In the over 65 category, women only outnumber men by 3 to 2, yet are *sixty* times more often diagnosed as obese. In every age category for men, a smaller proportion are diagnosed as obese than would be expected based solely on the numbers of men in these age categories. There is little correspondence between the NAMCS findings and the numbers of objectively obese people in these demographic categories in the United States. The numbers may not only reflect the fact that physicians' diagnoses are influenced by social factors, but also that more women or younger people are presenting themselves to physicians with weight as the presenting problem. Therefore, either the way in which diagnoses are made and/or the reasons that certain groups of people seek medical help for obesity is influenced by social factors.

The main problem with the NAMCS data is the lack of information on patients' actual weight and degree of fatness. A smaller, local study (Franks, Culpepper, and Dickinson, 1982) looked at how social factors affected diagnoses, using objective data on degree of obesity, and obtained similar findings, particularly regarding women being diagnosed as obese much more often than men. In contrast to the findings of Packer (1988), however, this study found those over forty years old to be more likely to be diagnosed as obese. The authors conclude that the ascription of a diagnosis of obesity is "affected by complex social and psychological interactions between physician and patient" (p. 746).

Social factors not only cause differential diagnoses of obesity, but also strongly influence which people will be most affected by being fat. Using data collected as part of the Rand Health

Insurance Experiment, Stewart and Brook (1983) found that 41% of people ages 14 and up consider themselves overweight, in contrast to about 24% who are overweight using objective standards (weight-for-height measures). Almost all individuals (88%) who perceive themselves as overweight worry about their weight and 18% experience some restricted physical activity. Some of this may be attributable to the stigma of being overweight -- while we would expect restriction of activities due to weight to be positively associated with increasing age, in fact both restriction of activities and worry about weight *decrease* with age. In addition, many more women than men experience these negative effects of overweight. People who try harder to lose weight are typically young women who experience more pain and worry, and who actually weigh less.

Of those in the Rand study who believe they are overweight, 7% are under a physician's care in order to lose weight. Women, and those who are considered severely overweight, are more likely to be under a physician's care. While 91% of these people are on reducing diets, an additional 41% are using diet pills.

The authors conclude that there are two approaches physicians can take with moderately overweight people, for whom there is little evidence for premature mortality. One approach would be to encourage weight loss; however, according to the authors, the effectiveness of weight-loss techniques must be demonstrated before this can be advocated. If efficacy cannot be shown, then "a large segment of the population may find themselves under expensive physician care . . . that [is] no more efficacious than individual approaches" (p. 177). The authors emphasize that a large proportion of patients are taking reducing pills "which may be no more effective than diet, and can under some circumstances do harm" (p. 177). The other approach they suggest is for the medical profession "to work toward legitimizing being moderately overweight . . . because . . . trying to lose weight and not being successful at it may do more harm than good" (p. 177). The negative effects of fatness that result from stigma may be minimized if physicians take the latter approach.

The Consequences of Physicians' Attitudes Toward Fat People

Ironically, with the intention of helping their fat patients, there are many ways in which physicians' behavior toward fat patients might conceivably contribute to further ill-health. As already stated, medical treatments for obesity are harmful to people's health (Ernsberger, 1982). Treatment by medication and/or surgery is extremely dangerous (Ernsberger, 1984; Smith & Fremouw, 1987; Vener, Krupka, & Gerard, 1982). Surgeons may delay *needed* surgery because of their belief that surgery is hazardous for fat people; despite this belief, approximately half a million fat people have had *weight-loss* surgery performed on them (Ernsberger, 1984). An editorial in *Lancet*, a medical publication, warns physicians that it is not their job "to increase the risks of the obese life with drastic cures" ("Drastic Cures," 1970, p. 1094), and suggests that surgery for obesity is punishment, similar to cutting off the hand of a cigarette smoker.

Physicians Attributing Symptoms to Obesity

Attempting to understand the underlying causes of events gives meaning to a person's experiences and makes the world seem more predictable and controllable. People primarily ascribe the cause of events to either personality or to environmental factors (Heider, 1958). Negative events, such as having a stigma, initiate a search by others for the cause (Weiner, Perry, & Magnusson, 1988). People whose appearance is unusual will cause attention by others. This attention encourages stereotyping and exaggerates causal perceptions (Fiske & Taylor, 1984). There is a tendency for individuals to overattribute behavior to a person's stigma (Jones et al., 1984). Similarly, they may be likely to overattribute characteristics as well. Physicians are likely to overattribute symptoms in a fat patient to their obesity because people tend to use shortcuts, or cognitive biases, so that they make judgments which are not totally based on the available information. Physicians may be using a "representativeness" bias (Tversky & Kahneman, 1982), whereby they may mistakenly assume a particular symptom to have stemmed from obesity because there happens to be a correlation between obesity and the symptom, and the "availability" heuristic (Tversky & Kahneman, 1982) may be contributing to this diagnosis because

other cases of fat people with the symptom easily come to mind. People tend to be selectively attuned to evidence that is confirmatory of their expectations (Jones et al., 1984). People tend to remember schema-consistent information (Fiske & Taylor, 1984), and are more likely to make inferences about out-groups with less information about them, because they have stereotyped schemas about them. Once a person is categorized, it slants the other's perception of him/her so that their behavior seems consistent with the stereotype. When people have certain expectations of someone, they will reinterpret the available evidence so that it fits in with the original expectation (Fiske & Taylor, 1984). Since many health professionals start out with negative attitudes and expectations, they may as a result see their patient's behavior as being in line with their negative expectations, and may not be compelled to look further at other possible causes of health problems. It is possible that physicians overattribute fat patients' symptoms to their weight because their stigma is so salient.

A tendency to attribute symptoms to obesity may lead in many cases to misdiagnosis and a consequent lack of treatment for the real cause of the medical problem. Instead of directly treating symptoms, physicians may inform the patient that they must diet, while allowing a dangerous medical situation to continue untreated. Haynes (1986) reports that physicians confronted with a hypertensive fat patient may delay implementing effective treatment, waiting for the patient to lose weight. According to Tobian (1978), if physicians wait to see if a diet will lower blood pressure while withholding blood pressure medication, the person's heart and arteries will be needlessly subjected to the stress of hypertension. Weight loss is often not possible; therefore the physician should be treating high blood pressure with medication, not waiting for the patient to lose weight (Fitzgerald, 1981). Emsberger and Haskew (1987) suggest that physicians' emphasis on weight loss prevents them from employing more useful preventive measures. For example, because fat women are more likely to develop cervical cancer, it would be advisable for a physician to suggest frequent pap smears; however, many physicians will instead exhort the patient to lose weight as the only preventive measure.

According to Meyerson (1988), while devalued groups are often seen as inherently inferior, that inferiority is often due to environments that limit the group's opportunities. Often self-fulfilling prophecies occur when a belief holder restricts the behavioral opportunities of the stigmatized person (Jones et al., 1984). If physicians tend to believe that fat people are unhealthy, and therefore physicians offer them little in the way of preventive health care, it is likely that fat individuals will become less healthy as a result.

Attributing Own Symptoms to Obesity

Fat people who believe they should diet may, like their physicians, attribute their own symptoms to their fatness; this may lead them to feel there is no need to visit a physician for these symptoms because they feel that if they lose weight the problem will be resolved. Although there has been no research conducted to determine whether fat people do, indeed, attribute symptoms to their weight and therefore delay treatment, similar research has been done with elderly people (Prohaska, Keller, Leventhal, & Leventhal, 1987), which has demonstrated that older individuals tend to attribute many symptoms to their age, leading to a reduced emotional response to the symptoms and a consequent delay in seeking treatment. This attribution may prevent them from taking action which might be beneficial to their health.

On the other hand, fat people who do not diet may not attribute symptoms to their weight but may be even more reluctant to visit a physician for symptoms that are considered weight-related, because they believe that the physician will not treat their symptoms, and will instead exhort them to lose weight.

Health Care Utilization

Compliance in health matters is increased when patients feel they are liked and respected by the health care provider, and where there is good communication between them (DiMatteo, 1979; Elling, Whittemore & Green, 1960; Krantz, Grunberg, & Baum, 1985; Rodin & Janis, 1979; Roter & Hall, 1989; Stone, 1979). Whether or not one has a collaborative relationship with their physician (DeAngelis, 1988) and the interpersonal message that the medical doctor gives to the patient (Stone, 1979) have a strong impact on adherence. Lack of rapport between physician and

patient leads to low patient satisfaction (DiMatteo, 1979; Krantz, Grunberg, & Baum, 1985) and causes patients to change primary care physicians (DiMatteo, 1979). Satisfaction with one's physician is an important predictor of whether a patient will follow his/her medical suggestions (DeAngelis, 1988; Stone, 1979) and whether the patient will return for subsequent visits (Stone, 1979). Compliance has been increased by training physicians to communicate effectively with patients and teaching physicians to address patient concerns in a more sensitive manner (Krantz, Grunberg, & Baum, 1985); improvement in physician's interpersonal skills may increase the effectiveness of medical treatment (DiMatteo, 1979).

Using a meta-analysis of over one hundred studies of doctor-patient interaction, Roter and Hall (1989) found that patient satisfaction and compliance was positively related to what they call "positive talk", which includes tension release, the physician giving approval or sympathy, using humor, friendly rapport or encouragement; "negative talk", such as anger, irritation, tension, or being critical is negatively related to satisfaction with physicians. The authors conclude that improvements in communication between patient and physician will result in better diagnosis and treatment, as well as higher satisfaction and compliance. Stone (1979) has remarked that hostility and tension in the physician/patient interaction lead to noncompliance.

While approximately half of patients don't comply with medical recommendations, compliance has been found to be related to certain background characteristics; it has been shown to increase with age, education, socioeconomic status, and to be higher among whites (Stone, 1979). Those who are at higher socioeconomic levels are likely to have more medical knowledge (Kirscht, 1983) and are more likely to seek health care (Kirscht, 1983; Ossenberg, 1962; Safer, Tharps, Jackson, & Leventhal, 1979). Whether or not one has health insurance, a regular source of medical care, the number of days someone is ill and self-reported state of health all contribute to the likelihood that he or she will use a physician's services (Becker & Maiman, 1983; Kirscht, 1983). Women utilize medical services more than men (Kirscht, 1983; Safer, Tharps, Jackson, & Leventhal, 1979); whites tend to use these services more than non-whites

(Safer, Tharps, Jackson, & Leventhal, 1979); and the greatest utilization is for those who are in their middle years (Kirscht, 1983).

According to the Health Belief Model, people are more likely to engage in preventive health measures when they believe they are susceptible to illness, that the consequences will be severe, that taking action will have positive benefits and that there are few barriers to action (Kirscht, 1983). Becker & Maiman (1983) define barriers to health care as the "unpleasantness or cost of taking the health action compared with taking no action and suffering the consequences" (p. 563). Of all the factors in the Health Belief Model, "barriers" has been shown to be the most important aspect of this model (Janz & Becker, 1984), surpassing even "benefits" in importance. Barriers are usually considered to be related to accessibility and availability of services, but negative feelings about potential interactions with medical care providers and feelings of low self-efficacy to produce required health outcomes are also formidable barriers. People are more likely to seek treatment if they believe their symptom will be cured (Safer, Tharps, Jackson, & Leventhal, 1979). Unless a person believes that a medical intervention will be efficacious, he or she will usually not seek preventive care (Becker & Maiman, 1983). People engage in health-promoting behaviors when they feel they are able to master and adhere to such behaviors (Bandura, 1986). People often give up trying to do something because they do not believe they can perform the required action, or because they don't believe their efforts will produce results due to a punitive environment, unresponsiveness or negative bias (Bandura, 1982). Rosenstock (1966) suggests that if an action is seen as being unpleasant, painful or upsetting a person may not attempt it, even if they think the action will be effective. According to Jones et al.'s (1984) definition of interpersonal power, physicians have differential power over their patients, and this power differential should be even more asymmetrical with stigmatized patients. Before a person will seek help from a health care provider, he or she takes into consideration the costs of taking action, including the cost of stigma and of feeling humiliated (Mechanic, 1978). These feelings may occur in anticipation of the way the person will be treated by his/her physician (Mechanic, 1978).

According to Antonovsky (1972), among the variables determining the likelihood that a person will visit a physician are the absence of stigma attached to visiting the physician and welcoming behavior on the part of the physician. The reasons individuals will decide to visit a physician are extremely varied. Some will go only when in extreme pain while others will go for preventive purposes at times when they are experiencing no symptoms at all. The majority of physician visits are for fairly minor disorders (Antonovsky, 1972; Zola, 1973). Also taken into consideration are possible competing interpretations for symptoms experienced (Mechanic, 1978). People estimate the likelihood that a treatment plan will help them in combatting illness, and people rely on their past memories to determine these probabilities (Fabrega, 1973). It would follow that memories of futile experiences in seeking health care would lead an individual to believe there is a low likelihood of receiving help in a current situation.

Because of negative attitudes displayed by physicians, fat people may begin to see their physicians as adversaries, which may then cause them to delay seeking needed medical care until it is too late (Allon, 1982). The fatter a person is, the more likely he/she would be to experience negative attitudes from physicians, leading to lower compliance, lower satisfaction and consequently lower health care utilization. Focusing on weight loss can disrupt the physician-patient relationship, lessening the probability that even health problems unrelated to weight will be addressed. Stunkard & McLaren-Hume (1959) found that 39% of medical clinic patients who were referred on to a hospital nutrition clinic to lose weight never returned to the nutrition clinic and fully 28% never returned to the medical clinic at all, not even for the reason they initially visited. A fat woman who now has cancer of the cervix wrote a letter to a medical journal in order to inform physicians about the role her weight played in her developing cancer. Her letter states that she did not have a pap smear for five or six years because "I was afraid my doctor would 'yell at me' about losing weight . . . I have tormented myself: I should have gone in earlier. I should not have cared what the doctor would say about my being fat" (Tiffany, 1986, p. 29).

Helplessness about Improving Health

One method by which stigmatized individuals preserve their self-esteem is by avoiding circumstances where the disadvantages of their stigma are emphasized (Crocker & Major, 1989) or where their stigma is particularly salient (Jones et al., 1984). For example, fat individuals may avoid physical exercise because it is an area in which they usually do not excel, and because it usually takes place in circumstances where their stigma becomes the focus (Packer, 1989). By the same reasoning, some fat people, particularly those who are not losing weight, may feel that health is an area in which they have little hope for success, and they may avoid seeing physicians because that situation is one that is particularly stigmatizing -- it is a situation in which the stigma of obesity is focused on and where the person is often given a clear message that he/she is not living up to expectations. Facing an actual situation in which one has no control over outcome may eventually lead to a feeling of helplessness (learned helplessness), whereby one stops trying to affect the outcome (Abramson, Garber, & Seligman, 1980). Those who see themselves as having little control may eventually cease any effort to change outcomes. The fact that there is such a pervasive belief that fatness automatically causes ill health may affect the fat person by causing them to give up on other areas of health; they may feel that their fate is sealed by being fat, and therefore question why they should bother to engage in other health-related behaviors (Ernsberger, 1982). The medical community encourages this way of thinking by leading patients to believe that losing weight is the only way their health can be improved. Fat people may believe that they have already failed at the one important thing they need to do for their health, and therefore not attempt to engage in health-promoting behaviors such as eating nutritional foods, getting regular exercise, and seeking health care for symptoms. Packer (1989) found that individuals who were dieting were more likely to be exercising than they were at a time when they were not dieting. According to Hollis, Carmody, Connor, Fey, and Matarazzo (1986), the heavier the people were that they studied, the more likely they were to feel helpless about eating healthfully. According to the authors, this feeling of helplessness may be an effect of

experiencing failure in weight control efforts. Repeated failure at dieting contributes to low self-esteem and feeling out of control (Willmuth, 1986).

Helplessness around the issue of health may cause delay in seeking medical care. According to Hayes and Ross (1987), "If people do not believe their actions are effective, no matter how much they are concerned with health, they will do little actively to protect it" (p. 128). Crocker and Major (1989) state that even if a particular goal is valued, if a person feels that it is not attainable he/she will not be motivated to strive for it. Because of the failure of dieting to produce long-term weight loss in the overwhelming majority of fat people, physicians' emphasis on dieting may cause fat people to feel they have little control over maintaining good health which may lead them to avoid physician visits. On the other hand, different types of preventive health actions, such as going for physical checkups, versus engaging in health practices such as dieting, may be relatively independent of each other (Kirscht, 1983); therefore, failure to diet might not cause a global feeling of helplessness over health among fat people. Abramson, Seligman, & Teasdale (1978) stress the importance of looking not only at internal versus external attributions, but also at global versus specific causes and stable versus unstable causes when addressing the issue of learned helplessness.

Coping Strategies and Attributional Philosophy about Weight

Coping Strategies Used by Stigmatized People

Jones et al. (1984) state that there are several options by which stigmatized individuals may manage their self-presentation through strategic alternatives. They may engage in "situation-selection", that is, they may carefully choose the interpersonal settings they enter, in order to have greater control over their self-presentation. They may choose to withdraw from some interaction situations, including those situations that might provide benefits to the person, if the potential benefits are not perceived as worth the costs of discomfort. Stigmatized people may need to make a conscious decision each time contact is made with others about whether the interaction is worth possible humiliation and negative reactions (Jones et al., 1984). Fat people

may therefore choose to avoid physician-patient situations whenever possible. However, another option is role acceptance -- stigmatized individuals get certain advantages by "knowing their place" and by confirming others' expectations of them. Resisting stereotypes can require a great deal of commitment and personal resources. Therefore, people who accept the "obese role", and who internalize the negative stereotypes and attempt to diet, should be less likely to avoid the physician's office because of overt conflict.

Other authors have discussed the different types of strategies that stigmatized people may choose to use in order to deal with their status. Many of the strategies discussed in the literature seem to be divided into two options -- that of either internalizing and accepting the negative beliefs about one's stigma or rejecting those beliefs. While Goffman (1963) has stressed the efforts of stigmatized people to "pass" as normal, some recent research on disability has focused on disabled people who do not accept society's definitions of themselves as having a negative characteristic, but instead attempt to gain self-empowerment by rejecting society's view (Frank, 1988). Instead of trying to hide their differentness, they take a confrontational approach in managing their interactions with those who are not stigmatized, and this contributes to their empowerment (Frank, 1988). Social movements are often joined by those making an attempt to disavow stigma and who feel that they have been unfairly made victims and do not deserve the stigma (Jones et al., 1984). Tajfel (1981) discusses a continuum of beliefs about intergroup relations. On one end is social mobility, where individuals believe they can leave their current group and move to other groups they would prefer to be in; at the other end of the continuum is social change, where people feel they cannot leave the group they are members of, and therefore must work with the group as a whole to change the conditions they live in.

Objectives of social movements include attempting to have others see the group as more acceptable and worthy, such as the Black is Beautiful movement, and to try to change the characteristics associated with the group (Breakwell, 1986). There is a recent social movement, sometimes referred to as the "size acceptance movement", through which people are attempting

to combat prejudice against fat individuals. They are attempting to have people of larger size become more acceptable to others and also to have them become more accepting of themselves.

It may be that fat people who internalize their stigma have lower self-esteem than those who do not; however, research on the self-esteem of stigmatized people is equivocal on this point. Prejudice generally does not result in lower self-esteem (Crocker & Major, 1989). One of the reasons for this may be that people attribute the negative feedback they receive to prejudice against their stigmatized group. On the other hand, individuals who internalize society's negative attitudes toward their group may be more vulnerable to lower self-esteem. Self-blame for one's condition may make one particularly at risk for low self-esteem (Crocker & Major, 1989). However, having the knowledge that one has the ability to exert control can protect one from the debilitating effects of aversive stimuli (Lefcourt, 1982). It may not be as damaging to a person's self-esteem to know that they are stigmatized when they believe that they have control over the stigma and can begin to change it at any moment of their choosing -- the belief that all one has to do is *choose* to lose weight and one will do it, may help to protect self-esteem.

Another way that stigmatized people protect their self-esteem is by making in-group social comparisons, that is, by comparing themselves with members of their own group rather than those outside the group (Crocker & Major, 1989). People who are stigmatized hold the importance of the stigma to their self-concept in varying degrees. Those for whom the stigma is a central aspect of their self-concept will be more likely to view others with the same stigma as part of an in-group, which should lead to higher self-esteem. On the other hand, those for whom the stigma is peripheral to self-identity may not see other's reactions to them as an outcome of prejudice toward the group, which may ultimately result in lower self-esteem. Jones et al. (1984) state that a nonconcealable stigma that is seen as unaesthetic is likely to lead to extreme and consistent negative reactions by others, which is likely to lead to a congruence between what others think of the stigmatized person and what the person thinks of himself. This congruence makes a person particularly vulnerable to low self-esteem. However, when a person associates with other similarly-stigmatized people, self-esteem is increased. Those who compare themselves to others with the

same stigma may be less inclined to seek treatment for their stigmatizing condition (Crocker & Major, 1989).

Support groups for stigmatized individuals help them to change the stigma from a drawback to an asset (Crocker & Major, 1989). Even if a social movement fails to modify the social order, its participants gain by improving their self-esteem (Crocker & Major, 1989). On the other hand, individuals who choose to disavow stigma have a self-concept that is very different from how others see them, consequently, their self-concept is often somewhat unstable and vulnerable (Jones et al., 1984).

The Role of Attribution of Responsibility for Weight in Physician Utilization

Fat people who internalize and accept the negative beliefs about their stigma should be more likely to diet and more likely to believe that they are responsible for their condition. On the other hand, those who reject the negative beliefs about fatness and who join together with similar others in an effort toward social change should be less likely to diet and more likely to believe that they are not responsible for changing their stigmatized status. Research has shown that those with an external control ideology are more likely to participate in social action than those with an internal orientation (Lefcourt, 1982).

A person's attributional philosophy about his or her own weight may mediate how likely a person is to be affected by a physician's negative attitudes or behavior. Brickman et al. (1982) developed a model which distinguishes between whether or not a person is seen as responsible for causing his/her condition, and whether or not he/she is seen as responsible for curing it. There are assumptions about responsibility underlying all treatment situations and it is the authors' contention that if a person seeks help from someone with a different model of attribution for the condition, problems will result and effective helping will be undermined. While these authors refer to the "medical model" as one where the person is seen as responsible for neither cause nor cure of their condition, this applies in most instances where a physical illness is seen as not being under one's control. Illnesses believed to be caused by a person's behavior, however, may be seen differently by those in the medical profession (e.g., lung cancer in a smoker is likely to be

looked upon as having been caused by the patient). The model that the majority of physicians seem to be operating under regarding obesity is one where the patient is seen as responsible not only for the cause of his/her condition, but for the cure as well (DeJong, 1980). If a fat person believes that he/she is responsible for causing his/her obesity (e.g., through overeating) and is responsible for curing it (e.g., by dieting), the person's philosophy is likely to fit well with that of his/her physician. The assumptions of both parties will coincide. However, if the patient does not believe he/she caused the condition (e.g., it is seen as genetic/biological) and does not believe it is his/her responsibility to change it, then conflict should ensue with most physicians, because the assumptions of both parties differ. According to Brickman et al. (1982), "many of the problems characterizing relationships between help givers and help recipients arise from the fact that the two parties are applying models that are out of phase with one another" (p. 375).

The assumptions of the Brickman model are supported by Freeling and Harris (1984) who report that differing assumptions by the physician and patient as to what the "real" problem is during a medical consultation leads to bad feelings on the part of both. These differences of opinion are often not discussed. As a result of the conflict in their points of view, both parties feel frustrated, irritated, and misunderstood. No condition can be effectively treated without agreement as to what the problem is. In addition, patients are more satisfied with medical care when they play an active part in deciding what is in their own best interest (Locker & Dunt, 1978). Stone (1979) has stated that whether or not a physician's recommendations address the problem the patient brings into the office has a strong effect on compliance. Often the patient and the physician have different sets of goals in the interaction.

Fat people who consult physicians for particular complaints are attempting to have their symptoms alleviated. If, however, the physician sees the patient's obesity as the root of the problem, and instead of addressing the specific complaint, focuses on the issue of weight loss, the physician and patient may be operating under different assumptions, and neither the symptom nor the obesity will be effectively treated, leading to further frustration on both sides. On the other hand, if the patient feels responsible for his/her condition, he/she may be more likely

to believe that his/her medical problem *is* the result of being obese, and will be more satisfied with his/her interactions with the physician.

Attributional Philosophy of Weight Watchers and NAAFA

Many fat people are members of organizations which promote different viewpoints or philosophies about being fat. According to Millman (1980) the basic philosophy of Weight Watchers, and other weight-loss groups, is that obesity's "cause and cure rest with the individual" (p. 29). The solution is to become thin. Weight Watchers stresses changing eating habits, and devotes group time to discussing members' "unconscious psychological problems" (p. 80) which drive them to overeat, and utilizes a specific low-calorie diet plan for their members. Literature available from Weight Watchers (1989) states that "losing weight can build your self-confidence and self-respect, and can help you feel more in control of yourself and your personal goals" (p. 1). Millman believes it is dangerous for individuals to believe "that all of the causes and solutions for their troubles are personal" (p. 81). This "illness approach" leads people to seek vainly for individual cures.

The philosophy of people who belong to NAAFA (National Association to Advance Fat Acceptance), on the other hand, is that social and political factors are responsible for fat people's suffering (Millman, 1980). The organization believes that dieting is not a simple solution to the problems fat people experience. They argue that fatness is often the result of body type, heredity, metabolism and childhood habits. The organization's central goal is to "help fat people accept and respect themselves as they are, to live the fullest and happiest lives possible" (Millman, 1980, p. 4). NAAFA describes itself as "a non-profit human rights organization that seeks to improve quality of life for fat people in ways other than dieting" (Smith, 1989, p. 1), such as group support and public education. NAAFA considers itself to be part of the size acceptance movement.

The differences in ideology between Weight Watchers and NAAFA seem to reflect the different strategies by which stigmatized individuals may choose to cope with their status. According to Breakwell (1986) stigmatized individuals use both intrapsychic and interpersonal

coping strategies. Intrapsychic strategies include acceptance strategies and "deflection" strategies which deflect the threat but resist change in one's identity structure, such as denial, fantasy, and redefinition. Dieters tend to use denial, in that they believe that they will not remain fat, and also use fantasy, as a way of wishing the threat of the stigma away; that is, they focus on the day that they will be thin. According to Jones et al. (1984), people may be able to see other "possible selves", that is, a fat person may believe that they could very possibly lose weight and be thin. When this possible self is extremely salient to a person, they may be able to treat their body like it is a foreign object and separate it from their mind (Jones et al., 1984). Other stigmatized people either redefine the properties of their stigma -- they deprecate the importance of some aspects of their situation or modify the meaning of the stigma -- or they redefine the reason they are in the stigmatized position, such as denying responsibility for it, and attributing the position to forces beyond one's control (Breakwell, 1986). People in the size acceptance movement tend to use redefinition of obesity. Some people tend to use acceptance strategies, by which they accept their position as a way of life, which ultimately results in less anxiety and depression (Breakwell, 1986). People in the size acceptance movement are likely to use this strategy as well. Interpersonal coping strategies are accomplished through changing relationships with others as a way to cope with one's stigma. Two of the ways of doing this are through "passing" and through "group action". Passing is a way of trying to remove oneself from a threatening position. Unfortunately, passing has psychological implications in that it results in hyperaffiliation to the group one passes into and causes strong prejudice against the group from which the person attempts to escape (Breakwell, 1986). Dieters are attempting to eventually "pass" as normative weight. The strong prejudice that even fat people have for other fat individuals (Maddox, Back & Liederman, 1968; Allon, 1973; Harris, 1982; Harris & Smith, 1983; Rand & Stunkard, 1978) may be the result of this effort to pass. On the other hand, in order to eradicate threats to one's identity, some people join social movements; they try to change the social order in order to increase their capacity for self-determination (Breakwell, 1986).

One of the biggest barriers to political action around a stigmatizing condition is reluctance to identify oneself as a member of the group (Scotch, 1988). Fat people tend to move in and out of their stigmatized status throughout their lives, through dieting. This changeability may contribute to the belief that thinness is an achievable goal for fat people. Having a stigmatized status which changes throughout life may make it difficult for fat individuals to identify with other fat people and prevent most from becoming involved in social action. Internalizing society's negative view of their stigma also prevents social action by most.

Assuming that most members of Weight Watchers and NAAFA believe in the respective attributional philosophy of their group, it is likely that they would exhibit different attitudes and behaviors concerning their relationships and interactions with physicians. As stated previously, it is likely that a fat person's attributional philosophy about weight will mediate their relationships with and attitudes toward physicians. People who belong to Weight Watchers would be likely to agree with physicians that they are responsible for losing weight, and would be likely to believe that physicians are correct to emphasize to them how important weight loss is; little conflict should result in these relationships. On the other hand, people who belong to NAAFA would be likely to have a philosophy that is very different from most physicians; this clash in attributional philosophy should result in greater avoidance of health care.

Summary

People who are fat evoke negative reactions from others. In addition, the way in which stigmatized people think about their stigma affects the attitudes they have about other people as well as their subsequent behavior during interactions. Fat people have varying philosophies about their weight, and how they think about it can have profound effects on their social interactions, particularly with people who focus attention on their weight.

It is likely that the weight and attributional philosophy of people who are fat will affect their attitudes toward and relationships with physicians, who typically see obesity as a medical issue. If a fat person's relationships with physicians are stressful and uncomfortable, this is likely to result in

lower physician utilization which may ultimately lead to poorer health. This is most likely to occur for those who are heavier and for those whose philosophy differs greatly from that of physicians.

Since physicians have been shown to have negative attitudes toward fat people, it is likely that those who are heavier will experience even more negative attitudes. Additionally, if a fat person's attributional philosophy consists of the belief that they are neither responsible for cause nor cure of their condition, their views are likely to clash with that of their physician. They are especially likely to react negatively to physicians' behavior toward them (such as attributing their symptoms to weight or focusing on weight loss in preference to employing preventive medicine) and to stigmatizing aspects of the office visit itself (such as getting undressed or getting weighed), which may lead to their developing a negative attitude toward physicians and to their avoiding or delaying physician visits. Fat people who agree with most physicians that they are responsible for the cause and cure of their condition will be more likely not to react in a strong negative manner to the office visit and to the physician's behavior, and may tend to feel that this behavior is justified and appropriate. How similar a fat person's philosophy is to that of physicians should influence how likely the person will be to make use of physician services, and this may ultimately affect the person's health.

Hypotheses

The specific hypotheses addressed in this study are stated below. It is indicated after each hypothesis whether the questionnaire or interview (or both) were primarily used to investigate whether the hypothesis was correct.

1. Participants who attend Weight Watcher meetings ("Weight Watchers") will be more likely to feel personally responsible for causing their fatness and for curing it than will those participants who attend NAAFA meetings ("NAAFAns"). (Questionnaire & Interview)
2. Weight Watchers will be more likely to have a regular physician than will NAAFAns. Those who weigh less will be more likely to have a regular physician. (Questionnaire)

3. Those who do have regular physicians will report that their physician's philosophy toward weight is more similar to their own philosophy than the philosophy of people in the other group. (Interview)
4. Weight Watchers will have had their regular physician for a longer period of time than NAAFAns. Those who weigh less will have had their regular physician for a longer period of time. (Questionnaire)
5. Weight Watchers will report less delay and avoidance of physicians than will NAAFAns (i.e., will have visited physicians more often, will report allowing less time to pass between the time they experience a symptom and the time they visit a physician, will be less likely to report that they would delay seeking an appointment with a physician for various symptoms, will be likely to report fewer reasons for not having visited a physician in the past, will be less likely to report that they have not visited a physician, or have delayed a visit, because of weight-related reasons). Those who weigh less will report less delay and avoidance. (Questionnaire & Interview)
6. Weight Watchers will have a more positive general attitude toward physicians than will NAAFAns. Those who weigh less will have a more positive general attitude. (Questionnaire)
7. Weight Watchers will report having had fewer negative experiences with physicians than will NAAFAns. Those who weigh less will report having had fewer negative experiences. (Interview)

Some exploratory issues which were also addressed included:

- Whether participants in the two groups tended to have a different history of dieting and weight loss. (Interview)
- Whether there was a relationship between self-esteem and group membership. (Questionnaire)
- Whether participants felt they do not engage in other health-promoting activities because they feel helpless about improving their health. (Interview)

- **What participants' beliefs are regarding the connection between obesity and health.
Whether participants tend to think that their weight is a medical problem. (Interview)**
- **Whether participants believe that weight is an appropriate topic to be discussed between physician and patient. (Interview)**
- **Whether participants believe that physicians have the ability to influence weight loss, and what methods physicians have actually used or suggested in order for participants to lose weight. (Interview)**

Note 1: A note on the use of language: Throughout this dissertation, the words "fat" and "obese" will be used to describe people who, according to cultural and or medical definitions, are above the norm in their size or the amount of fat on their bodies. An effort has been made to use the term "obese" only when used in a medical sense, and to use the word "fat" as a physical description or as an identity that a person may have, although occasionally the words will be used interchangeably. The word obese is associated with the medical model of fatness, and carries with it the negative implication of disease, and comes from Latin for "overeate", despite overwhelming evidence that fat people, on average, do not eat more than those who are not fat (Huenemann, 1972; Maxfield & Konishi, 1966; Rose & Mayer, 1968; Willmuth, 1986; Wooley & Wooley, 1979). The word "fat" is preferred by many people because it implies a descriptive characteristic of a person (similar to "tall", or "brown-eyed") and does not necessarily carry implications of ill-health (Bennett & Gurin, 1982; Millman, 1980). I will be using the term "normative weight" to refer to people who are not fat, rather than using the popular term "normal weight", because the *average* (normal) weight American is actually obese by modern medical standards (Ritenbaugh, 1982).

Method

This study utilized both questionnaires and interviews in order to study how weight and attributional philosophy for weight impacts upon physician utilization. Because both qualitative and quantitative methods have different drawbacks, using both to study the same issue should lead to data that are easier to interpret. According to Webb, Campbell, Schwartz, & Sechrest (1966), it is important to use multiple methods when conducting research, because the use of only one method can lead to false confidence in results. A recent article from the U.S. Department of Education (1989) discusses the drawbacks of using only quantitative research for studying disabled people, and suggests that the field can profit from qualitative approaches which do not ignore the context and content of people's responses. According to McKinlay (1972) the health care utilization literature, in particular, would benefit from small-scale exploratory studies focusing on social psychological factors including attitudes and beliefs. Research utilizing qualitative methods allows the researcher a glimpse at how the world is construed by the respondents (McCracken, 1988). By using a diversity of methods, one guards against the most common source of validity errors -- that of asking the *wrong* questions (Kirk & Miller, 1986).

McCracken (1988) suggests that qualitative methods should not be used in isolation; interviews work together with quantitative methods to not only investigate the world view of respondents, but to determine how generalizable that world view is to others. This study used both quantitative and qualitative methods in order to explore what effect weight and weight philosophy have on the relationships between women above normative weight and their physicians, and whether these factors affect health care utilization.

Questionnaire Phase

Participants

Participants were 58 adult women who attended a meeting of Weight Watchers (a weight loss group) in New York or New Jersey, and 60 adult women who attended a meeting or social

event of the National Association to Advance Fat Acceptance or NAAFA (a self-described human rights organization) (Smith, 1989), in New York or Philadelphia, who filled out and returned a written questionnaire, and would be considered to be 30% or more overweight by medical standards, using a measure of Body Mass Index (BMI), described in the next section. Also returning questionnaires were an additional 47 women from Weight Watchers and 1 woman from NAAFA who were less than 30% overweight using this criterion, and an additional 6 Weight Watchers and 1 NAAFAn who did not indicate their current weight on the questionnaire. Data from the latter participants were not analyzed for this study. In addition, one return was from a male Weight Watcher who was less than 30% overweight, and 16 returns were from NAAFA men, only three of whom were more than 30% overweight. Because of the small number of fat men who responded to the questionnaire, and the fact that none of the fat men volunteered to be interviewed, these data were not analyzed for this study. The Weight Watcher participants ranged in age from 19 to 70 years, with a median age of 43, while the NAAFAn were somewhat younger on average, ranging from 24 to 55 years, with a median age of 33. The religious makeup of the Weight Watcher and NAAFA groups were practically identical with the largest number being Jewish (37% and 39% respectively), followed closely by Catholics (35% and 36% respectively). An additional 11% and 12% respectively were Protestant, with the remaining being of other religious backgrounds. Overall, 59% of the Weight Watchers and 58% of the NAAFAn were of Christian faiths. The racial makeup of participants was similar as well. Participants were overwhelmingly white: 71% of the Weight Watchers and 83% of the NAAFAn, with an additional 2% and 5% respectively, indicating they were white and one other race. Twelve percent of the Weight Watchers and 7% of the NAAFAn were black; 12% of the Weight Watchers and 2% of the NAAFAn were Hispanic. None of the Weight Watchers were Asian or a Pacific Islander, while 1 NAAFAn (2%) was. One of the Weight Watchers (2%) indicated that she was a Native American while one NAAFAn (2%) indicated that she was black and Native American.

Both groups were fairly well educated. The NAAFAn were somewhat better educated than were the Weight Watchers, with 92% having attended at least some college, while 71% of

the Weight Watchers did similarly. While parents' education between the two groups was similar -- on average, the majority of parents of people in both groups had a high school education or less -- the parents of the NAAFAAns were somewhat better educated overall, with 33% of the fathers and 27% of the mothers having had at least some college, compared to 25% and 11% respectively for the parents of the Weight Watchers.

NAAFAAns, on average, were much heavier than were Weight Watchers; the former ranged in weight from 185 to 500 pounds, with a median weight of 280, while the Weight Watchers ranged from 148 to 311, with a median weight of 197. These weights, taken together with the person's corresponding height translates into median BMIs of 33 for the Weight Watchers and 45 for the NAAFAAns.

Body Mass Index

In order to determine whether respondents would be considered 30% or more above medical standards for weight, the Body Mass Index (BMI) was calculated for each individual by taking their weight in kilograms, and dividing by their height in meters squared. For example, a person who is 5 feet tall (approximately 1.52 meters) and 130 pounds (approximately 59 kilograms), would have a BMI of $59/(1.52)^2$ or 25.5. The National Health and Nutrition Examination Survey (Najjar & Rowland, 1987) defined overweight as BMI greater than the 85th percentile for males and females aged 20 - 29, and severe overweight as BMI greater than the 95th percentile. These figures correspond respectively to approximately 20% and 40% above desirable weights as defined by tables based on Metropolitan Life Insurance data (Najjar & Rowland, 1987, Burton, Foster, Hirsch & Van Itallie, 1985). National Institutes of Health (NIH) Consensus Development Panel on the Health Implications of Obesity (Burton, Foster, Hirsch & Van Itallie, 1985) states that weighing 20% or more "above desirable weight body weight, although arbitrarily selected, is associated with sufficient risk to health to justify clinical intervention" (Burton, Foster, Hirsch, & Van Itallie, 1985, p. 157). The report includes critical BMI figures that correspond to 20% and 40% above the standard insurance weight goals developed by Metropolitan Life Insurance. The extrapolated BMI figure corresponding to 30% overweight is approximately 29.2 for women, and

was chosen for this study because it is a more conservative figure than the 20% that is often cited in the medical literature, and would therefore be more likely to include individuals who would be considered fat by others who come in contact with them, yet would include those who are not considered "*severely overweight*."

Several problems with the BMI are noted in the literature. The most important drawback is that the index reflects both lean tissue and fat tissue, and cannot distinguish between the two. Other problems are that it is stature-dependent, especially among those under 15 years of age, and it may be affected by leg length (Garn, Leonard, & Hawthorne, 1986). Despite these drawbacks, it is widely agreed that in the absence of anthropometric measures of fatness, BMI is a fairly valid and reliable measure of degree of obesity (Mann, 1974, Garrow & Webster, 1985), especially at higher weights (Abraham, Carroll, Najjar, & Fulwood, 1983).

Recruitment and Procedure

Participants were recruited at meetings of Weight Watchers, and meetings or social events of NAAFA and were asked to fill out a questionnaire and to consider volunteering for an in-person interview. Only participants who appeared to be over 18 years old were approached, and both men and women were approached, although Weight Watcher meeting attendees were virtually all women, and NAAFA meetings were attended almost entirely by fat women and normative weight men.

Weight Watchers. Potential participants were approached outside of Weight Watchers classes, as they were going into the buildings where the classes were held. They were handed a one-page flyer which stated that a dissertation research project concerning physicians and weight was being conducted and asked them for their participation in taking a questionnaire home with them on their way out, to be mailed to the researcher; the flyer also asked them to consider volunteering for an interview at a later date. As potential participants later departed their meeting, they were asked to take home a questionnaire and if they consented, they were handed a questionnaire, and an addressed stamped envelope in which they could mail it back.

NAAFA. The first data collection was held at a social weekend in New York. As potential participants came in to register for the weekend, they were handed a one-page flyer, again stating the topic of the research and requesting their cooperation in filling out a questionnaire and considering a later interview. This flyer was almost identically worded to the Weight Watcher flyer except that it stated that questionnaires would be available in a “hospitality suite” during particular times of the weekend. As people came into the suite during those hours, they were asked to fill out a questionnaire and to return it by dropping it in a box in the corner of the room at their convenience. Later data collection for NAAFA participants was more similar in method to that of the Weight Watchers. Potential participants were approached at various meetings and social events with a similarly-worded flyer, asking them to consider taking home a questionnaire and mailing it back. As potential participants departed their meeting they were asked to take home a questionnaire and to mail it back in an addressed stamped envelope.

Mail Versus In-Person Data Collection

A pilot test had been conducted at a Weight Watchers class in which participants were asked to fill out questionnaires in the lecture room before class, and return them at the end, in person. This procedure turned out to be problematic because some of the Weight Watcher personnel made it clear that they did not approve of the data collection, and because it was somewhat disruptive when the class began. In order to minimize the participants' awareness of any disapproval by Weight Watcher personnel and in order to make the data collection run smoother, a decision was made to have participants return questionnaires by mail. While it would have been possible to use an in-person procedure for all the NAAFA participants, a procedure similar to Colombotos and Kirchner (1986) was used in order to minimize and determine any differences caused by using two different collection procedures, mail versus in-person. Data were collected by mail at all but one NAAFA site; only the first NAAFA data collection used an in-person procedure, because that data had already been conducted prior to the collection of Weight Watcher questionnaires. All subsequent data collection using NAAFAs had participants return the questionnaires by mail, in order to make the procedures used for NAAFA and Weight

Watchers as similar as possible. Following Colombotos and Kirchner (1986), data were analyzed to see whether the utilization of mail versus in-person procedures made a difference in the responses of the NAAFA participants. Particular attention was paid to questions which might have been influenced by social desirability needs such as self-reported weight or self-reported health status. Differences between participants at the in-person administration and the mail administrations were examined using t-tests for continuous variables, and chi-square tests for discrete variables, where appropriate. Results showed that answers to questions which might have been influenced by social desirability needs were not significantly different, and few of the other variables turned out to be significantly different. Participants in the former group were more likely to be non-white than those in the latter group $\chi^2(1, N = 60) = 6.06, p = .014$. The finding about race does not appear to reflect a non-response bias -- it happened to be that there were almost no non-whites in the later NAAFA settings where data was collected by mail, although at the first site, a social weekend, there were a few non-whites. Participants differed significantly on two of the dependent variables. Those in the in-person group reported that for their last physician visit, they had let more time pass before they saw their doctor (in fractions of a year) ($M = .174$) than did the mail group ($M = .048$), $t(36.11) = 2.75, p = .009$, using a separate variance estimate because of differences in the standard deviations of the two groups. In addition, those in the former group reported that they would be less likely to see a physician if they experienced major physical symptoms ($M = 20.84$) than did those in the latter group ($M = 26.27$) on a scale ranging from 11 to 55, $t(55) = 2.07, p = .044$.

Because of the large number of t-tests and chi-square tests performed (39 and 14 respectively), one would expect approximately two or three statistical tests to turn out to be significant at the .05 level by chance alone. Only three tests turned out to be significant, supporting the position that the method of data collection had little influence on the types of individuals who were willing to participate, and any non-response bias for mail and in-person data collection procedures were similar.

In order to minimize the non-response rate by mail, techniques suggested by Armstrong and Lusk (1987) were used which included first class postage using several stamps of varying denominations on each return envelope in order to emphasize to participants the personal effort and costs involved in the project, and the use of commemorative stamps. In addition, each envelope had the address hand-stamped in order to emphasize the personal effort involved. The return rate for the in-person NAAFA data collection was 70% (64 questionnaires handed out and 45 returns) and the return rate for the mail data collection was 45% for NAAFA (33 returns out of 73) and 57% for Weight Watchers (112 returns out of 196 questionnaires). Note that these return rates comprise all persons who returned questionnaires, including those who were less than 30% overweight, and including men, because the number of people in these latter categories who originally received the questionnaires cannot be determined.

Instrument

The questionnaire (see Appendix A) collected data on people's health status, current physician and health insurance information, demographic data, political leaning, attitudes toward physicians, measures of readiness to visit a physician, reasons for avoiding such visits, a self-esteem scale, smoking history, weight and dieting history, and a measure of attributions for fatness. At the end of the questionnaire, participants were asked to include their name and phone number if they would consider volunteering for an interview.

For the scale assessing participants' weight philosophy, two questions were adapted from Saltzer's (1978) Weight Locus of Control Scale. According to the author, this scale assesses how much control a person perceives they have over their weight. Unfortunately, Saltzer did not include reliability data for the scale in her research report. Saltzer's original scale included two internal and two external items. One of each was adapted for the present study, in addition to the inclusion of three additional items specifically addressing responsibility for cause and cure of overweight, and optimism about successfully losing weight and maintaining the weight loss.

The Satisfaction with Medical Care Scale (Roghamann, Hengst, & Zastowny, 1979) was used in this study. This scale attempts to measure general attitudes toward physicians, rather

than specific attitudes toward a particular physician. According to the authors, the scale consists of positive items which indicate agreement with positive stereotypes that people have about physicians, and negative items which tap feelings of hostility and resentment toward the medical profession; these two feelings toward physicians can coexist, indicating a feeling of ambivalence toward medical professionals. The authors report that the positive and negative clusters correlated .489. The authors were able to show that satisfaction, as measured by the scale, predicted utilization of health care services.

The measure of self-esteem used in this study was the Rosenberg Self-Esteem Scale, a scale measuring global self-esteem, which has been shown to have a test-retest reliability of .85, and has been shown to be unidimensional (Rosenberg, 1965). Extensive validity testing has been conducted, including demonstrating that individuals with low self-esteem are more likely to exhibit depression and neuroses while people with high self-esteem are more likely to be chosen as leaders by others (Rosenberg, 1965).

Note that NAAFA participants who were approached at the first data collection had completed an earlier version of the written questionnaire, which excluded five questions that are included on the attached version (see Appendix A) -- questions 14, 15, 18, 22 and 23. In addition, they were not asked for the age of their physician. Participants from this group who were chosen for in-person interviews were asked to complete those questions at the interview. Appendix B provides the purpose and rationale for questions used in the questionnaire, and provides information on questions and scales that have been used previously in other studies.

Interview Phase

Volunteers vs. Non-Volunteers

An analysis was performed to see if people who volunteered to be interviewed differed in any significant ways from non-volunteers. Weight Watchers and NAAFAn were examined separately, in order to detect any patterns that were particular to one of the groups. T-tests were conducted between volunteers and non-volunteers for continuous variables, and chi-square

tests were performed on discrete variables, where appropriate. As stated previously in the section describing the analysis of mail versus in-person data collection methods, because of the large number of t-tests and chi-square tests performed, one would expect that approximately two or three statistical tests for each group would turn out to be significant at the .05 level by chance alone. The number of significant tests was close to that estimate -- 4 tests for the NAAFA participants and 2 tests for the Weight Watchers -- although the significance level of many of these tests were much stronger than .05, indicating that there may have been true differences.

Among the NAAFAns, whites were much more likely to volunteer than those of other races or of mixed races, $\chi^2(1, N = 60) = 6.46, p = .011$. Among the Weight Watchers, this was also the case, $\chi^2(1, N = 58) = 5.58, p = .018$. NAAFA volunteers were more likely to have seen a larger number of different physicians over the past five years ($M = 3.8$) than were the non-volunteers ($M = 2.4$), $t(58.6) = 2.59, p = .012$, using a separate variance estimate because of differences in the standard deviations of the two groups. The NAAFA volunteers also considered themselves to be more liberal ($M = 3.5$) than did the non-volunteers ($M = 5.0$) on a liberal-conservative scale ranging from 1 to 9, $t(30.4) = 2.95, p = .006$, using a separate variance estimate. NAAFA volunteers were less likely to have a regular female physician than were the non-volunteers, $\chi^2(1, N = 43) = 5.85, p = .02$. Weight Watcher volunteers reported that they dieted fewer days during the past year ($M = 104$) than did non-volunteers ($M = 179$), $t(54) = 2.18, p = .033$.

On the important variables of age, weight, health status, and socioeconomic status (as measured by mother's level of education), differences between volunteers and non-volunteers were far from reaching significance in either the Weight Watchers or NAAFA group.

Choosing Interview Participants

From the 118 participants on whom questionnaire data were collected, whose BMI was greater than 29.2, 39 NAAFA participants (65%) and 24 Weight Watcher participants (41%) volunteered to be interviewed. From these volunteers, 20 were selected for in-depth, semi-structured interviews. Because the Weight Watchers tended to have much lower BMI's than did the NAAFAns, seven Weight Watchers who were at the higher end of the Weight Watcher

distribution on weight, and seven NAAFAn who were at the lower end of the NAAFA distribution on weight were chosen for interviews. According to McCracken (1988) it is more important when utilizing long interviews to select fewer people to interview thoroughly than to superficially interview large numbers of people. Those volunteers who best matched a person in the other group on weight (BMI), race, age, health status, parent's education, own education and whether or not they were fat as children, were selected. While minorities made up a small percentage of all people who returned questionnaires, volunteers who would be considered 30% or more overweight were almost entirely white. Therefore, all interviewees selected were white females. In addition to the variable of race, the variables of weight, age and health status were considered of primary importance in matching the participants, with the other variables secondary. Finding good matches was very difficult, given the characteristics of the volunteers. Matching on the important variables was particularly difficult because, as a group, the Weight Watchers were older and weighed much less. After examining available information on the volunteers, a decision was made to make matches based on ages being within ten years of each other, subjective health status being within one category of each other (e.g., "good" versus "very good" would be acceptable), provided their objective measures of health status (i.e., days ill, in bed or in the hospital over the last year) were not very discrepant, and weight being within 8 BMI points. Using these rules, the seven best matches were made from the volunteers who were available. Because it was not possible to match participants well on each of these variables as well as on the secondary variables, care was taken to ensure that as a *group* they matched fairly well on all of these factors. Looking at each of the two groups' average on each of the important characteristics, the matches were fairly good: the Weight Watcher participants weighed 221 pounds on average, compared to 238 for the NAAFAn; taking height into consideration, these weights translated into BMIs of 36.5 and 39.4 respectively, which would be equivalent to approximately 219 pounds and 236 pounds respectively for an average height, 5'5" woman. The Weight Watchers were 44 years old on average (ranging from 34 to 61) and the NAAFAn were 36 years old on average (ranging from 27 to 55). Treating health status as interval data (with excellent

health as a 1, and poor health as a 5), the two groups were similar on average for this variable: 2.3 for the Weight Watchers and 2.6 for the NAAFAns (representing somewhere between good and very good). Five out of seven of the women in each of the two groups were fat since childhood. Although the highest educational levels achieved for parents of the Weight Watchers were slightly higher than for the NAAFAns, they were not very discrepant, differing by less than one educational category on average for mothers and fathers. Regarding their own education, the groups were very similar; the majority of both groups had had at least some college education. One variable on which the participants in the two groups differed was on the highest amount they ever weighed. Although most of the participants currently weighed somewhat less than their highest weight ever (while not pregnant), NAAFA participants, on average, had lost much more weight. The amount of weight that Weight Watchers had lost, on average, was 22 pounds, ranging from 9 to 48, not including one woman who did not previously weigh more. NAAFAns had lost an average of 63 pounds, ranging from 20 to 140 pounds, excluding two participants whose highest weight was current.

An additional six NAAFA volunteers were chosen, whose weight was far above the range of the Weight Watchers, in order to explore the physician-patient experience for very large women. A cutoff was arbitrarily made to include only those women who had a BMI of greater than 50, in order to include only the largest women among the volunteers. The weights of the six women chosen to be interviewed ranged from 350 to 500 pounds, averaging 415 pounds. Other than weight, these six women were fairly similar to the other two groups on the matching variables, except that they were somewhat younger on average. Their average age was 34, ranging from 29 to 39. Among these 6 participants, all were fat from a young age. Half of these women also had lost large amounts of weight, ranging from 17 to 80 pounds, excluding the three participants who are now at their highest weight. The average health status of these six women was 2.2, similar to the other two groups. The educational status of these women and their parents differed on average by less than one educational category from the women in the other two groups.

The women in the three groups did not match well on current smoking status: one of the Weight Watchers, three of the smaller NAAFA group and 1 of the larger NAAFA group are currently smokers. However, taking into consideration how many of the women had *ever* been smokers, three to four women in each of the groups had been smokers at one time in their lives.

Procedure

Participants selected for interviews were contacted by telephone and were asked to participate. All agreed to do so. They were informed about the general nature of the interview, the approximate length (about two and a half hours) and the amount of compensation for the interview (\$20). A mutually convenient time was set up, and the interviews took place either at the subject's home, at a hotel room set up for the interviews, or in a private office at the City University of New York. The interviews were taped on a small tape recorder, with the participants' knowledge. The interview included open-ended questions for the purpose of clarifying and expanding upon some of the items found in the written questionnaire. Interview techniques suggested by McCracken (1988) were used, including drawing out participants' answers without supplying words that restricted their natural responses, asking biographical questions at the beginning of the interview, using planned prompts only when absolutely necessary to get at needed information, and organizing interview questions ahead of time, while posing them in a way that allowed participants to discuss the issues in a way that was meaningful to them and that allowed for the opportunity to understand how they think about the issues. The goal of qualitative research is to isolate and define categories during the process of collecting data. The nature and definition of analytic categories often change during the process of research (Glaser & Strauss, 1967, McCracken, 1988). As the interviews progressed, new "grounded" theoretical relationships (Glaser & Strauss, 1967) emerged from the data; that is, issues that were unforeseen at the time the interview questions were decided upon, but which participants appeared to think were important and relevant to the topic, were discussed at length during the interviews. Because of the nature of grounded theory, it was not possible for every new issue to be discussed with each of the twenty participants. However, once an issue appeared to have

some importance, it was discussed with subsequent participants. In this way, theoretical saturation was reached (Glaser & Strauss, 1967).

The taped interviews were transcribed and the resulting data were examined to see what relationships emerged, using several techniques described in Miles and Huberman (1984). An initial list of codes were generated from the data, which represented recurring themes alluded to. As new ideas and themes were generated from the interviews which did not fit into established codes, codes were revised or new codes were added. Chunks of data representing one idea or theme were assigned a code. Groups were then compared on the way participants felt about particular themes that were mentioned, as well as differences in how themes clustered together.

Some Observations about the Data Collection Procedure and Potential Participants

Several observations were made about what types of individuals cooperated in agreeing to take a questionnaire home. Unfortunately, it was not possible to maintain a record of actual numbers for the purpose of obtaining accurate estimates of certain characteristics, because potential participants had to be approached very quickly in each situation, and there was not enough time to keep track of actual numbers (e.g., how many refused a questionnaire, the number of men, etc). In an ideal data collection situation, where either the questionnaire distribution could be done at a slower pace, or where several experimenters or research assistants are on hand to record information, it would have been beneficial to keep track of this sort of information. Unfortunately, that was not the case for this study. However, observational notes were made during the data collection, and these will be reported on below. Obviously the estimates of numbers cannot be completely accurate, but will give some idea of the numbers that were unable to be accurately tracked.

The data collected on Weight Watcher participants is overrepresented by larger women because the data collection situation worked in the following manner: All potential participants were approached at the door, outside the Weight Watchers class, on their way into the meeting and were handed a flyer. Then as people trickled out of their class, each person was approached and asked to participate by taking home a questionnaire. Typically, however, while about one

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third to one half of the class would leave sometime during the meeting, one at a time, the remainder of the class would all depart almost at once. Since it was impossible to get to all the people leaving, an effort was made to target the larger women, since they were the main focus of the study. Therefore, the results indicating participants' weight range is probably not an accurate reflection of the weights of people who actually attended the Weight Watcher classes, but is overrepresented by larger women.

Although questionnaires were handed out to men during the data collection phase, Weight Watcher classes were attended almost entirely by women, and men at NAAFA events were virtually all normative weight. Although the data collection situation did not make it possible to keep an exact count of the number of men who were handed questionnaires, I would estimate that only about 5 men at Weight Watchers were given questionnaires, only one of whom appeared to be fat. I am unable to give an estimate of the total number of NAAFA men handed questionnaires, but would estimate that only about 6 or 7 men altogether appeared to be fat.

I would estimate that 1 or 2 people out of every 10 Weight Watchers refused to take a questionnaire, while almost all the NAAFAs took one. Therefore, the mail return rate for the two groups (57% and 45% respectively) may actually be very similar, since many of the Weight Watchers who were not willing to participate tended not to take a questionnaire to begin with. If the number of refusals to take a questionnaire had been kept track of, the *effective* mail return rate for the two groups may have been approximately the same.

Notably, although fat individuals who appeared to weigh in the upper 200's and above were rare at Weight Watchers, those who were approached with a questionnaire were more likely to refuse than were people at all other weight ranges; in fact, several seemed to physically cower when asked to participate. On the other hand, it appeared that normative weight people were no more likely to take a questionnaire than were those who weighed in the low 200's, or in-between. There did not appear to be any weight-related pattern as far as which potential NAAFA participants agreed to take a questionnaire.

One additional observation involved race. Again, accurate numbers were not able to be kept because of the data collection situation. However, I would estimate that approximately one quarter of the Weight Watchers were black, while there appeared to be relatively few black NAAFA's. Despite this high number of blacks within Weight Watchers, relatively few returned the questionnaire, although almost all agreed to take one.

Cooperation of the Organizations

One concern about collecting data in the two groups was that NAAFA personnel approved of my soliciting participants at their events, while preliminary information-gathering indicated to me that Weight Watchers would not. As stated earlier, in order to keep any possible expressed disapproval of Weight Watcher personnel to a minimum, I chose to solicit potential participants outside of the Weight Watcher premises. With the exception of one rather extreme case which will be discussed in the next paragraph, it appeared that overall, any possible disapproval of the study by Weight Watcher personnel was not obvious to participants, as evidenced by many potential participants who seemed eager to participate; several made comments such as "make sure you give a questionnaire to the lecturer -- she'd be very interested in this." At least half a dozen Weight Watcher attendees I approached on the way out of their class mistakenly thought the study was being conducted *by* Weight Watchers, despite my indicating clearly on the flyer and questionnaire exactly who I was and why I was conducting the study. Some participants made statements such as "should I bring the questionnaire back to class next week?" When this type of comment occurred, I made it clear that I was not connected with Weight Watchers, and reiterated that I was conducting the study for school, as part of a doctoral dissertation.

The one exception to potential Weight Watcher participants not being aware of Weight Watcher personnel disapproval was in one situation where a male lecturer came outside where I was standing and insisted that I leave. I informed him, in a congenial manner, that I would not since I was on a public street, and he threatened to inform the Weight Watchers Organization about it if I didn't leave, which I did not. According to his class members, he spent a good deal of his lecture

time discussing the situation of my collecting data, and told his class not to cooperate with me because I did not have Weight Watchers' approval. Despite the lecturer admonishing people not to participate, several people chose to take a questionnaire anyway, with one making a comment to the effect that the lecturer had "a lot of nerve" telling them what to do. This was the only situation to my knowledge where Weight Watcher personnel made any disapproval about the study obvious to people in their class. Since I got no feedback of this sort from participants in the other classes, I assume that either the lecturer was not even aware that I was collecting data outside, the lecturer did not care, or the lecturer approved of it. In fact, I had been made aware of some guarded but enthusiastic approval from several people who worked for Weight Watchers. One lecturer was very interested in the study, and offered to fill out a questionnaire for me. She discussed the study with me for several minutes and invited me to come to another class she was giving later that week, but asked me not to let anyone know she allowed it because she felt she would "get into trouble". One lecturer who I know personally was very interested in the study and in helping me to get participants. However, she said that while I could stand outside her class and give out questionnaires and flyers, she could not allow me to do this in her class, and she asked me not to let *anyone* know that she knew about the study. At two other classes, I happened to have approached people who work for Weight Watchers, both of whom informed me of this fact, and then asked if that meant that they couldn't participate. I told them they could and they were happy to take a questionnaire. Overall, the Weight Watcher personnel were very nice (but very nervous about getting into trouble with the organization). The members were very pleasant, and almost all seemed quite eager to participate. NAAFA personnel were interested in my study, and allowed me to hand out flyers and questionnaires at their meetings and social events, although I was never there in any "official" capacity. The NAAFA members were also pleasant and seemed interested in the study and eager to participate.

Overall, the reactions of the participants themselves seemed very similar between the Weight Watchers and the NAAFAs, and the rate of return of the questionnaires were similar. It is

unlikely that organizational attitudes in any way affected which individuals responded or the way in which they responded.

Quantitative Results

Data collected during the questionnaire phase of the research were analyzed statistically, and are reported here. First, factor analyses were conducted in order to analyze three scales that were included in the questionnaire. Then the two groups (Weight Watchers versus NAAFA) were compared, using t-tests and chi-square tests to see if there were significant differences on any of the variables. Data were then subjected to regression analyses in order to determine the effect of weight-related items and group membership on the dependent variables, while controlling for other relevant variables. Finally, because many of the health care questions utilized on the questionnaire have also been used in large national studies, data on participants will be compared to normative data. Additional relevant analyses will also be presented where appropriate.

Factor Analyses

Separate factor analyses were conducted for three scales that were included in the questionnaire, and Cronbach alpha coefficients were calculated: Question 13 (a scale intended to measure the likelihood that people will visit physicians for various major and minor medical symptoms), Question 16 (a scale created and validated by Roghmann, Hengst, and Zastowny, 1979, and found by them to contain a negative and a positive factor for attitudes toward physicians, and to measure the likelihood that people will visit physicians), and Question 18 (a scale intended to measure people's philosophy about their weight). (See Appendix A for the exact wording of these questions). The results of the factor analyses follow:

Q.13: A factor analysis was conducted using oblique rotation with listwise deletion. There were 109 individuals included in this factor analysis. Two factors emerged – one for serious symptoms and one for non-serious symptoms, accounting for 54% of the variance in scores. These are the same factors that emerged from the pilot data (See Appendix C). Interestingly, “pain in legs while walking” fell into the serious factor when tested on relatively young college

students. However, when tested in the current study using older, fat women, this symptom clearly fell into the non-serious category.

As a test of the factors that emerged from the pilot data, two additional items had been added: "runny nose", which was expected to have a high factor loading on the non-serious factor, and "loss of feeling in an arm" which was expected to have a high factor loading on the serious symptom factor. The latter symptom turned out to have a high factor loading (.78) on the serious symptom factor. "Runny nose" had a high factor loading (.76) on the non-serious symptom factor, but unfortunately, also had a moderately negative factor loading (-.38) with the scale for the serious symptoms. "Runny nose" was removed from the scale, as was "shortness of breath" and "fever", all of which had factor loadings of more than .30 with both of the factors. "Loss of feeling in an arm" was kept in because of its high factor loading with only one factor.

Below are the loadings of the factors (above .30) on each of the symptoms:

	Factor 1 (Non-serious symptoms):	Factor 2 (Serious symptoms):
Runny Nose	.76	-.38
Cough	.76	
Trouble Sleeping	.73	
Headache	.71	
Leg Cramps	.69	
Back Ache	.67	
Fatigue	.64	
Sore Throat	.64	
Diarrhea	.64	
Fever	.62	.35
Heat Rash	.62	
Pain in Legs while Walking	.53	
Shortness of Breath	.45	.44
Loss of sight in one eye		.88
Blood in urine		.83
Loss of Feeling in an Arm		.78
Chest Pain		.77
Fainting		.63

Before removing any items, this scale yielded a very high Cronbach alpha coefficient (.90). When the scale was separated into two scales for non-serious versus serious symptoms, and removing the three items that correlated highly with both factors, the alpha coefficients were extremely high. The alpha coefficient for the non-serious symptoms and for the serious symptoms remained almost the same (.87 and .85 respectively), despite being based on many fewer items.

Q.16: A factor analysis was conducted using oblique rotation with listwise deletion. There were 113 individuals included in this factor analysis. Note that the scale used in the questionnaire did not use two of the original items from the scale developed by Roghmann, Hengst, & Zastowny (1979), based on pilot study results (see Appendix C) which showed that the scale was improved by the elimination of these items. Two factors emerged -- one for positive attitudes toward doctors, and one for negative attitudes toward doctors, accounting for 43% of the variance in scores. These are the same factors that emerged from the pilot data, as well as the same factors found by the authors of the scale.

As a test of the factors that emerged from the pilot data, two additional items had been added: "most doctors are able to improve your health" (item 16B) which was expected to have a high factor loading on the positive factor, and "most doctors do not care how medical procedures personally affect you" (item 16D) which was expected to have a high factor loading on the negative factor. Both symptoms turned out to have factor loadings on the expected clusters: .46 and .82 respectively. Because of the high factor loading of item 16D, a decision was made to include this item as part of the scale for the purpose of analysis.

The items falling into each of the factors were fairly similar for the current study and the pilot study. Interestingly, of the six items that at face value indicate negative feelings about physicians, only the four that refer to interpersonal relations with the physician (items 16C, 16D, 16F, 16G), rather than the physician's healing capacity, fell into the negative cluster in the current study. The two items referring to the latter (items 16I and 16M) were negatively correlated with the

positive cluster. This may indicate that the negative factor, for this group, does not represent a global negative feeling about physicians, as suggested by the scale's authors, but only a negative feeling about their interpersonal skills. Because the positive cluster, as tested by Roghmann, Hengst, and Zastowny (1979) and by the pilot data, contained only positively-worded items, and because the two negatively worded items that fell into this cluster in the current data collection were among the three variables with the lowest factor loading, a decision was made to include only those items with a factor loading of greater than .54. Therefore items 16B, 16I and 16M were removed from the final analyses.

Below are the loadings of the factors (above .30) on each of the symptoms. (Refer to Appendix A for the exact wording of each of the items, referred to here by item number only for the sake of simplicity of presentation):

	Factor 1	Factor 2
	<u>(Positive attitudes):</u>	<u>(Negative attitudes):</u>
16K	.80	
16N	.70	
16E	.68	
16H	.65	
16L	.64	
16A	.63	
16J	.54	
16M	-.52	
16B	.46	
16I	-.40	
16F		.83
16D		.82
16G		.61
16C		.56

The overall Cronbach alpha obtained for the scale as a whole was not very high (.34). However, when the scale was separated into positive and negative scales, eliminating items 16B, 16I and 16M, much higher alphas were obtained (.81 for the positive scale and .70 for the negative scale).

Q.18: A factor analysis was conducted using oblique rotation with listwise deletion. There were 91 individuals included in this factor analysis. One factor emerged, accounting for 64% of the variance in scores. Below are the factor loadings for each of the items. Note that the scoring for item 18D was reversed, resulting in a positive correlation with the factor. (Refer to Appendix A for the exact wording of each of the items, referred to here by item number and a one-word description only, for the sake of simplicity of presentation):

Factor
(Weight Philosophy):

18B	(cure)	.90
18A	(cause)	.84
18C	(optimism)	.78
18D	(luck)	.75
18E	(control)	.72

The overall Cronbach alpha obtained for the scale (.85) was very high.

**Analysis of NAAFA Versus Weight Watcher Participants and Lower-Weight
Versus Higher-Weight Participants**

T-tests:

T-tests were run on continuous demographic and outcome variables of interest in order to examine how participants in the Weight Watcher group differed from those in the NAAFA group and how higher-weight participants differed from those who were lower-weight. Because there were large differences on background variables such as weight and age, it is not clear from the t-tests alone to what factors any differences are attributable. This will be explored further in the section below which reports on multiple regression analyses that were performed in an attempt to determine the relevant factors.

Note that in order to conduct t-tests for higher-weight versus lower-weight participants, those whose Body Mass Index was higher than the median for all 118 participants were considered to be in the former group, while those below the median were considered to be in the latter group. Since many of the NAAFA participants were heavier than the Weight Watcher participants, there was a strong correspondence between the lighter-weight group and the Weight Watchers, and between the heavier-weight group and the NAAFAnS. Nevertheless, ten of the NAAFA participants were in the lighter-weight group, based on Body Mass Index, and nine of the Weight Watcher participants were in the heavier-weight group. This shift of 19 participants into other groups was responsible for somewhat different findings when comparing participants on weight versus comparisons on group membership.

Tables 1 and 2 show the group means and standard deviations for the background variables, as well as the results of t-tests. Tables 3 and 4 show the same information for the outcome variables of interest. The tables show that for the background variables, the Weight Watchers were significantly older than the NAAFAnS ($p < .001$), the NAAFAnS were somewhat better educated ($p = .05$) and their mothers and fathers had achieved higher education levels ($p = .004$ and $p = .03$, respectively). The NAAFAnS weighed more ($p < .001$), while the Weight Watchers were more likely to attribute responsibility to themselves for being fat and to feel they had more control ($p < .001$). The Weight Watchers were more likely to have attempted to reduce their food intake for more days over the past year ($p < .001$). They also tended to have older physicians ($p = .001$), which is probably due to the fact that they themselves are older (the correlation between personal age and physician's age was $r = .031$, $p = .008$). The lower-weight participants weighed significantly less than the higher weight participants ($p < .001$), were significantly older ($p = .002$), were more likely to attribute responsibility to themselves for being fat and to feel they had more control ($p < .001$). The lower-weight participants were more likely to have attempted to reduce their food intake for more days over the past year ($p < .001$), and tended to have older physicians ($p = .04$). No significant differences in personal education or parents' education obtained when looking only at weight. However, lower-weight participants tended to

perceive themselves as less fat than those of higher weight ($p=.02$), and tended to have better health insurance coverage ($p=.03$), two findings that did not obtain when examining participants by group. For the physician-related outcome variables (Table 3), Weight Watchers had more positive attitudes toward physicians ($p=.02$), and reported that they would be more likely to visit a physician for serious symptoms ($p=.02$) than the NAAFAnS. Similarly, Table 4 shows that the lower-weight participants had more positive attitudes toward physicians ($p<.001$) than the higher weight participants, and reported that they would be more likely to visit a physician for serious symptoms ($p=.03$). In addition, the lower-weight participants were also more likely to visit a physician for non-serious symptoms ($p=.008$), and to name fewer weight-related reasons ($p=.01$) and non-weight-related reasons ($p=.03$) for having ever avoided a physician visit.

Chi-Square Tests

Chi-square Tests were run on discrete variables of interest in order to examine the differences between Weight Watcher members and NAAFA members, and between those of lower-weight versus those of higher-weight. Tables 5 and 6 show the results of these tests. The only significant differences were that NAAFAnS were more likely to be fat as children ($p=.04$), and Weight Watchers were much more likely to be currently dieting ($p<.001$); similarly, higher-weight participants were more likely to be fat as children ($p=.04$), and were much less likely to be currently dieting ($p<.001$) than those of lower weight.

Multiple Regression Analyses

In order to examine the effect of participants' weight and group membership on their responses to the dependent variables being studied, while at the same time controlling for other relevant variables, a series of regression analyses were conducted. The following procedure was used for each analysis:

- 1) Independent variables that theoretically should have been related to the dependent variable were chosen.

2) Using a forced-entry technique, variables were entered in blocks in the following order, so that earlier variables were controlled for when examining later variables: demographic, developmental, health-related, psychological, weight-related, and group.

3) Interactions, particularly those involving group membership (Pedhazur, 1982), were examined to see whether, if entered last, they would contribute significantly to the equation.

4) Because a large number of variables were entered in the same blocks, occasionally a non-significant block included a variable with a significant b-weight. In those instances, the regression equation was rerun, including only the variable with the significant b-weight in the block to see if, by itself, it added significantly to the R^2 . The results of these second equations are referred to in table footnotes.

5) In all cases, the residuals were plotted, and were checked for normality and for homoscedasticity. If these appeared problematic, the data were transformed using a log function, square root, or inverse function, in order to see whether the data would conform better to the assumptions of the regression procedure. Transformations resulting in the most improvement were chosen for each analysis.

Missing data did not appear to have any distinctive pattern, based on background characteristics. Since no systematic bias was apparent, a decision was made to use listwise deletion of missing data for all the regression equations, rather than using a method of extrapolation to replace the missing data.

Similarity of Variables: For some items of interest, there existed several variables which gave similar information. An effort was made to choose only one or perhaps two of the variables, in an effort to simplify the analyses and avoid multicollinearity problems. In each case where this occurred, the correlation matrix between all the variables was examined in order to determine whether more than one variable could be used, or whether one appeared to be a better variable than the others. In examining the current health status of participants, four measures were included on the questionnaire: a subjective measure of perceived health status, and three objective questions concerning the number of days over the past year that either 1) illness kept

the participant from performing her normal activities; 2) illness kept her in bed most or all of the day; or 3) she was a patient overnight in a hospital. The item concerning hospital days was not a good one for these participants, since almost none had been in the hospital over the past year. It turned out that while bed days and days ill were very highly correlated with each other ($r=.86$, $p<.001$), days ill and the subjective measure of health status did not correlate significantly ($r=.07$, $p=.07$), although bed days and the subjective measure were significantly correlated ($r=.24$, $p=.01$). Therefore, days ill and the subjective measure seem to be measuring a somewhat different construct of health status. For analyses of the physician-related dependent variables, both of these variables were entered. Bed days and hospital days were not used for these analyses. Note that correlations were initially examined separately for the Weight Watchers and NAAFA members to see whether one group had a stronger correlation between the objective and subjective measures of health. In fact, the correlations were very similar for the two groups, with bed days showing the best correlation with the subjective health measure.

Similarly, a choice had to be made between using a participant's weight philosophy versus her group membership (NAAFA versus Weight Watchers). Despite a very high correlation between weight philosophy and group membership ($r=.69$, $p<.001$), Figure 1 shows that there was some overlap between the philosophies of the members of the two groups. Unfortunately, however, data on group philosophy was collected on fewer than half the NAAFA members, because an earlier version of the questionnaire did not include this item. Therefore, a decision was made to use the group membership variable as the independent variable of choice, in order not to lose power. However, all regression equations were re-run using the weight philosophy variable, and in no case did it add a significant amount of variance to the R^2 . In addition, a set of regression equations were run using only group membership and weight philosophy to see which of the two accounted for a higher proportion of variance (see Table 20). For only one variable -- positive attitudes toward physicians -- did weight philosophy explain more variance than group membership. However, after controlling for other variables, neither added significantly to the prediction of this dependent variable.

In choosing between the variables of dieting versus the number of days participants attempted to reduce their food intake this year (which were moderately correlated; $r=.48$, $p<.001$), it turned out that the former variable was more highly correlated with other variables it should have theoretically been related to than was the latter (e.g., weight philosophy correlated .64 with dieting and .34 with the latter measure). Therefore, dieting was the independent variable of choice. Similar decisions were made regarding smoking items and other dieting items. It is interesting to note that among the NAAFans who responded that they are not currently dieting (47 participants, or 78%), more than a third of them (16 participants) stated that they had attempted to reduce their food intake in order to lose weight during the past year, with the average number of days being 112, (s.d.=95). The median number of days was 80.

In order to get a measure of socioeconomic status, mothers' and fathers' highest education level were examined. Mother's education was available for all participants who answered the education questions, while data on father's education was missing for three participants who were able to provide the information for their mothers only. Since mothers' and fathers' education was moderately correlated ($r=.50$, $p<.001$), it was decided to use mother's education only, as a measure of socioeconomic status, in order not to lose information on participants and consequently lose power.

Composite Variables: Several variables were created from other variables, in order to simplify the analyses, and to avoid multicollinearity problems. A composite variable was created from the health insurance information provided by participants, which ranges in value from 0 to 3, with zero representing a person with no insurance, and 3 representing a person whose insurance covers hospital stays, doctors visits, and medical checkups. Only in rare instances did participants report that their insurance covered health services by non-physicians unless the person was also covered for the other three, therefore this information was not taken into consideration for the composite variable. Questions addressing the reasons that participants gave for having actually avoided a physician visit in the past were transformed into four continuous variables representing the number of reasons listed. The four variables were made up of recent reasons (over the past

year) that were related to weight and not related to weight and past reasons (*ever* a reason for avoiding a physician visit) related to weight and not related to weight.

"Truncated" Variables: Several of the variables contained rather extreme outliers. For example, for the question asking participants how many days they were ill this year, the response of four of the participants was more than one hundred days. In order to minimize the inordinate influence of outliers on these variables, a rule of thumb was used whereby cases that were more than three times the interquartile range from the median were recoded into the highest category. For example, for the variable "number of days ill", the interquartile range was 9 days, and the median was 4. Therefore, those reporting that they were ill more than $(9 \times 3) + 4 = 31$ days, were all placed into the category "32 days (or more)". These truncated variables were used in the regression equations, and to determine correlations. However, the T-tests reported earlier, and the information in Tables 1 through 4, contain information on the true means for the data.

Variables Included in the Equations

According to Norusis (1983), it is not a good strategy to include a large number of independent variables into a regression equation unless there are strong reasons for including them; by including many variables, the standard errors of estimate are increased, and the model is often difficult to interpret. While several independent variables that were not expected to be related to the dependent variables were purposely left out of the regression equations, many were included in later analyses, to see whether, in fact, they would have contributed to prediction. The results of these subsequent analyses are reported in this section.

All regression equations used the demographic variables age and mother's education, the developmental variable indicating whether or not participants were fat as children, four weight-related variables (whether or not they were currently dieting, how much weight they've lost from their highest weight ever, their weight perception in comparison to the norm, their current weight measured in Body Mass Index units), and their group membership (NAAFA or Weight Watchers).

All regression equations for the physician-related dependent variables included five health-related variables (number of days ill during the past year, perceived health status, level of

medical insurance coverage, whether or not they had a regular physician, and whether or not they currently smoked), all of which should presumably affect one's level of physician utilization. These variables were not expected to affect participants' self-esteem or weight philosophy and were not included in the regression equations for these two variables. However, the health-related independent variables were included as a block in subsequent regression analyses for self-esteem and weight philosophy and were found not to contribute a significant amount of variance to the R^2 for either one.

It was expected that both political leaning and self-esteem would be related to participants' weight philosophy; these variables were included in the regression equation predicting weight philosophy. Unfortunately, these two variables (political leaning and self-esteem) were not included in an earlier version of the questionnaire and are not available on the majority of NAAFA participants. It was not expected that political leaning would be related to any other variable besides group philosophy. In addition, t-tests showed no differences on this variable by group or by weight. For these reasons it was eliminated from analyses for the other dependent variables. It seemed, on the other hand, that self-esteem might have some impact on the physician-related variables, although t-tests showed no differences on this variable by group or weight. Because the inclusion of this variable would have greatly diminished the number of participants that could have been included in the analysis, a decision was made not to include it for the physician-related variables. Subsequent analyses were run with self-esteem, to see if it would have contributed significantly to the equation, and, in fact, it did not.

Physician's age was also available only for a limited number of NAAFA participants, and its inclusion would also have reduced power. Since physician's age was moderately correlated with participant's age ($r=.31$, $p=.008$), a decision was made not to include this variable in the regression equation, in order not to reduce the size of the sample.

Because participants' education level was moderately correlated with mothers' level of education ($r=.37$, $p<.001$), it was not included in the regression equations. This variable was

tested afterward, however, to see if it would have added significantly to the equations. It did not do so.

Because the participants were predominantly white, it was not expected that including race in the equations would help prediction. Preliminary analyses of variance were conducted to see if there were any significant differences between three groups: white, non-white, and those who considered themselves both white and another race. On only one out of 15 dependent variables were the groups significantly different. Non-whites were more likely than whites, $F(2, 114) = 4.92, p = .009$, to name non-weight-related reasons for not having seen a physician within the past year ($M = 1.87$ and 1.00 reasons respectively). Since only this one variable was significant, and since three similar variables concerning reasons for not visiting a physician were not significant, it is likely that this difference was due to chance alone. A decision was made to leave race out of the regression equations, although subsequent equations including race were tested. Again, race only contributed significantly to the R^2 of the variable which measured the number of reasons for not seeing a physician within the past year (the b -weight was $-.153$ and the beta weight was $-.229, t = -2.503, p = .01$). This one significant finding did not add meaningfully to the understanding of how race affects fat people's attitudes and behaviors toward physicians, so this variable was left out of the equations.

Additional variables included in the questionnaire, such as physician's sex, or participants' religion, were included in the questionnaire in order to see if there were any noticeable differences between participants by group or weight. These variables have not been included in the regression equations.

Self-Esteem

The variables at the first step, age and mother's education, did not add significantly to the R^2 , nor did whether or not a person was fat as a child, after accounting for the two previous factors (see Table 7). The variables related to weight did add significantly to the R^2 , but group membership did not. Of the weight-related variables, only weight perception contributed significantly to the equation -- the higher one's perception was of how heavy one is relative to the

norm, the lower one's self-esteem. Current weight did not contribute significantly to the equation, nor did any interactions.

Weight Philosophy

Neither age, mother's education, nor whether a person was fat as a child contributed significantly to this equation (see Table 8). Politics contributed significantly, while self-esteem did not. The weight-related variables seemed to contribute significantly to the R^2 , but once group membership was entered, and an interaction of group with politics, the b-weights for the weight-related variables were not significant. Finally, group membership contributed significantly to the equation, as did a politics by group interaction. Group had the highest beta-weight in this equation. The main effect for group membership indicated that Weight Watcher members were more likely than NAAFA's to believe they have responsibility and control over their weight. The main effect for political leaning indicates that those with a more conservative political view are more likely to believe they have responsibility and control over their weight. The politics by group interaction (see Figure 2), shows that while political leaning has very little effect on the Weight Watchers, most of whom believe very strongly that they are responsible for their weight, it had a much stronger effect on the NAAFA's -- those who consider themselves more conservative are more likely to think similarly to the Weight Watchers, while those who consider themselves liberal are more likely to believe they have less responsibility for, and control over, their weight.

Physician-Related Dependent Variables

The remaining dependent variables which were subjected to regression analyses all addressed the issue of physician visits, delay, and attitudes toward physicians, and the same independent variables were entered for all, in the same order. Note that the analysis for the variable regarding length of time a person has their current physician included only those participants who had a regular physician; therefore, this regression analysis did not include the dummy variable of whether or not one has a current physician.

- Length of Time Has Current Physician

This variable was transformed to make the residuals somewhat more normally distributed, using a log function. Neither of the demographic variables, age or mother's education, contributed significantly to the equation (see Table 9). Whether or not one was fat as a child contributed significantly to the R^2 , indicating that those who were fat from childhood were likely to have had their physicians for less time than those who became fat at a later age. The health-related variables did not contribute significantly, nor did the weight-related variables. Group membership, however, contributed significantly to this equation, even after controlling for the other variables, indicating that Weight Watchers were more likely to have had their physicians for a longer period of time than the NAAFA's. Although one might expect that those who are older would have had their physicians longer, age was not significantly correlated with this variable ($r < .001$, $p = .993$). No interactions contributed significantly to this equation. The variable addressing whether or not participants were dieting had a significant b-weight in the final equation, although the weight-related variables as a whole did not significantly increase the R^2 . The regression equation was rerun with this variable in the block alone (removing weight lost, weight perception, and current weight), but even then, dieting did not contribute significantly to the R^2 .

- Length of Time Since Last Saw a Physician

Only the subjective and objective measures of health status contributed significantly to this equation (see Table 10), indicating that those who were less healthy were likely to have seen a physician more recently than those who were healthier. Objective health status had a higher beta-weight than subjective status, but both helped in prediction. Neither of the demographic variables, nor whether one was fat as a child contributed significantly. None of the weight-related variables, nor group membership were significant, and no interactions contributed significantly to the equation.

- Delay Before an Appointment to see a Physician

No variables at all contributed significantly to this variable. Even with all variables included the R^2 was equal only to .14 ($F=1.15$, $p=.33$), with an adjusted R^2 of just .02. It is possible that the wording of this question led to two different interpretations by participants. Respondents may have interpreted the question to be asking how long a time the person themselves delayed in seeking a physician's care (a time period mostly in the control of the participant). On the other hand, respondents may have interpreted the question to be asking how much delay there was between the time an appointment was made and the time the person actually got to see the doctor (a time period mostly out of the control of the participant). This confusion over meaning may have led to very little variance being accounted for by the independent variables.

- Number of Times Saw Any Physician over the Past Year

Only the subjective and objective measures of health status contributed significantly to this equation indicating that the less healthy participants were likely to have had more physician visits over the past year (see Table 11). The objective measure of health status had a higher beta-weight than the subjective measure. None of the other variables contributed significantly to this equation, nor did any interactions.

- Number of Different Physicians Seen over the Past Five Years

In order to improve the homoscedasticity of the residuals, this variable was transformed using a log function. Whether or not one was a fat child contributed significantly to the equation, indicating that those who were fat as children were likely to have seen more physicians over the past five years (see Table 12). Neither of the demographic variables contributed significantly. Smoking status contributed significantly to this equation -- those who do not smoke were more likely to have seen a larger number of different physicians than those who smoke. The objective health measure was also significant -- those who were healthier saw fewer different physicians. None of the weight-related variables contributed significantly to the equation. Group membership did not contribute significantly to the equation before the inclusion of a smoking by group interaction, after which the b-weight for group was significant, indicating that Weight Watchers

were likely to have seen a larger number of different physicians. Finally, a smoking by group interaction was found to be significant (see Figure 3), indicating that, while for the Weight Watcher group, smokers were slightly more likely to see a larger number of different physicians, for the NAAFA members, those who were smokers were very likely to have seen many fewer different physicians than were those who did not smoke. Note that although the addition of this interaction caused a multicollinearity problem (resulting in a beta-weight of greater than 1), this term is clearly significant and added an additional .05 to the R^2 .

- **Likelihood of Visiting a Physician for Serious Symptoms**

Only age contributed significantly to the R^2 indicating that those who are older are more likely to visit a physician for serious symptoms than are those who are younger (see Table 13). No interactions contributed significantly to this equation.

- **Likelihood of Visiting a Physician for Non-Serious Symptoms**

Similar to the previous equation, only age contributed significantly to the R^2 indicating that those who are older are more likely to visit a physician for non-serious symptoms than are those who are younger (see Table 14). No interactions contributed significantly to this equation.

- **Positive Attitudes Toward Physicians**

Only the weight-related variables contributed significantly to the R^2 (see Table 15). No interactions contributed significantly to this equation. Current weight was the only variable with a significant b-weight, although the equation as a whole did not account for a significant amount of variance. The equation was rerun, using only current weight in the block for weight-related variables, still controlling for the earlier variables. The second equation did result in a significant R^2 , indicating that those who currently weigh more have a less positive attitude toward physicians. This second equation resulted in b- and beta-weights of -.152 and -.287 for the current weight variable ($t=-2.772$, $p=.007$). The total R^2 for the equation was .159 ($F=2.06$, $p=.04$); the adjusted R^2 was .08.

- **Negative Attitudes Toward Physicians**

None of the variables contributed significantly to the equation. Even with all variables included the R^2 was equal only to .13 ($F=1.05$, $p=.41$), with an adjusted R^2 of just .01. Although this variable proved to be internally consistent (an alpha coefficient of .70 was obtained), independent variables which should have been expected to be related to negative attitudes did not add a significant amount of variance to the equation. It is not clear whether the variable is measuring something other than what it was intended to measure, or whether there was a problem in measuring the independent variables. Since many of the expected relationships were obtained for other variables, it may be that the negative attitude variable is measuring something other than that intended.

- **Weight Related Reasons for Ever Avoiding Physician Visits**

This variable, as well as the next three similar variables, was transformed to make the residuals somewhat more normally distributed, using a log function.

Only age contributed significantly to R^2 , indicating that those who are older named fewer weight-related reasons for ever having avoided physicians (see Table 16). No interactions contributed significantly to the equation.

After all variables had been entered, whether or not one had a regular physician, and one's current weight both had significant b-weights. The equation was rerun with only the regular physician variable in the health-related block, and only current weight in the weight-related block. Both variables contributed significantly to the R^2 , indicating that those who have a regular physician name fewer reasons for having avoided physicians, while those who weigh more indicate more reasons for avoidance. This second equation resulted in b- and beta-weights of .136 and .192 for the regular physician variable and .006 and .232 for the current weight variable ($t=2.125$, $p=.04$ and $t=2.424$, $p=.02$, respectively) causing the age variable to no longer be significant. The total R^2 for the equation was .142 ($F=3.53$, $p=.005$); the adjusted R^2 was .101.

- **Weight Related Reasons for Avoiding Physician Visits (Past Year)**

Only the variable indicating whether or not the participant was fat as a child contributed significantly to the R^2 (see Table 17). However, the regression equation as a whole was not significant. While the health-related variables did not contribute significantly to the R^2 , with all variables entered the variable indicating whether or not a participant had a regular physician had a significant b-weight. The equation was rerun with only this variable in the health-related block, and the resulting equation was significant, indicating that those with a regular physician indicated fewer weight-related reasons for avoiding physicians in the past year, and those who were fat as children also indicated fewer reasons. This second equation resulted in b- and beta-weights of .140 and .239 for the regular physician variable ($t=2.593$, $p=.01$) and the b and beta-weights for the fat as a child variable were .109 and .203 ($t=2.161$, $p=.03$). The total R^2 for the equation was .105 ($F=3.17$, $p=.02$); the adjusted R^2 was .072. No interactions contributed significantly to the equation.

- **Non-Weight Related Reasons for Ever Avoiding Physician Visits**

Only age contributed significantly to R^2 (see Table 18), indicating that those who are older gave fewer reasons for having avoided physician visits. Although the weight-related variables did not contribute significantly to the R^2 , the b-weight for current weight was significant. This equation was computed again, including only current weight in the weight-related block. In the second equation, current weight contributed significantly, indicating that those who weigh more are likely to name more non-weight related reasons for avoiding physician visits. The b- and beta-weights for current weight were .006 and .202 ($t=2.052$, $p=.04$) and the b and beta-weights for the age variable were -.009 and -.298 ($t=-2.898$, $p=.005$). The total R^2 for the equation was .218 ($F=3.13$, $p=.002$); the adjusted R^2 was .149. Age had a higher beta-weight than the weight variable did. No interactions contributed significantly to the equation.

- **Non-Weight Related Reasons for Avoiding Physician Visits (Past Year)**

Only age and whether or not one had a regular physician contributed significantly to the R^2 (see Table 19), indicating that those who are older and those who have a regular physician

indicated fewer reasons for having avoided a physician in the past year. Having a regular physician had a higher beta-weight than the age variable. No interactions contributed significantly to the equation.

One additional analysis was performed on the latter set of four variables. Obviously, participants indicated a greater number of reasons for having ever avoided physicians than they gave for avoiding physicians only over the past year. In an attempt to see whether this change in number was similar for the Weight Watchers and the NAAFAns, t-tests were performed to examine the difference between the two groups in the amount of change (that is, how many fewer reasons were given recently). While for non-weight-related reasons, the means representing the amount of change were not significantly different ($M=1.01$ vs. 1.82 respectively, $p=.07$), for weight-related reasons, the NAAFAns were significantly more likely ($p=.03$) to have given fewer reasons now ($M=1.08$) than were the Weight Watchers ($M=0.51$). In other words, while all participants indicated fewer reasons recently for avoiding a physician visit than they had over their lifetimes, for the NAAFAns this change in weight-related reasons was greater than for the Weight Watchers.

There were no significant interactions of group and weight for any of the fifteen dependent variables. Because all of the analyses entered current weight before group, it was important to see whether group or current weight accounted for a higher proportion of variance in each of the dependent variables. A set of regression equations were run using only group membership and current weight to see which of the two accounted for a higher proportion of variance (see Table 21). For three variables -- weight philosophy, length of time one has their regular physician, and likelihood of visiting a physician for serious symptoms -- the group variable accounted for a higher proportion of variance. However, none of these findings were masked by entering the weight variable first. For five variables -- number of times one has seen a physician over the past year, the number of different physicians seen over the past five years, positive attitudes toward physicians, weight-related reasons ever avoided physicians, and non-weight-related reasons ever avoided physicians -- the weight variable accounted for a higher proportion

of variance. Note however, that when the regression equation controls for other factors, these variables contribute significantly to only some of these variables.

Table 22 summarizes the results of the regression analyses in one table. The discussion section will explain the findings in more detail.

Comparison of Study Participants to National Norms

The questionnaire used in this study included several questions which have also been used in large national studies. It is important to note, however, that the sample used in this study was not one representative of fat women in general, nor even of fat women within the two organizations Weight Watchers and NAAFA; therefore, any comparison with national statistics must be interpreted cautiously.

National data collected on the number of times people had contact with a physician in the past year generally show between 5 and 6 contacts a year on average (National Center for Health Statistics, 1987, Wilensky & Bernstein, 1983, Moss & Parsons, 1986). In some studies this number includes telephone contacts as well as actual visits. Participants in the present study averaged 4.8 visits (Weight Watchers) and 8.4 visits (NAAFAns). After truncating the variables because of outliers, the means were 4.0 and 4.9 respectively. Since the current study did not ask about telephone contacts, these numbers seem to indicate that participants in this study were no less likely to visit physicians than those in the general U.S. population.

Among those in the general population, physicians most likely to be contacted are general practitioners (42%), internists (12%) and obstetrician/gynecologists (7%) (National Center for Health Statistics, 1987). In the present study, these are also the three types of physicians participants were most likely to have as their regular physician. Weight Watchers had the three types of physicians as their regular physicians in the following percentages: 48%, 24% and 24% respectively, while the NAAFAns had these types of physicians 44%, 30% and 10% respectively as a regular physician. Note that the national data represent physician contacts over a year, rather than a person's regular physician, so the data are not directly comparable. However, the similarity

in numbers shows the current study participants to be similar to those in the general population. Note also that since the present study used only women, the use of obstetrician/gynecologists should be expected to be much higher than for the general population which also included men. While this was true for the Weight Watchers, it was only slightly higher for the NAAFAns.

For the general U.S. population, 75% have contacted a physician at least once during the past year, while only 4% have not seen a physician for five or more years (National Center for Health Statistics, 1987). Among the NAAFAns, 90% have seen a physician during the past year, and 2% have not seen a physician for five or more years; among the Weight Watchers, the corresponding percentages are 92% and 2%.

For women, ages 17 to 64, a range of 76% to 88% have a regular source of medical care, generally a private physician (Bloom & Jack, 1985). Among the present study's participants, 77% of the NAAFAns, and 81% of the Weight Watchers have a regular physician.

While these numbers seem to indicate that the women in the current study, who are at least 30% overweight according to medical standards, are just as likely to make use of health care as is the rest of the population, it is noteworthy that this group of women perceive themselves to be much less healthy than do those in the general population. Among women in the general population, 36% consider themselves in excellent health, 28% very good, 25% good, 8% fair and 3% in poor health (Moss & Parsons, 1986). Among the current study's participants, the corresponding percentages for NAAFAns were: 15%, 45%, 27%, 13% and 0%; and for Weight Watchers: 9%, 40%, 45%, 5%, and 2% (see Figure 4). Since it has been shown that those who perceive themselves to be less healthy make greater use of physicians and other health care practitioners (Bloom & Jack, 1985; Mugge, 1983; National Center for Health Statistics, 1987), it is possible that for similar levels of perceived illness, the fat women actually use health care less often. In addition, the participants in this study differed from the general population in that they are all women and have much higher education levels, both characteristics that have been shown to lead to greater health care usage (Safer, Tharps, Jackson, & Leventhal, 1979). Since the usage rates appeared to be similar despite background characteristics that usually lead to

increased health care usage, it is possible that if one were able to control for background characteristics, those who are fat would be shown to have lower physician utilization rates than others in the population. Because the national sample and the present sample cannot be compared directly, this latter hypothesis is purely speculative, and might be investigated more directly by conducting a secondary analysis of the national data, examining weight as an independent variable.

Qualitative Results

This section will discuss findings from interviews conducted with 20 participants whose selection was described in the methodology section. Three groups of women interviewed will be compared with one another; for the sake of convenience and clarity, the three groups will generally be referred to as "Weight Watchers" (seven women chosen for interviews from the Weight Watcher group), the "smaller NAAFA group" or "smaller NAAFAns" (seven women selected for interviews from the NAAFA group, whose Body Mass Index was less than 50) and the "larger NAAFA group" or "larger NAAFAns" (six NAAFA women whose Body Mass Index was greater than 50). Quotes from participants will be followed by an indication as to which group they belong: "[Weight Watcher]", "[NAAFA A]", or "[NAAFA B]", respectively. In the interest of anonymity, individual quotes were not identified in a way that they could be linked with all other responses made by the same person; however, where additional information about the respondent aids in the understanding of the point being made, and where it is not in conflict with ethical principles, that information has been made available. Note that the participants who were interviewed were not randomly selected from their organizations and are not necessarily representative of the views of the other members of those organizations.

A word about how the groups were split: It is important to note that while all the women in the first group were current Weight Watcher members, all the women in the second group were active in NAAFA and were matched for current weight with the first group, and women in the third group were selected for being active in NAAFA and being at very high weights, the same 20 women could have been partitioned by their highest weight rather than their current weight. Using this criterion, two of the women in the the smaller NAAFA group who have lost a lot of weight would have been in the larger group and a third would have come close. It is possible that many of the comments made by these participants may reflect their experiences at their former weight status, rather than their current status. This alternative way of partitioning the data was kept

in mind throughout this analysis and will be mentioned when clear differences seemed to emerge based on highest weight rather than on current weight.

Note also, that while physicians were the main focus of the interviews, comments from participants which related to other types of health care workers were also included.

Participant Characteristics not Directly Related to Weight

While participants discussed in depth issues related to their weight and health, they were also asked about their ethnic and religious background, marital status, and level of political activity to see if there were any strong differences between the groups.

Ethnic/Religious Background

The ethnic and religious backgrounds of people in the three groups were very similar. All of the participants were either from Northern or Eastern European backgrounds, and were either Jewish or Christian. All participants were white.

Participants were asked whether they thought their ethnic background was related in any way to their family's attitude toward weight. Only one person in each group believed there was a relationship: the Weight Watcher Quaker felt that her background stressed an understanding that people's bodies are their own, to do with what they wish, and that others are not free to comment on it; and one Jew in each of the two NAAFA groups felt that among poor Eastern-European Jews, there are strong efforts to be upwardly mobile, and that fatness is not as acceptable because thinness helps one attain a higher status. Interestingly, almost all respondents felt that their ethnic backgrounds contributed in some way to their being fat, either because it is in their culture to "push" food, or because the typical foods eaten by their ethnic group are more fattening.

Marital Status

The Weight Watcher participants were more likely to be currently married than those in the two NAAFA groups. Four participants in the former group were currently married, while only one participant in each of the two NAAFA groups were currently married. One person in the Weight

Watcher group and one in the larger NAAFA group was separated, and one woman was widowed and one divorced in the smaller NAAFA group. The difference in the number married is not surprising in light of the fact that NAAFA is considered a social group as well as a human rights group, and is a place where many single fat women go to meet men.

Political Activity

Participants did not differ between the groups in their level of political activity participation. Only one participant, a Weight Watcher, said that she is currently politically active (in groups that are involved in social causes). Two of the larger NAAFAnS stated that they are politically involved in fat activism, but not in other political causes.

Participants' Weight and Dieting History

Number of Other Family Members Who are Fat

Almost all respondents reported that most relatives in their family of origin were fat. Only one Weight Watcher, and two of the smaller NAAFAnS did not come from families that had a lot of fat members. Every participant but one indicated that they were the fattest member of their family, although one Weight Watcher, and two of the smaller NAAFAnS indicated that at least one other family member was equally as large. Only one participant (a smaller NAAFAn) had a family member (a brother) who was fatter than she. Notably, while participants in the Weight Watcher group and in the smaller NAAFA group reported similar weights for the fat members of their families, participants in the larger NAAFA group reported their family members to be much larger than those in the other two groups. Most of the fat family members of the Weight Watcher group and the smaller NAAFA group were reported to be anywhere between 30 to 100 pounds above normative weight (the two exceptions to this was one family member who was reported to be approximately 150 pounds above normative weight, and one who was approximately 250 above.) Most of the participants in the larger NAAFA group reported family members who were more than 200 pounds above normative weight, and some who were well over 300 pounds above normative weight.

Age First Fat

Almost all of the participants had been considered fat from a young age. The Weight Watcher group and the smaller NAAFA group had a similar profile: three in the former group and two in the latter were considered fat before they were 2 years old, two in the Weight Watcher group and two in the smaller NAAFA group became fat before they reached their teens, one in each group became fat as a teenager, and one in each group became fat in their 20's. By contrast, five out of six of the larger NAAFA group were considered fat as babies, and the other became fat by the age of 6.

Attitude of Family of Origin

One notable way in which the groups differed was in their family's attitude toward their weight while they were growing up. Every Weight Watcher participant, without exception, reported being raised in a family where weight was not a big issue, and where they were not pushed to diet or made to feel bad about themselves because of their weight. Some Weight Watchers reported that their family was somewhat concerned about their weight and gave them some encouragement to diet, but it was not an issue that was repetitively discussed, and the participants felt basically supported by their families. On the other hand, almost every participant in the two NAAFA groups was treated in an extremely negative manner by family members because of their weight, and were pushed constantly to diet. In many cases, weight became the central issue of their lives – they were not allowed to eat the same foods as other family members; they were often made the center of attention regarding their weight; they were often embarrassed in front of others because of their weight; and they were made to feel worthless unless they were able to reduce. Among the NAAFA participants, there were a few exceptions to families having extremely negative attitudes: one participant in each of the two groups came from very supportive families regarding weight, and one of the larger NAAFA group participants came from a family that was not strongly negative about her weight, although also not particularly supportive.

The following are examples of some of the comments made by Weight Watcher participants about their family's attitude toward their weight:

"My family didn't constantly nag me or anything. My mother didn't say that I *had* to lose weight, that I *had* to go on a diet." [Weight Watcher]

"Their attitude toward gaining weight was 'you're not fat you're healthy'. They were the type of people who, if you asked for another helping of whatever, 'Uh, leave them alone, they're not getting fat, they're healthy, they like to eat', and they would give you more. That's my grandparents. My parents were the same way. " [Weight Watcher]

"It really didn't matter. If you were happy with what you were like, no one said anything. They still don't. No pressure was put on me to lose weight. My family loves me." [Weight Watcher]

"Of course they didn't want me to feel neglected food-wise. That was a way of showing love obviously. But they never really said much. 'Oh, when she gets older, she'll grow out of it.'" [Weight Watcher]

On the other hand, these are some of the comments made by participants in the smaller NAAFA group:

"My father was the most upset about my weight. There were lots of cracks about it. I could not eat comfortably around him. Anything that was ever missing in the household, it had to be me who had eaten it. A lot of insulting comments were made. 'Whoa. Why don't you eat more ice cream, that's just what you need.' That kind of stuff, in front of the whole family. He let me know that I was such a pretty child, and that I was the apple of his eye and that he was utterly disappointed in me." [NAAFA A]

"They were always 'you should lose the weight'. It was always like my responsibility to lose the weight but they never gave me any encouragement to go along with it. No incentive, no help. The minute you reached for the piece of bread, she [her mother] would say 'aren't you supposed to be on a diet'? She would look at what you were eating. She'd look disapprovingly. My mother's mother and aunt, at any kind of family function, if you took 2 grains more than the rest of the people did, they'd 'tsk, tsk, tsk', and their heads would shake. I was always, always being watched by people." [NAAFA A]

Even the one NAAFA participant who did not become fat until she was in her 20's, was raised in a family where weight and body size were a major issue, and she was made to feel that her body was not right.

"I considered myself fat when I was even thin. As a young child, we are not a thin family, and my father was very troubled by anything that wasn't intensely thin. When I was a young child and I was very thin, I worried about being fat. I started breast development early. I developed a body, a figure, early and I think that was considered a sin in those days. For some reason I was embarrassed, in gym classes, in college. My father never thought I was attractive or well-groomed." [NAAFA A]

These are some of the comments made by participants in the larger NAAFA group:

"It was terrible. I mean it was like diet, diet, diet. They put me on diets when I was very young. I mean maybe when I was seven years old I went on my first diet. And it was always something. It was always Weight Watchers, or diet pills or this, or that." [NAAFA B]

"I was told 'you don't need that. You can't have it.' That was the phrase that stands out the most in my mind -- 'you don't need that. And your brother and sister could afford to eat that. You can't.' Milk and cookies -- they got like a handful of cookies and a glass of chocolate milk. And I got a little bit of milk and a cookie or two and I *hated* milk. But 'if you are not going to drink it plain, you are just not going to drink it'. . . I ate compulsively because I felt deprived and it got to a point where it didn't even matter what it was. I just kept eating." [NAAFA B]

"They were not pleased. They were very unhappy. My mother was devastated by my weight. I mean, my mother's dead now, and if she wasn't, my [recent gain in] weight now would kill her." [NAAFA B]

Several of the participants reported that their family's attitude has changed quite a bit from when they were growing up. In two cases, the attitudes of the Weight Watcher's family became more negative, while four of the NAAFAns' became more positive. Not surprisingly, the one Weight Watcher who did not become fat until her 20's reported that her family is very bothered by her weight, while weight was not an issue in her family at all while she was growing up. Another Weight Watcher reported that her family is now very negative about her weight even though they were very supportive of her as a child. This, she believes, is due to the fact that her fat mother became diabetic because of being fat, and the family is now very concerned about the participant's health. On the other hand, two individuals in each of the NAAFA groups reported that since they have become involved in the size acceptance movement, and have had many discussions with their families about their activism, and about their efforts to feel good about themselves at their current size, their families no longer openly bother them about their weight. In some cases, the NAAFAns have convinced their families of the damage that was done to them by the family's negative attitudes, e.g., one of the smaller NAAFAns had stopped eating at one point and was "headed for anorexia" which scared her parents, who now no longer bother her about weight loss. In other cases, the families have given up because the participant insisted that they do so. For example, one of the larger NAAFAns said:

"They were always hounding me and I finally told them. I said 'look, this subject is no longer up for discussion. You just cannot talk to me about it anymore. It is my life and that's the end. And I don't want to hear it. If you feel the way you feel, keep it to yourself. Talk amongst each other. Don't talk to me about it anymore.' And they kind of, you know, they respected me for what I had to say, and they left me alone afterwards about it. My father, I actually had to even be more stern with him. You know it got to a point that finally I went over to visit him and he started hounding me and hounding me and hounding me and I just said 'you know, my life is more than just about my weight. You know I'm more than just a person who has a problem with weight. I have a life. You know, I have

interests'. And I said to him that he has reduced our relationship down to only being about weight. And it was true. At that point that is all he did." [NAAFA B]

Other NAAFAns stated similarly that they have "told off" their families and that their families "wouldn't dare mention it" to them anymore. On the other hand, many of the NAAFAns had families who continue to be critical of their weight. One of the smaller NAAFAns said:

"Oh god! I can't stand it. They want to send me away to a fat farm. You know, stuff like that. They are very embarrassed. They can't understand why I'm not going on a very strict diet. Some place -- a health place, a nutritionist whatever." [NAAFA A]

Another woman in that group stated that her family was full of praise for her when she lost weight from being severely diabetic "even though I was unhealthy when I was doing it."

As adults, most of the participants experienced their family wanting them to lose weight, but, again, the flavor of the family's interactions was very different for the Weight Watchers versus the NAAFAns. One of the smaller NAAFAns had gone to visit her father who was in the hospital for a serious illness, and he looked up and said:

"My god, do you know how many people in this room are looking at you? I just watched you bounce all the way over here, and all these people are looking at you.' What could I do about it? I don't know to this day what he thought he was gaining by it." [NAAFA A]

One of the larger NAAFAns recalled this story:

"There was a time, you know maybe it was a year ago, two years ago, that as a family we all went out to a restaurant on some occasion or something, and it was very crowded and we had to wait outside to get tables. And my father started yelling at me at the top of his lungs in front of these people about my weight. Just like that -- like an animal. He thought he could embarrass me into going on a diet and losing weight." [NAAFA B]

Some of the Weight Watcher participants described their family's desire for them to lose weight like this:

"My mother, I think, went through periods where she was supportive and then she'd be, not critical exactly, more kind of 'you have to do it on your own'. Sometimes I think she'd have the attitude 'gee, there really isn't too much you can do about it. It kind of runs in the family.'" [Weight Watcher]

"I think in general, most of the people around me did not make fun of me or give me a lot of pressure about it. But there was, sort of encouragement to do something about it. They're still very encouraging, asking me how Weight Watchers is going, and giving me encouragement and so forth. My parents have both been encouraging, and not very intrusive in my life." [Weight Watcher]

Even one of the Weight Watchers whose family now feels negatively toward her weight described it in a fashion that seems mild in comparison to how many of the NAAFAns described their families:

"She [her mother] used to pat me on the rear and say 'oh that's a lot there'. She did try to talk to me about losing weight diplomatically. Like she would say 'are you losing anything? How are you doing?' But my father is not diplomatic. And he tried to get me to lose the weight. I guess he would just talk to me. He would say you know 'how much weight have you put on? How many pounds have you put on?' He is always very to the point."
[Weight Watcher]

Perhaps as a reaction to their family's negative behavior toward them, four of the NAAFAnS, two from each group, spontaneously reported that they had blocked out of memory large portions of their life, mostly their earlier years:

"I had numbed so much out that I didn't have normal reactions to things. I would just block it out -- it didn't exist . . . That was always my way of handling things. I either went into a fantasy world or I just totally blocked it out -- it didn't happen. You know, bad things didn't happen. They did, but then I would immediately put the walls up, and then they didn't exist." [NAAFA A]

"I don't remember my 20's. It's like, there's a certain period of my life, that my life consisted of getting up in the morning, walking the dog, going to work, coming home, walking the dog . . . There's a span of approximately 15 years in there. As far as I'm concerned, I always considered that my hibernation. Like cryogenics. I spent 15 years as a somnambulist, just sleep-walking through life." [NAAFA A]

"One way I defend against pain is I forget a lot of things. Sometimes it's really hard for me to remember things in the past, if they're negative. I've worked on that a lot -- to try to remember the facts without remembering the pain . . . I learned early in my life that you can choose to remember things and forget things, you can choose to see things and not see things . . . I'm very effective at blocking things out." [NAAFA B]

"I don't really remember my childhood. It's been blocked out somehow, I don't know why. In general, I don't remember childhood." [NAAFA B]

The difference in family attitudes between Weight Watchers and NAAFAnS is striking, and probably explains another interesting area in which the groups may differ -- their perceptions of their body size as children. One Weight Watcher participant and three NAAFAnS spontaneously mentioned that they either looked at pictures of themselves as young children, or thought back to that time and were surprised at their size; the Weight Watcher was surprised at how fat she was and the NAAFAnS were surprised at how small they actually were in comparison to how they felt:

"I didn't think of myself as fat. I looked back at pictures of myself as a child and I said to myself 'My god, was I that fat?'" [Weight Watcher]

"I considered myself fat . . . When I was a young child and I was very thin, I worried about being fat . . . I look at the pictures now, and I had the greatest body." [NAAFA A]

"Looking back, I wasn't that fat. Being in NAAFA, you hear about people who are enormously fat, even as children. I think I was heavier, I was tall, I was big, and I was heavy. I always felt on the margin. I was always self-conscious that I was fat. But I wasn't always 'that fat.' I mean, I was fat, but I wasn't always 'that fat'." [NAAFA B]

"It's very interesting. Looking back I don't think I was that fat. But I think everybody for some reason had this thing that, you know, everybody made me feel like I was tremendously fat. But I don't really think I was that fat. I think I was a little chunky. I did a TV show a couple of years ago through NAAFA. And they asked us, it was all about, you know, fat-related issues. And they had asked us to go and dig through our pictures because they wanted to show pictures of us growing up in different stages. And one of the things that all of us in the group realized when we had gone through our pictures was that we really weren't that fat. Yet we felt tremendously fat. I mean we felt like we were, you know, like outcasts of the world. And I really feel it had to do with our parents, and, you know, our peers at school. Just really making you feel, you know, so out of place because of it. And yet we really weren't that fat. You know, *now* is another story. But back *then*." [NAAFA B]

Attitude of Current Family

In discussing family attitudes, participants also talked about their current families -- spouses, children and lovers. In contrast to the generally positive attitudes of the families of origin of the Weight Watchers, and negative attitudes of the NAAFAns' families, the pattern was somewhat opposite for mates. All of the NAAFAns who are currently married or involved with someone reported their partners to be supportive of their weight, and the same was true of the husbands of those previously married as well. However, one woman reported that her weight had not been a problem at all in her marriage, but when it came time for her divorce, her husband brought up her weight as the reason for the failed marriage:

"Weight was the reason for the divorce, of course. I was, quote, so cruel, and tyrannical, that I didn't realize the emotional harm I was to my daughter and him with my excess weight (laughs). Do you like that one? Did anyone ever have a divorce reason like that? That's what his counter-suit was. He had to say something. He never said a word to me [about weight]. Never. Only during my divorce. And then not to me. To the papers. I don't think it was an issue. I think it was something the world would buy." [NAAFA A]

Among the Weight Watchers were several women whose mate was unhappy with their weight. One was separated from her husband:

"That was a sore point in the marriage. The weight had always been a problem. He came from a thin family, so it was a hard concept for him to accept and I did put on quite a bit of weight since I'm married. That compounded things." [Weight Watcher]

One of the women is currently married, and her husband would like her to lose weight:

"He says 'Oh, you are going to retire in December', and he says something like 'well I guess you don't mind going into the retirement dinner waddling'." [Weight Watcher]

Another is a lesbian whose lover has said to her:

"My god, you've gained a lot of weight in the year that I've been with you.' . . . my lover is really turned off to it . . . She'll say to me, 'you know, you've really got to lose weight', or she'll make a joke . . . So it's an issue." [Weight Watcher]

On the other hand, one woman had a husband who actually says to her that he has no problem with her weight, but she will not believe him:

"My husband doesn't say anything [about my weight]. He likes me the way I am. (laughs). That's what *he* is saying. But I'm quite sure he would like me to lose some weight. He doesn't want to tell me to hurt my feelings. [He never says] that I should lose weight. He won't say that to me. But I know. Like I said, he would say to me 'I like you the way you are' or whatever. But for myself, I would like to lose some weight. And I would just feel better." [Weight Watcher]

As far as children's attitudes, of the five Weight Watchers who have children, only one reported that her children discuss her weight with her and pressure her to do something about it. Of the two NAAFA's who have children, only one reported that her daughter has always been unhappy about her weight. As an adult, her daughter told her that when she was a child:

"She thought that I was wearing a fat-suit that I tied on, when she was very little, just to embarrass her when I was coming to school . . . She said 'I didn't believe anybody could have that much weight on their body, so I thought you had something that you tied on to do this.' And that my gaining weight was designed to embarrass her." [NAAFA A]

Dieting History

The age at which participants began dieting appears to have been influenced both by the age at which they were considered fat, and by their family's attitudes. While the Weight Watchers and the smaller NAAFA's had a similar profile for the ages at which they became fat, the Weight Watchers tended to have started dieting at later ages. All of the Weight Watchers started dieting after 14 years old, and two started as adults. For the the smaller NAAFA group, three started before the age of 14, and the rest started in their teens. For the larger NAAFA group, all of whom were fat as young children, every person but one started dieting before 11 years old and one started at 14 (the one larger NAAFA whose family was very supportive about her size).

While some participants had no trouble remembering how much they weighed at particular ages during childhood and adolescence, it was very difficult to elicit such "weight landmarks" from many of the participants, particularly Weight Watchers. Although many were not able to say exactly how much they weighed as children or adolescents, almost all who were fat before adulthood remembered that they were the fattest child among their group of friends and peers. Many of the NAAFA's were able to name weight landmarks at many ages, almost as if their

family's emphasis on their weight branded these numbers in their memories. From the somewhat limited information obtained on early weights, no patterns emerged to distinguish between the groups.

One difference between the groups' dieting histories was in how often participants were dieting throughout their lives. While all of the Weight Watchers and larger NAAFA's were dieting very often throughout their lives, four out of seven of the smaller NAAFA's reported dieting only sporadically throughout their lives. The three participants in this group who *had* dieted a lot were also those who had lost a very large amount of weight, two of whom would have been in the larger NAAFA group based on former weight.

All of the participants reported having lost significant amounts of weight in their lives by dieting, ranging from 20 pounds to 130 pounds; the average weight loss in the three groups was very similar. Two of the women in the smaller NAAFA group and one in the larger NAAFA group had had weight loss surgery, which resulted in weight losses from 100 to 200 pounds. While some of the participants were moderately successful at keeping the weight off that they lost, some keeping it off for almost five years, almost everyone gained back all of the lost weight, and even the three participants who had had weight loss surgery gained back a significant portion of the lost weight. Participants in all three groups reported having lost tremendous amounts of weight (75 to 100 pounds) over and over again throughout their lives, only to have gained it back.

Participants named a litany of diets and weight loss methods that they tried. The number of methods used is too long to list in its entirety, but included mainstream methods such as: exercise programs, low calorie diets, Weight Watchers, Diet Workshop, NutraSystem, TOPS, diet pills, fasting, Overeaters Anonymous; fad diets such as: the Grapefruit Diet, Atkins, Stillman, Cambridge, Scarsdale; and several unconventional methods illustrating their desperation to lose weight: ex-lax, shots from pregnant women's urine, shots from monkey urine, acupuncture, ear stapling, jaw wiring, stomach stapling, intestinal bypass surgery. Some participants named almost all of these methods. The women in the larger NAAFA group were much more likely to report that they had tried many more methods to lose weight. The only participants who had tried the

unconventional methods were women in the larger NAAFA group and two of the women in the smaller group who had been much heavier before weight loss surgery.

All but one NAAFAn in each group had been to Weight Watchers at some time in her life. (While all the NAAFA participants were familiar with Weight Watchers, not one Weight Watcher participant had ever heard of NAAFA.) The NAAFAns' weight loss patterns while members of Weight Watchers was varied, ranging from going for just a few weeks and losing little weight, to reaching "goal" after losing 110 pounds and being asked to become a Weight Watcher lecturer. All gained back the weight they lost. Many rejoined Weight Watchers several times. One of the larger NAAFAns said that she joined Weight Watchers so many times, and lost and regained the weight so often that "I felt I was entitled to a frequent fatter coupon." Several of the NAAFAns criticized Weight Watchers because they felt it encouraged obsessive thought and discussion about food or because they had been humiliated in front of other members when they gained weight. Despite these criticisms, several NAAFAns praised Weight Watchers for its healthy diet.

Attitude of Peers

For the most part, participants in the three groups described their relationships with peers when growing up similarly. While one woman in each group described herself as having been a loner, most had friends who were supportive or for whom weight was not an issue, although almost everyone who had been a fat child described being ridiculed somewhat by other children because of their weight. One Weight Watcher described how badly hurt she had been by other children's cruelty:

"I've had many friends that would call me fatso. I think when you're a child and you're heavy, I think that's one of the cruelest things to ever be, that's heavy. Children in this world, and even then, can be very very cruel. There's not a kind word for a child who's heavy, that you're constantly taunted, teased, ridiculed, made fun of, left out. Children are cruel. When they tease and torment another child for being different from what they are, whether they're handicapped, heavy, obese or deformed in one way or another. When I was growing up, children weren't supportive. They didn't know how to be supportive of another child who's trying so hard to lose weight. Even friends. When you are a child and you are growing up, I don't think there's too many heavy children who have friends, because I never did, I was always a loner. I did not have a wide circle of friends. It gives you a very different outlook on people as you're growing up. Because children don't know *how* to understand that there's another child who's trying desperately, to either lose weight, or trying to accomplish something. No matter what it is, they don't

seem to understand, or want to understand. They don't know how important it is to that other child. They do some serious damage." [Weight Watcher]

Other participants described similar taunting they received, and several mentioned derogatory names that were given to them by other children, several rhyming with their first or last name. Despite being teased and taunted, most described having good friends, some of whom encouraged them to lose weight and others who never mentioned it, but all of whom did not make the participant's weight central to the relationship.

Similarly, as adults, all participants have supportive friends for whom their weight is not an issue. Again, several have friends who wish they were thinner but it is not a central theme of their relationship. Many of the participants specifically stated that their friends like them whether they are thin or fat, dieting or not, and the relationship does not change based on these factors. One of the smaller NAAFA's, and two from the larger group stated that they do not remain friends with people who have a problem with their weight:

"I don't think it's an issue at all. And if it is, I don't tend to keep that relationship, I really don't. If they don't like me for the way I am then forget it." [NAAFA A]

"My friends are not permitted to talk to me about problems they have with my being fat, unless it's to solve them -- their problems. I don't stay friends with people for whom fat is a problem." [NAAFA B]

"I don't allow anyone to be in my life that's really negative with the exception of my family. Most of my friends are NAAFA people because that's what I choose." [NAAFA B]

Three of the smaller NAAFA participants reported that they had very few NAAFA members as friends, while one from that group and two from the larger group stated that almost all their close friends were from NAAFA. The rest of the NAAFA participants had both NAAFA and non-NAAFA friends. Overall, the groups did not seem to differ much on their peer relationships as either children or adults.

The Experience of Stigma

Participants in all groups reported being the object of discrimination and people's negative attitudes. Almost every participant in all three groups spontaneously brought up the issue of clothing. In the context of discussing their life and weight issues, clothing seemed to figure in as one of the biggest issues. Clothing is symbolic of how different they are from other

people -- they cannot shop in "regular" stores and cannot have a choice of pretty, affordable, stylish clothing, if they can find clothing that fits at all -- and further limits their possibilities of appearing attractive in a society that finds fatness undesirable. Participants in all three groups mentioned clothing as one of their reasons for wishing to be thinner.

Participants in all three groups mentioned that their weight has been the object of attention by strangers, and several mentioned that they have been told they have "such a pretty face", a phrase often used by others to convey the notion that fat women are not acceptable as they are, and that if only they would lose weight, they would not only be "normal", but would be considered highly attractive:

"Because I've met men like, in clubs, and we'll have a wonderful time all night, and it always will come up -- 'Oh, you have such a beautiful face, why don't you lose weight?' Or they'd say 'Haven't you ever thought about losing weight?'" [NAAFA A]

"Most of my life I felt like I was a terrible person, like I wasn't doing what I was supposed to do. I grew up with 'you have such a pretty face'. And 'you are so talented and this and that and the other thing'. And then at some point, I started to wonder how people could say these things to me. I *still* have a pretty face. There's just more flesh around it." [NAAFA B]

One Weight Watcher summed up many participants' feelings about this phrase by saying:

"'You have such a pretty face.' It seems to be a standard routine. I'm sure there have to be *some* ugly people, *somewhere* who are overweight. But everybody has 'a beautiful face' (laughs). I have heard it so often about everybody." [Weight Watcher]

Women in all three of the groups mentioned facing discrimination because of their weight, especially in employment:

"People have certain biases. I think all things being equal, people go in and you have one overweight person and one not. I think it's the same story, I think people just tend to be biased toward people who don't fit their idea about weight." [Weight Watcher]

"Recently I thought about losing weight only because I couldn't find a job. And I felt the only thing that was causing it was because I wasn't skinny, someone cutesy that they want to look at. And the only kind of jobs that I came across were jobs that they really had a volume of work and that I look that type of person. I guess fat people are known to be, maybe you look like a worker, you could take advantage of that person. Because I had a couple of bad experiences before I found the job that I have now. And that is how they took me as. And I felt maybe in those cases if I was skinny, they wouldn't have treated me in such a manner. You know, 'We don't think much of her'. Like they think fat people don't have feelings and we don't think much of ourselves or have self-esteem -- we just take the brunt of the world on our shoulders." [NAAFA A]

"I had trouble finding a job when I was out of high school, when I was 18 years old. I had a lot of trouble, I went on a lot of interviews, and at that point, they took one look at you, and

you were fat, forget it. They were not going to hire you -- they see their insurance rates going up." [NAAFA B]

A woman in the smaller NAAFA group stated that fat women experience much more discrimination than fat men, and that she has seen this personally by observing the reactions and attitudes of others toward her brother who weighs 100 pounds more than her:

"This particularly affects women. My brother, who's more overweight than I am has had much less discrimination in his life than I have. And there are times where even *he* isn't empathetic. He just doesn't believe some of the stuff that I've had to put up with. 'Oh come on, don't you think you're exaggerating it?' When it comes from him, I really want to belt him. He does not believe that there is a whole lot of job discrimination. And fat men do not have as much job discrimination against them. He's just a big man, and that's okay. But a big woman is not okay. He has not personally experienced the discrimination that I have. It doesn't seem right somehow." [NAAFA A]

While participants in all three groups experienced negative responses from others because of their weight, the NAAFA women seemed to be more aware of it and the larger women seemed to have experienced it much more often; several of the latter group mentioned having had to make a conscious effort to try to ignore others' intrusiveness, in order to proceed with their everyday lives. Women in larger group also mentioned the issue of environmental access as interfering with their lives, for example not being able to use turnstiles or not being able to fit in airplane or movie theater seats. One of the smaller NAAFAs mentioned this problem as one she sees larger people struggling with all the time:

"Accessibility is a major thing that really bothers me about it and that to me is not their fault either. You know, that society shouldn't build everything for size 12 people. That there should be room for everyone. People shouldn't have to feel afraid to walk out in the sunlight. Nobody owns that. Everybody has a right to it. But some people feel like they can't, because it's not their world. And it's not right." [NAAFA A]

Self-esteem and Body Image

Issues regarding self-esteem came up in the course of talking about participants' family history and weight and dieting history. The ways in which the NAAFAs and the Weight Watchers talked about themselves and their bodies were markedly different. While almost every participant mentioned not liking her body, several of the Weight Watchers used extremely derogatory language in describing themselves, for example, calling their legs "thunder thighs", while the NAAFAs tended to simply acknowledge that they were not happy with their bodies.

These are some examples of the derogatory way in which Weight Watcher members described their bodies:

"[Describing herself as a child] her arms look like they're encased in sausage casing and her arms are just bulging out from it." [Weight Watcher]

"I feel like a beached whale, laying in bed . . . I want to be able to stand in the mirror and not see all this crater-like substance on my thighs . . . The first thing people look at is the way you look, the way you carry yourself, and I feel it. I sit in a chair, and I feel the weight's going up the chair. I just feel clumsy, I feel awkward, I don't feel like I do anything with grace. It's like with a 'plop', like with a humpty-dumpty look to it. There's nothing attractive about it." [Weight Watcher]

On the other hand, typical statements from NAAFA participants were the following:

"I didn't like my own body, I never liked my own body, I still don't like my own body." [NAAFA A]

"For a long time I had a problem with my legs -- I have very heavy legs. It always bothered me." [NAAFA B]

"My breasts are large, and they hang down, and that's not how they're supposed to look . . . And I'm very self-conscious about that." [NAAFA B]

Interestingly, while many of the participants specifically had a problem with their body image, most expressed that their weight generally did not affect their overall feelings about themselves. It is notable that NAAFA participants in both groups felt that their weight led to feelings of low self-esteem in the past, and that they no longer experience this.

Only one participant, a Weight Watcher, felt that her weight currently affects her self-esteem:

"I'm bitter, and I have a pretty low self-esteem right now, because of my weight. I mean, I come off happy-go-lucky, and I do what I have to do, I'm active, but it's not with full verve, it's like with a prompted type of effort . . . it's just the way I see myself in relation to other people . . . It's really affecting the way I'm relating." [Weight Watcher]

Both smaller and larger NAAFA participants talked about their past feelings of low self-esteem:

"[When gained weight back after a diet] it would be like 'oh god, I failed again, I failed again.' So you were failing losing the weight, you were failing at school, you were failing everywhere. I was constantly failing." [NAAFA A]

"I don't remember having any friends in high school. What I think happens to a lot of fat people is, we ostracize ourselves. We get it into our heads that we're undesirable, that we're not worthy, and we shouldn't let anybody get close to us. That there's something wrong with us. And anybody that wants to get close to us, they're either sicker than we are, or they want something. You build a wall around yourself. You put a barrier between

yourself and everybody else, because you don't want to be hurt. And anybody that tries to breach that has to be very persistent." [NAAFA A]

"You still look around in society, and say, well, I must be a slob. I must be doing something wrong. That kind of thinking dies hard. Those kinds of images and messages are everywhere. That thin is in, and you are *out* babe." [NAAFA A]

"[When she would gain weight] I thought it was 'oh my god I have no will power'. And 'I was a weak person'. And 'what's wrong with me that I can't stop eating'. 'I can't stop bingeing'. And, you know, I thought 'oh, what a terrible person.'" [NAAFA B]

"[Recalling her mother putting her on her first diet at seven years old] in front of me she put a bowl of Wheaties with skim milk and no sugar. That was my dinner. And everybody else had real food. And I felt so humiliated. Now it makes me angry. Back then I just felt humiliated. This was all that I was *worth*. I was bad." [NAAFA B]

"When I was younger, I didn't think I looked good at all. My sister and I always had a fantasy that we would cut her head off, and put my head on her body, because, I guess I was better looking than her, so we would then throw the rest out -- the waste." [NAAFA B]

Several of the NAAFAs reported that they currently felt good about themselves fat, although they did not like the stigma it carried with it. Notably, other NAAFAs gave the impression that they would gladly become thin if it were reasonably achievable for them:

"I don't feel a failure anymore. I wish I were thinner, I really do. I think I'd be happier in today's society. But it wouldn't make me a better person. I've gotten to the point of, 'like me the way I am or drop dead'. I don't care. I really don't care as much." [NAAFA A]

"It's hard sometimes, because as much as I have this view of, well this is who I am, and accept me for who I am, there's still a large part of me that is -- I don't want to be this way, I wish I didn't have to be this way, I wish there was some way to change it." [NAAFA B]

Only one of the Weight Watchers said that she feels okay with herself and her body the way it is, but added that perhaps it is because she knows she is dieting:

"I don't feel it. I don't feel like I'm carrying 242 pounds. I feel much less, but unfortunately the scale doesn't want to agree with me. Because generally I feel very energetic and I feel very good about myself. Maybe because of my mental outlook right now, that I am trying to do something." [Weight Watcher]

Philosophy about Weight and Dieting

The differences in philosophy between the groups was reflected in participants' choice of words to describe their weight. Five out of six of the larger NAAFAs preferred the word "fat" and one did not have a preference, while only one of the Weight Watchers preferred the word "fat", and most of the others preferred "overweight" to describe themselves. The one Weight Watcher who expressed poor self-esteem preferred the word "obese". Among the smaller NAAFAs most

had no preference as to which word they were most comfortable with. Some participants reacted very strongly to other words:

"The word I can't stand is obese which is what I know I am but I hate to see it in print. I picture an elephant. I'm very weight conscious, and overweight doesn't hurt as much. [Obese] hurts, because it is the truth." [Weight Watcher]

"Anything but obese, I don't know why I don't like that word. Big. Abundant is one of the ones I feel most comfortable with. And fat is what I am. It's more a fact than a descriptive word." [NAAFA A]

"I prefer fat. The use of the word fat decriminalizes the negative connotations that we grew up associating with such a word. It's simply an adjective, and I think that euphemisms like plump, chubby, heavy, portly, overweight are more offensive. People seem to struggle more in trying to find something that they think has less bite but still conveys their point. I don't care for that." [NAAFA B]

"Euphemisms [for 'fat'] show a real reluctance to face something that's awful. It means that what you are avoiding is not good. I mind these words very much." [NAAFA B]

One recurring theme among the NAAFA participants was their belief that pressuring a person to diet may cause the person more problems than they had to begin with and, in fact, may exacerbate the very problems for which the dieting was suggested as a solution. None of the Weight Watcher participants expressed such a belief.

"[Having diabetes] leaves me pondering dieting again, which disturbs me. I hate pondering what I eat. I hate concentrating on dieting. For the 5 or 6 years since becoming a NAAFA member, and for the few years before that, I really gave no attention to food at all and therefore I had lost weight and kept it off and it was fine. If I don't think about food I do very well. Now, I have to count units again, and it's setting me off on an upward spiral . . . [Was able to keep weight off] because I wasn't tuned into food. I wasn't thinking about it. I wasn't counting. I think that helps me a lot. I think that's part of my fear in watching food again, becoming food-obsessed again, and I know that, while it isn't for weight reduction, it's still food obsession." [NAAFA A]

"Everyone thinks that if you lose weight your problems will be over. Well, my medical problems haven't been greater or less whether I've been thin or fat. And I think, largely because I've been both so many times, I've killed the entire arterial structure (laughs). That's what I think the major problem is right now. And the medication I took to do it." [NAAFA A]

"I always say don't make such an issue out of it [losing weight]. I really feel that if you make an issue out of it, it's not going to do you any good. You have to be comfortable with however you are, for anything to happen, kind of. I think a lot of times they put too much emphasis on losing weight, and they panic over it, and I don't think they're going to lose anything if they do that, or if they do lose it, it'll come right back. And if they were more comfortable with themselves, it wouldn't matter as much to them, and maybe that would make it easier for them to lose weight -- if it weren't the most important thing to them." [NAAFA A]

"The value of good health versus good mental health [is important.] People who are dieting all the time are not mentally healthy. Mental health is an indicator of personal health, and it's *important* in personal health." [NAAFA B]

"[Doesn't know why she's recently lost weight because] I haven't dieted. I don't know why. I don't watch what I eat anymore . . . I think you crave the food more when you're trying to diet. When you allow yourself, you finally say to yourself, 'okay, it's okay to eat whatever you want to eat', you don't tend to eat as much. I really feel that dieting back and forth screws up your system so badly, even if it's only a five-pound weight loss, it's not normal. It just doesn't seem to be normal at all, to your body. I believe that you're better off leaving well enough alone. I just feel a lot more healthy now that I don't bother, I don't worry about it. It just seems like there's a weight lifted off of your shoulders. You feel better about yourself -- it's kind of like your emotions, how you feel about yourself. I think all those things play very strongly on it." [NAAFA B]

"I think that the greatest, the largest cause of my fatness is deprivation-related. The deprivation [of food by her family] made me compulsive. It made me obsessive. I ate compulsively because I felt deprived and it got to a point where it didn't even matter what it was. I just kept eating. I think that the greatest cause of my fatness was deprivation because it caused me to become compulsive . . . I think I was predestined by genetics and heredity to be fat to some degree. I think if it hadn't been for all the deprivation and everything else I endured, that I would *still* be a fat adult. But I would probably be somewhere around 200, 250 pounds rather than 400 and something." [NAAFA B]

"I truly truly believe that if my family would have left me alone and *not* put me on diets at seven years old that I would *not* be as fat as I am today. I clearly gain my weight after I'm on a diet. And so I really feel that, you know, every time they put me on a diet it just made me worse than I was before. If they would have left me alone, I would still be fat. But maybe I would weigh 250 pounds rather than 440." [NAAFA B]

"[The reason for my weight is] a damaged relationship with food, due to early dieting . . . I have a lot of scarcity issues around food, and I act around food the way people act in scarcity situations sometimes. Not even so much bingeing -- that isn't even so much an issue now, but I think that I had food taken away from me at a very young age, and food is very primal, and people in this culture should be able to take food for granted, and I don't. I never took it for granted I'd be allowed to eat certain things. So I think that damaged my relationship to food." [NAAFA B]

Overall, NAAFans appeared to have much more negative feelings about dieting than did the Weight Watchers. In spite of this, quite a few of the NAAFans were either currently dieting or were open to dieting but were just not actively dieting at the time of the interview. While all of the Weight Watchers were currently dieting, two of the smaller NAAFans and one of the larger NAAFans were currently dieting. Another two from the smaller NAAFA group and one from the larger group expressed that they were open to dieting. The remaining NAAFans do not actively diet at all.

Curiously, although many of the NAAFans are not currently dieting or open to dieting, it was the rare person who actually did not wish to lose weight. In fact, only two (one from each NAAFA group) said that they did not want to lose at all, although the NAAFAn from the larger group gave the impression that even she would lose weight if it were really an achievable goal, but

since she feels it's not, she must get on with her life and not look to weight loss as a solution for her:

"I want to have a life where I'm not oppressed. But a goal for me would not be losing weight now. And I would not ever diet again. Losing weight is not a goal. It is not foreseeable for the future, but one never knows . . . It doesn't feel like a realistic possibility." [NAAFA B]

The other participant who did not want to lose weight was not sure if, perhaps, it was only the fact that her mate likes her fat that is keeping her from wishing to be thinner.

The contrast between NAAFA members' politics around weight loss and dieting and their actual feelings about it for themselves was quite strong. Many of the NAAFAs recognized that it is a strong political statement to espouse the point of view that dieting is detrimental to people's physical and emotional health and that permanent weight loss is not achievable, yet at the same time, these same individuals suffer from society's negative attitudes toward them, some of which they themselves have internalized. This leads to a tremendous conflict in which the person advocates one point of view for the public, yet feels different privately, still wishing to be able to find a solution to "fit into" society. One of the larger NAAFAs, who no longer diets, said:

"Do I want to lose weight? Do you want my politically correct answer (laughs) or do you want another answer? Yeah, if it were possible, I would like to. Yeah, I would like to lose weight . . . If we talked about, that if I could wake up tomorrow, and be any weight that I wanted to be, and it would just stay there, without effort, I guess I would want to be about average size." [NAAFA B]

Also, the feeling of wishing to be thinner is seemingly contradictory with the expressed feelings of several NAAFAs who said that they like themselves fat. Perhaps they are comparing their present feelings about their size to how they felt years ago, and by comparison they are relatively positive today. Alternately, they may actually feel fine about themselves as is, but still wish to live a life free from stigmatization or a life where they experience less physical problems which they tend to attribute to their weight, as will be discussed in a later section.

Optimism About Losing Weight

Most participants gave the impression that they were not optimistic about actually losing weight and keeping it off. The Weight Watchers did not seem to be any more convinced that they would actually be successful in ever "solving" their weight problem than did those from NAAFA.

One Weight Watcher said "keep it off forever? No, because I think I've been overweight all my life and it's just not meant for me to be thin." Two of the Weight Watchers who have been attending weight loss lectures for several months and are currently losing no weight at all, stated that they continue to go to Weight Watchers because it is keeping them from gaining any *more* weight.

This is what some of the others had to say about dieting:

"Well, I would say any time I got on a scale the doctors would say I'm overweight even if I went down to 175 pounds, which I would like -- they would even tell me that I'm overweight. Because I should be down to maybe 135 or 140. No matter how thin I would think that I am they'll keep on saying that I should lose weight . . . but I don't think you should have to be so skinny either just for the sake of pleasing other people." [Weight Watcher]

"I hate the word diet, it has the word 'die' in it. The word diet is a very negative word to me. There's nothing about it that's exciting. The word I want to know and feel is 'life'. That's a four-letter word, just like diet. And it has more positive attributes than dieting. Dieting is not fun, we all know how to do it. I want to enjoy living, not dieting. It's a problem I've had for 21 years of my life, most of my adulthood, and it's very difficult for me." [Weight Watcher]

"I'm in the process of saying to myself I'm going to stay at this weight. And if I gain any weight, I'm just going to stop eating (laughs) until I lose some pounds. And that is how I'm looking at it. I'm not looking at it that I'm going to restrict myself so much that I'm going to lose 75 pounds. Not yet -- I have too many things going on in my life that I can't concentrate on that. Because to me that is a very big concentration because it changes your whole life and your whole attitude about what is going on in your life." [NAAFA A]

"I've always been successful on a diet once I've committed myself to it. That's why you get mad when people talk about not having willpower -- it's just, how long can you have it? You have to have it *forever*, you know?" [NAAFA A]

"Only 2% succeed, and I'm not one of those 2%. I'm not going to live my life constantly on a diet. Constantly trying to lose weight. Feeling that I was no good because I was overweight. And I still have some of that -- it's a lot to overcome, you have to overcome that a little bit at a time. If I could find a way to lose weight that was *possible*, or would make it successful, sure, I'd do it. But I don't think there is such an animal right now." [NAAFA A]

"I guess I would want to be about average size. But within the realm of reality, to me, I guess that doesn't seem realistic." [NAAFA B]

"Really, the hardest part is not taking it off. It's maintaining. Even though I've never been at goal ever -- my goals keep getting higher -- we all know that it's just going to go back on. Because we have to change our way of eating for the rest of our lives. And I am not willing to do that. I'm really not." [NAAFA B]

Why Participants Wish to Lose Weight

The amount of weight that participants wanted to lose was surprisingly similar for all three groups (despite the fact that the women in the larger NAAFA group weighed so much more than

those in the other two groups.) All except three wanted to lose 50 to 100 pounds. Two of the smaller NAAFA's wished to lose only 30 pounds. The largest woman interviewed, who can no longer walk any significant distance without a wheelchair or other assistance, wished to lose 250 pounds in order to be able to walk. Many expressed that they would be happy to lose even a little weight, whether or not they ever actually reached the ultimate goal they wish for. The reasons participants specifically mentioned for wanting to lose weight were appearance, clothing, physical health, psychological health, mobility, access and discrimination by others. While appearance and health seemed of equal importance to the women in the two smaller groups, the larger NAAFA's did not mention the issue of appearance at all. However, the other issues mentioned by the larger group did not differ much from those in the other groups. One participant in each of the two smaller groups specifically made a point of stating that she wanted to lose weight for appearance only, and not at all for health.

"I'm healthy. I'm fine . . . My weight doesn't bother me. But just for appearance sake I would like to lose some . . . I'm not an unhappy person. But I'm not happy of the way I look. I mean I think if I were to lose some weight, especially my stomach, and my lower rear, I would feel better. I wouldn't feel self-conscious taking off a jacket. I would keep a jacket on. But when the summer comes you have to take it off, you know, or you would sweat to death. So you would keep it on as long as possible because you see all these thin girls walking around and here you feel that everybody's looking at you and saying oh how fat you are. Like I said it's just really for appearance sake." [Weight Watcher]

"Because I'm getting very sick and tired of looking like I look. [Would like to lose weight] mostly for appearance. And it *would* be nice not to have to go to NAAFA to meet a man, but to go to just any old function. Because my friends are trim, thin, and it would be nice to just be able to go with them . . . So I look at it as appearance, not health. Because I don't have any health problems." [NAAFA A]

Several of the women in the two smaller groups mentioned that they have dieted in the past "for other people", and that it is important that that not be their motivation:

"I think life is too short to deprive yourself. I think you're only here on borrowed time, and you should enjoy life. You really should. Not that you should just be heavy and go out and eat and eat and eat but I don't think you should have to be so skinny either just for the sake of pleasing other people. That's what it is. I think you're just really pleasing other people -- I don't think you're really pleasing yourself." [Weight Watcher]

"It's like I always did it for someone else, you know, I never really did it for me. I never really did it because I wanted to feel healthy and I wanted to look good. I always did it -- well, maybe they'll like me more. Maybe I'll be more desirable." [Weight Watcher]

"I don't know what ever motivated me except outside pressure. It was never an internal need. So I don't see it [dieting] right now. I think I was fearful of not having approval. I

don't think it's because I didn't like the way I looked. If you're not comfortable with it, then you have the right to do what makes you happy. You should be losing weight for you, not for the rest of the world." [NAAFA A]

"I'm a person who likes food. And I'm not going to stay away, you know, just because somebody else tells me to. I'm going to do it only because I want to." [NAAFA A]

Views on the Cause of Being Fat

Participants were asked why they thought they were fat. In answer to this question, five of the seven Weight Watcher participants assumed that the question was "why do you overeat", to which they began to respond. Not one NAAFA participant interpreted the question in a similar way. Even those NAAFAns who answered that food or overeating was the cause of their weight, clearly understood the question to be aimed at determining which of many possible causes they thought was the reason for their being fat. All but one of the Weight Watchers felt that overeating was the main cause of their being fat, while the remaining Weight Watcher felt that genetics played a major role. In contrast, only one of the larger NAAFA group felt that food played a major role in her fatness, while all the others felt that genetics and metabolism were the major factor in their weight. The smaller NAAFAns were split, with three feeling that food was the major cause, three feeling that genetics and metabolism were the major cause, and one feeling that lack of exercise was the major cause in their being over normative weight. Despite these differences in opinion about the *major* cause, looking at contributory causes overall, the groups were fairly similar in attributing their weight to a variety of causes. The only notable difference was that 5 out of 6 of the larger NAAFAns attributed their weight to deprivation of food as children, while no one from the other two groups did so. While almost all participants believed their fatness was somewhat due to overeating, participants attributed different reasons to the overeating itself, such as liking the taste of food, eating for emotional reasons such as depression or fear of intimacy, and eating too much food out of boredom or habit. Not one of the larger NAAFAns attributed their weight to emotional reasons, while approximately half of the other two groups did so. Those who felt their weight was attributable to genetics/metabolism did so by citing reasons such as having come from a family with many fat members, having been diagnosed as having a thyroid condition, and gaining

weight while eating very few calories. Although many participants felt exercise had an influence on their weight, all but one felt it was of fairly minor importance.

Personal Responsibility for Cause and Cure

In discussing whether they felt they were personally responsible for causing their fatness, all but one of the Weight Watchers felt they were. Of the smaller NAAFA group, one felt they were and two were not certain. Of the larger NAAFA group, two people felt they were personally responsible and one was not certain. All but one of the participants who felt personally responsible for causing their fatness also felt that overeating was the main cause of their being fat. Most of the participants who felt they were personally to blame stated that nobody "forced" them to eat. For instance, one Weight Watcher, whose mother had come from a very poor background and consequently always put a strong emphasis on her daughter being well-fed and always encouraged her to eat, said:

"My mother didn't cause my overweight. She didn't shove the food in my mouth. Yes, I did tell you earlier that she did make me sit there. But she wasn't going to ram it down my throat if I didn't eat it. She wanted me to know what it is to eat healthy food, but she didn't ram it down my throat. I caused my own obesity, she didn't cause it." [Weight Watcher]

Similarly, one of the larger NAAFAs said:

"I certainly think it should be my responsibility. I think everyone should be responsible for their own lives. I was pushed to eat, and stuff. I could have said no. You know, I could have said 'Sorry, I'm not doing it'. But I didn't." [NAAFA B]

One of the smaller NAAFAs who felt mixed about her responsibility for causing her weight said:

"I'm sure that I had *some* responsibility in causing my weight, but I also think that there's a genetic or metabolic process. I think everybody overeats, at some times, but not everybody pays as high a price as I have, as far as weight gain goes." [NAAFA A]

All but one participant who felt they were personally responsible for causing their fatness also felt they have a personal responsibility to cure it by losing weight. One Weight Watcher felt that she caused her fatness in order to build "a barrier between me and the rest of the world", but does not feel that she has to do something about it. She feels that she still holds on to the weight to "protect" herself. The one Weight Watcher participant who felt that her weight was caused mostly by genetics, did feel a personal responsibility to lose weight. Only the three NAAFA participants who felt personally responsible for cause, thought they had a personal responsibility

for cure. The few who were somewhat ambivalent about their role in causation did not feel they had any personal responsibility for "curing" themselves.

In order to understand how some participants were able to develop a philosophy about fatness that did not make overeating central to causation, those participants were asked what influenced them in their thinking. The overwhelming response of those who attributed their weight to metabolism or genetics was that careful reading and observation had led them to their unconventional beliefs. Many read scientific articles which outlined recent findings concerning the role of biological influences on weight, and others observed that their weight and the weight of others did not logically follow their long-held notion that people gain weight in proportion to the amount of calories that they eat:

"I've always thought there's a big genetic component; it's kind of built in. I've read over last few years about the physiological component. Set-point is important . . . there's just too many overweight people for it to be all willpower or whatever. I think that there's much more to it . . . just from looking at your family tree; they're bigger boned. I think I surmised it. Maybe you feel it's always a kind of out; it isn't all my fault. A reprieve. The more you tried to say it, the more people thought you were looking for an excuse. You're sort of boxed in. " [Weight Watcher]

"What I started consciously to realize is that no matter what I did, the minute I went off a diet, I had no maintenance range. I could lose at 1200 calories nicely, and I could maintain from 13-1400, and I was gaining over 1400. It was coming back. My body had no range at which I could stay comfortable, while other people could eat so much more food . . . I thought this about myself, that it was an inherited factor, but this was not something that I would ever share with anyone else, because they would have pool-pooled it and made more fun of me, so it was just how I felt. I never shared it." [NAAFA A]

"I live it. I mean, I *live* it. And not only do I live it but my friends live it. I see what it is. I see there are people out there who are thin who eat what I eat. And they don't gain weight. So it's like I love to observe things. And so for me it is just an observation, and information that I have read about, heard about." [NAAFA B]

"My sister who was very thin when I was growing up ate *twice* of what I ate . . . I figure it has a lot to do with metabolism . . . I really believe that it's hereditary, and it has a lot to do with metabolism." [NAAFA B]

"I started to learn from the things that I was reading that it wasn't entirely my fault. And that being fat didn't make me a bad person. And some of the things that I had done to become a person of acceptable weight had probably done more damage to me than they ever had the potential of doing good." [NAAFA B]

Group Philosophy

In order to establish whether Weight Watchers and NAAFA members understood their respective group's philosophy to be the same as that postulated for the purposes of this research, each

participant was asked what they thought their group's philosophy was regarding responsibility for the cause and cure of fatness. Participants were very much in agreement about their group's philosophy, which concurred with that postulated for this research. Every Weight Watcher but one, who was not really sure, felt that Weight Watchers espouses the point of view that people are personally responsible for being fat, and all Weight Watcher participants believed that Weight Watchers' point of view on cure is that people are personally responsible for doing something about their weight. Alternately, eight out of thirteen of the NAAFA participants believed that NAAFA's philosophy about cause is that people are not personally responsible for being fat, while the remaining five either were not sure, or stated that NAAFA does not have a position on cause, because cause is not important as far as human rights are concerned. NAAFAs were unanimous that their group espouses the philosophy that people do not have to feel responsible to do something about their weight, although most qualified this by saying that the organization feels people should decide for themselves whether they want to try to lose weight, and that NAAFA is supportive of individuals' decisions to diet.

In spite of this, about half the NAAFAs expressed their belief that within the NAAFA organization, dieting is seen as a stigma. Four of the seven smaller NAAFAs mentioned this, as did two of the six larger women. Three of the larger women specifically stated that it *is* acceptable to diet within NAAFA, whereas none of the smaller women mentioned this. Interestingly, three of the smaller NAAFAs who had never been much fatter reported that they felt they were not really accepted in NAAFA because of their relatively small size. It may be that individuals within the organization find it more acceptable for very fat people to diet, whereas it is more threatening when the smaller members who are already close to "passing" in society are attempting to lose weight. One of the smaller NAAFAs said this about dieting:

"NAAFA denies it, but their attitude toward weight loss is you shouldn't do it. They don't like it. And part of it is very human -- women who have lost a lot of weight will come back to NAAFA, and the men don't want any part of them, and the women don't want any part of them because, one, they don't feel they belong in NAAFA anymore, and, two, human nature -- they're jealous of them, because they now more fit the norm of what society will accept . . . They sure never talk about it [dieting]. Maybe one on one. But in an open group, I don't think they would talk about it. Because NAAFA society is -- everybody's

happy. Everybody has accepted their weight. You know, we can conquer everything, and nobody can tell us what to do with our bodies. But you know the old thing, that in every fat person is a thin person yearning to be free, I think everybody who's been obese or is obese would like at some point to be thin, just to see how it feels." [NAAFA A]

Another of the smaller NAAFAn said that she believes many of the NAAFAn are secretly dieting:

"When I first joined NAAFA, when I listened to people talk, they would say that you know, it doesn't matter how fat I am. I almost got the impression that god forbid you mention diet, they would have an absolute stroke and a half. You know, like 'you don't talk about diets, people don't go on diets, diets are bad. Period. Amen. End of conversation.' . . . I sometimes think that's the impression they like to give people, but when I started talking to some of them on a one-to-one basis, I found out, no, that's not really what they believe. But, my one girlfriend said to me one time 'well, that's the impression you have to give to the public.'" [NAAFA A]

One of the smaller NAAFAn had an interesting philosophy on weight and dieting. She felt that she was fine at her current weight, although she was vigilant about not gaining any more weight. At the same time, she was very judgmental about the weight of those who are much larger than her. These comments, from a woman who weighs 240 pounds, are reminiscent of the attitudes of many normative weight women who are constantly watching their weight to keep it at an acceptable level, and believe that others could easily do the same:

"The only thing they ever talk about is that 'well, if we're going onto an airplane, the seats are not large enough for us or going to the theater and the seat isn't large enough for us' - stuff like that. And my opinion is, lose weight and you'll fit in the seat. The rest of the world is a certain way and that's it. And for a small portion of the population they're not going to make these tremendous changes. You sound like you're a handicapped person where you literally can never change. But you can change yourself somewhat. They could be *my* size. By dieting . . . Metabolism means instead of being 120 pounds at normal metabolic weight you are 140 pounds at normal metabolic weight. But that really doesn't mean that you are huge or 500 pounds. That is not metabolism. That is called your mouth . . . Nobody diets [at NAAFA]. I must be [the only one who diets], or else I would be 500 pounds too. Oh yeah, I could definitely eat and eat and eat and be 500 pounds. Sure. I could be 500 pounds easily . . . They like to eat. Just like I like to eat. Only me, I say to myself 'hey, hey, hey, whoa. Slow down here. You are going to weigh just this much and that's it for life' . . . But if you have to be in a wheelchair because you just can't button your lips, *that's* your problem! And you shouldn't go around having thoughts that just because you are 500 pounds, nobody should call you fatso or not look at you. / even stare and look at them, because / can't believe it is happening." [NAAFA A]

Becoming involved in the Group

As would be expected with a diet group, all Weight Watchers said that they joined the group because they wanted to lose weight. Three participants had friends or relatives who were already members, so there was some social motivation as well. Surprisingly, very few NAAFAn

became involved in their organization for political reasons. Only two in the smaller group and one in the larger group said they joined for political reasons. In fact, the main motivation for almost all NAAFA participants was to meet men. Six out of seven of the smaller NAAFAs became involved for this reason, as did three out of six of the larger NAAFAs. Three of the larger group named support and a striving for self-acceptance as major reasons they became involved. Several NAAFAs also mentioned becoming involved in order to make friends. Despite their initial motivation for becoming involved in the organization, many found themselves being influenced by NAAFA's political ideology in ways which changed their ideas about fatness and which led to better feelings about themselves and their bodies; acceptance by men in the organization who are attracted to fat women also influenced them to feel better about themselves:

"[After joining NAAFA] I did not feel the need to diet. I felt beautiful, loved, wanted, desirable, everything great, and therefore dieting was no longer part of it." [NAAFA A]

"It's like any self-help organization. You recognize yourself in them. And it blows you away. It blows you totally away, because you thought you were alone. You knew there were other fat people out there. But all their lives were fine. It only shit on you. And you sit there and you listen to somebody, and they had your childhood, or they had your adolescence, or they had your job experiences, or whatever piece -- and it may be only one little part of it, and it blows you totally, totally away. That you're not alone . . . It helped me to see that I wasn't a worthless lump of manure. That there were men who were attracted to me, because of the weight." [NAAFA A]

"[After joining NAAFA] I have to say that my view of my body has changed a lot based on men's attitudes, that I never had before. Suddenly, I can look at my breasts differently, or I can look at my arms differently . . . I think I learned a lot more about why people are fat, and that was helpful." [NAAFA B]

Almost all NAAFA participants stated that their involvement with the group influenced their philosophy and feelings about weight, and two in the smaller group felt the organization reinforced feelings that they already held. Only one in the smaller group and two in the larger group did not think their feelings about weight were influenced by the organization. The organization's ideology also affected participants' *behavior* as far as dieting is concerned. While three women in both the smaller and larger group stopped dieting even before they joined, one in the smaller group and three in the larger group decided to stop dieting as a direct result of their involvement in the group, although one subsequently began to diet again. It is important to note here that several participants consider themselves to be non-dieters, although they admit to

actively watching their food intake. They no longer believe they are dieting to become *thin*, but seem to make an effort to maintain their weight or decrease it slightly in order to increase their mobility or energy level, and therefore do not consider themselves *dieters* in the sense of the word as it is commonly understood.

An unexpected finding emerged when some of the smaller NAAFAn were discussing how they were influenced by the group. Of the four smaller NAAFA participants who stated that they were influenced by the group's philosophy, three felt that the organization had either a negative impact on them, or had influenced them in the *opposite* direction of the group's philosophy by scaring them into wanting to be thinner:

"I never felt like there should be like a limit. Like a limit to the size you should be in life. I'm starting to feel like that now. I started to feel this about a year ago when I joined NAAFA. I said, you know, 'this is it. This is as large as I ever want to be in life' . . . it turned me off to thinking that you could be just any old size. You *can't*. You really *can't*. You really have to say to yourself that enough is enough already. Going there kind of like keeps me in check, boy! Because when I go there, I don't want to eat, and I realize their problems, what they are going through, and their discrimination. And it keeps me in check. I really tell you. It is the best diet group (laughs) I ever went to. It really is. It has gotten me to believe that, you know, I *do* have to shut my mouth. Look where I could be in a couple of years if I keep going the way I'm going." [NAAFA A]

"I felt like I didn't belong in NAAFA as far as weight is concerned, and I didn't belong in a thin person's world so therefore it changed my attitude towards becoming thin . . . because I definitely don't want to get any heavier than I am. I did decide that. I don't know how some of these women walk around. It scares me, it really does. Not only does it scare me, but it – it's not a pretty sight. I mean to me it's not. To me it's ugly. And I don't know if that's because our society influenced me that way or because it *does* look ugly to me. You know, to see a woman with her stomach hanging down to her knees." [NAAFA A]

"To me, it was a negative change. Because initially, what I did was, I said 'Well, these men are supposed to like me no matter what size I am and everything, so who cares what I eat, or don't eat.' And I proceeded to gain weight . . . Then I stopped and asked myself what I was doing. I had always said that whether I gain or lose weight should not be a matter of what other people think. I had gotten past that, and I had to do it for me. Whether I did it or didn't it had to be for me. And I knew that I didn't want to gain weight. I said 'you can't do this to yourself'. I realize now, that food is not the end-all of my existence." [NAAFA A]

Even one of the larger NAAFAn had a similar feeling, watching some of the women larger than herself at NAAFA events. Although her self-esteem and body image are improving as a result of being a NAAFA member:

"I feel that maybe, especially the larger people, have gone to the extreme of sort of glorifying fat . . . once there are distortions of the body, I find it harder to see how that's beautiful, even though I know there are people who do believe that's beautiful. But to me, that feels a little 'kinky' (laughs). I also feel that while being moderately fat can be healthier for some people, you can't deny the medical risks of being 100 pounds, 200

pounds overweight . . . I have trouble with this 'cult of fatness', 'fat is beautiful' . . . that someone could, like, glorify this distorted hanging stomach as beautiful, you know, I just have a little trouble with that . . . there's something that's just not right here, you know? . . . When I started going to NAAFA events, the very, very large women upset me tremendously, and I came to the realization that I couldn't really accept myself until I could accept them . . . because suddenly I realized how people reacted when they saw me, that here was, like, my worst nightmare, in front of me . . . It still scares me. I mean, I don't want to gain another hundred pounds." [NAAFA B]

Among the Weight Watchers, none felt that the organization itself influenced their basic philosophy and feelings about weight, although most felt that the group reinforced feelings that they already had about being responsible for being fat, and several reported that Weight Watchers helped them to understand the cause of their overeating:

"I'm beginning to see losing weight as power. I caused myself to gain weight. I did it on purpose. If I decided to lose weight, I can do that on purpose too. It gives me a sense of power." [Weight Watcher]

"Each person is responsible, that it's their duty to lose the weight, I think that's very strongly Weight Watchers' way . . . Weight Watchers has broadened my way of thinking on how to lose weight, and why I'm heavy. It's opened up very deep and inner thoughts of myself. About the reasons why I'm heavy, why I eat the way I do. Food to me would be like Linus's security blanket. Food is a crutch. I feel much better after I eat a quart of ice cream. Weight Watchers brought that out . . . they reinforce that food is a crutch, and this is how you get off of that crutch, this is how you go about it." [Weight Watcher]

"Yeah, I think their philosophy was similar to mine, and helped me see the causes of my behavior a lot deeper, more deeply. It helped me to clarify it, it still hasn't totally made it possible for me to be totally in control." [Weight Watcher]

Health Status and Beliefs

Health Status

In looking at the types of health problems that participants currently experience, the groups were not very different overall. However, it seemed that the larger NAAFA's experienced "aches and pains" more intensely and more often than did the others. As far as serious medical problems, the groups seemed fairly similar. One or two women in each group currently had fairly serious medical problems including diabetes, asthma, and a rare blood disorder affecting clotting. One woman had an ovarian cyst and was going for surgery shortly to have it removed. Participants experienced less serious disorders in similar numbers across the groups, although the smaller NAAFA's seemed to have had somewhat more of these problems. The less serious medical issues included problems such as endocrine disorders, allergies, high blood pressure and gout.

Only one or two participants in each group were currently experiencing no health problems. Additionally, the types of medical problems that participants experienced in the past were even more similar across the groups, and included many of the same operations and disorders.

As far as perceived health status, Weight Watchers considered themselves to be somewhat healthier overall than did those in the two NAAFA groups. All but one of the Weight Watchers considered themselves very healthy, while the remaining woman felt she was not very healthy. Three women in the smaller NAAFA group considered themselves very healthy, three were moderate, and one considered herself not very healthy. Two of the women in the larger NAAFA group considered themselves very healthy, and the remaining four considered themselves moderately healthy. An interesting difference emerged between the two smaller groups and the larger NAAFA groups: the former considered themselves healthy because they are rarely sick, have few medical problems and/or have a lot of energy, while several of the latter group considered themselves healthy because they did not have life-threatening illnesses. Despite experiencing health and mobility problems, these women still tended to feel that they were fairly healthy. Even one woman, the heaviest person interviewed, who was no longer able to walk short distances without assistance, felt that she was fairly healthy. For these fatter women, the issue of healthiness was seen in a very different light from those who were smaller. They felt it was important to project to the world that they could get on with their lives despite their weight, and that in relation to the possible serious health problems they *could* be experiencing, they felt they were fairly healthy. Additionally, they felt it was important to separate out mobility issues from health problems. The following comments are from the three largest women interviewed:

"In a lot of ways, you feel healthier when you have a positive attitude. You know, if you sit and you think about every little ache and pain you have, and there are a lot of them when you're super-sized, you're really gonna feel unhealthy. You can't give yourself a lot of permission to do that, you know, and keep going . . . For me, when I think about health, I think about dying early. That's what I think about. Not like living with pain or with difficulty. I think about *dying* early. Dying tomorrow, because I'm fat. And in that sense, I feel like, well my cholesterol level is good, I have no problems with my heart, and I'm healthy. To me that's healthy. Now, the fact that I have aches and pains and issues here and there doesn't relate to health for me. It relates to what I call a mobility issue, not to a health issue. The emphasis for a fat person is that you're going to *die* young. So that's what we think about when we think about health. When am I going to die? You know? Not like the every day quality of life, particularly." [NAAFA B]

"I think it has a lot to do with what one does to care for one's self and to promote good health. It would be real easy for me to say I'm very sickly and I have all these problems. And then people think you are not reliable or you wouldn't be potentially employable and people would feel very uncomfortable around you. However, if it's presented, and this is the way I prefer to do it, that yes I do have some things that I have to deal with but this is what I do -- I take my insulin [for diabetes], I eat. I don't do everything the way that I should, but I'm smart enough to be aware of what it is that I *need* and to make sure that if there is a problem that I get treatment. I could have just continued walking around and wheezing and saying it's my asthma and there is nothing I can do about it. But I knew that there might be something else wrong and I know better than to take chances . . . I'm not terribly restricted. I do most of the things that I want to do. I don't *not* do things because of this. I won't go running in a field full of ragweed and ticks and other stuff but I'm in generally good health. I can get up in the morning and do things that I generally have to do. And even if I'm in poor health, I'm in good enough health to take care of myself. I don't have to have someone coming in to take care of me to give me my injections and administer to me all those things." [NAAFA B]

"I think I'm healthy, except for aches and pains. My joints. I can't walk. I have a bad back. I'm day-to-day healthy. In other words, I don't think I'm gonna die this minute, but I'm disabled, because I can't walk . . . I don't have cancer. I'm not diabetic. I don't have a lot of illnesses that some people have. I don't have gall bladder problems. I don't have any of that stuff. Other than a bad back, and maybe arthritis a little bit, that's it. Oh, and my blood pressure's high . . . See, health to me is colds and like, *internal* illnesses. But like physical disability -- I don't know if that's health. Is a bad back health?" [NAAFA B]

While the larger women specifically stated the importance of separating out mobility issues from health problems, it appears that many of the women in the smaller groups seemed to also disregard mobility problems when reporting their health status; when the smaller women were asked to discuss whether and how their weight affects their health, several mentioned problems such as having trouble catching their breath and experiencing heart palpitations, although these issues were not brought up when the participants discussed how healthy they feel in general.

A striking finding was the discovery of a large number of serious psychological problems among participants in the three groups, and a large number of participants who were either currently in psychotherapy or had been previously. This finding may simply reflect a self-selected population of people who are willing to participate in a psychological study; that is, those who are willing to see psychotherapists, or who have psychological problems, may be more interested in a study of a psychological nature, and therefore be more willing to volunteer to participate. Therefore, it is important to keep in mind that one might not find such high numbers within the normal population of fat people. Among the Weight Watchers, two were currently in therapy and

one had previously been in therapy. One stated that she is manic-depressive, while another stated that she had been institutionalized for schizophrenia as a young woman. One of the smaller NAAFAn had previously been in therapy, and another is currently being treated for depression. Even more of the larger NAAFAn experienced psychological problems. Three are currently in therapy and two had been in therapy previously. In this group, one of the women experiences severe depression, and two suffer from serious agoraphobia. It is important to note that participants were not asked about mental health issues, but this information came up in the course of the interviews. It is possible that even more of the participants might have stated that they have been in psychotherapy or that they experienced serious psychological symptoms, if they had been specifically asked about it.

Relationship between Weight and Health

Participants were asked whether they felt their health has been negatively affected by their weight. The larger NAAFAn unanimously said that it was, although three qualified their answers by saying it was true only if one considered mobility issues to be part of health. In addition, several mentioned that while weight may have exacerbated some of their conditions, it did not *cause* them. Another suggested that perhaps her beliefs about her poor health are due to "years of brainwashing. I mean, I think that's why I don't think I'm healthy, because all my life I've been told it's so unhealthy to be fat, and I'm so fat, so I must be unhealthy." Most of the women in the two smaller groups did not think their health was negatively affected, but most feared that in the future it would be. Three of the Weight Watchers and two of the smaller NAAFAn felt that their weight is currently affected, one of the Weight Watchers and three from the smaller NAAFA group did not feel it was affected and did not mention their fear about the future, and the remaining participants all expressed their worry that their weight would at some time in the future affect their health negatively. One woman in the smaller NAAFA group who had been much heavier previously, and one woman in the larger group expressed the fear that they would at some point become seriously disabled because of their weight:

"I think at some time it's going to take a toll. I just want to live as healthy as I can, for as long as I can. And when I see people who are tremendously overweight, some who are almost practically housebound because of it, I just don't want it to happen. I really really don't. And if I am not careful and I don't watch, to some extent, I do believe it could happen to me. Because I do have that in my background, as far as me, and I don't want to see it happen to me. I don't want to get to that point where I have to be totally dependent on another human being." [NAAFA A]

"The physical dependence part is scarier because I'm fat, because it would be so much harder for someone else to have to take care of me. I mean, it would be a horrible thing if anybody had to end up in a wheelchair. It's like ten times worse if it's a fat person. You know, the wheelchair doesn't fit. You get a larger chair, and it doesn't fit through the doorway, so who can push you around? . . . When you're larger it *is* harder to move. It takes more energy to move, to do things, and sometimes you just have like this precarious little system of how you get things done." [NAAFA B]

Reasons that participants gave to justify their belief in a relationship between their weight and health included their experiencing shortness of breath, mobility problems, aches, arthritis, back problems, lack of energy and high blood pressure. As mentioned previously, although several participants experienced these problems, almost none took the symptoms into consideration when they discussed how healthy they feel in general. Perhaps only serious medical problems were considered when they were asked about their general level of health. Also, since almost all symptoms mentioned were either mobility or mobility-related problems (e.g., shortness of breath, arthritis, aches, back problems, lack of energy) it is likely that the participants tended to treat health and mobility as two separate entities. As already presented, this was clearly the case for many women in the larger group.

In addition to talking about physical health problems, three of the Weight Watchers, and one of the larger NAAFAans expressed their belief that their weight affects their mental health, two specifically blaming that negative outcome on the stigma they experience:

"It's really your outlook. Psychologically. It can cause a great depression on you. It makes your outlook on life look a little stinky. It really does. It makes it look really like life is not really worth living anymore." [Weight Watcher]

"Not medically -- but emotionally! Just being, I guess sort of stigmatized. Society is just so weight-conscious. You feel like you're the odd man out even though you know you're certainly not alone." [Weight Watcher]

"I think that [fat people's] mental health is more at risk than their physical health, generally speaking. I think that the stress caused by the repercussions of being fat in our society present a much greater danger than the simple addition of pounds." [NAAFA B]

Participants were also asked whether they believed that, in *general*, people's health is affected by being fat. The answer to this question was overwhelmingly affirmative. Only one of the smaller NAAFAns did not think this was so. Even participants who did not think their weight was affecting their own health, believed that weight affects other people's health. It is important to note that many of the women qualified their belief about this relationship. One Weight Watcher noted that dieting has a much worse effect on health than does being fat. One of the smaller NAAFAns felt that the relationship between weight and health is not as strong as people believe it is, and another felt that many of the health problems come from the stress of living as a stigmatized person. Two of the larger NAAFAns felt that the relationship exists only at very high weights, and based this observation on their own experiences when thinner. Two others in this group mentioned that despite the negative health effects, there are some ways in which fatness contributes to improving health.

How Being Fat Affects Attitudes about Health

Participants were asked about the ways in which being fat might affect their attitudes about their own health and health care. Four of the Weight Watchers, two of the smaller NAAFA group, and one of the larger group currently felt that being fat meant that they were not taking good care of their health. One additional Weight Watcher, one of the smaller NAAFAns and three of the larger NAAFAns stated that they used to believe this was true. Despite the fact that six participants currently believed that because of their weight they were not taking good care of their health, not one reported that this has kept them from seeking health care. Only one person in the smaller NAAFA group who used to be fatter, and one of the larger NAAFAns stated that in the past their belief that they were not taking good care of their health had kept them from seeking health care:

"I have often thought that if I'm not taking good care of myself, and my weight is my direct fault, that there's sometimes no reason [to see a physician or] even to go on. I've been suicidal about my weight." [NAAFA A]

"It's part of the masochism. You saw yourself as masochistic, because other people did. Because only a masochist would continue to be fat. So it's easy to continue denying yourself stuff. Until you've lost weight. It's part of the dieting mentality. You always

denied yourself, until you lost weight. You'd deny yourself a doctor. You'd deny yourself anything. Any consolation at all. Because, of course, everything, I thought, was my fault. I felt the doctor might help the symptoms, but that I was the cause. It was me, I was so mentally disturbed that I was, you know, making my body go wrong." [NAAFA B]

Other than not seeking health care, not one participant felt that their being fat had ever influenced them to avoid engaging in other health-related behaviors, such as stopping smoking or engaging in physical exercise. Participants mentioned several different health-related behaviors in which they currently engage. Many of the participants indicated that they make a strong conscious effort to eat healthy foods. Several of the Weight Watchers stated that they eat healthy foods but that they eat too much of them. Many of the NAAFA participants, both those who diet and those who do not, report that they try very hard to eat a healthy balanced diet with little fat, cholesterol, salt or sugar, but that they do not try to restrict the amount of healthy foods that they eat. Several participants reported that they engage in regular physical exercise, and several have successfully given up smoking.

Participants were asked whether they felt they would deserve better health care if they were thinner. Two of the Weight Watchers felt that they would, while none of the others did, although one of the smaller NAAFAs who used to be fatter and two of the larger group reported that they used to feel this way. The Weight Watchers who believed this, stated that they would deserve better health care because:

"I would make better use of it. If I lost weight I would live longer. I think I would get better care if I were losing weight, and it would be much more worthwhile to give me better care if I lost weight, because ultimately I would live longer." [Weight Watcher]

"I've felt that doctors would think 'how much more do you expect us to do if you're overweight'. I think in some respects they're right." [Weight Watcher]

One of the NAAFAs who used to feel this way said:

"I thought that if I were *thin*, I would have received better health care. And I would have deserved it, because I was in control of myself, and therefore I was a good girl. I think doctors thought 'why should I go out of my way for you -- you don't care for yourself all that very much' . . . it's certainly been implied." [NAAFA A]

Not one of the participants felt they deserved negative treatment from physicians, although two Weight Watchers, one of the smaller NAAFAs who used to be fatter and two from the larger

group stated that they used to believe this was true. These are some comments from participants who used to feel they deserved to be treated poorly:

"I believed it when people told me that I was slovenly and self-indulgent. In my earlier years, I definitely believed that this was true. That I must be self-indulgent. I didn't know that there was an alternative [to being treated poorly], and I figured, it's all right, it's only me, it's not like it's somebody of value. I believed for a long time that I was self-indulgent because of my weight." [Weight Watcher]

"I think I did at one time. Because I accepted the way they treated me then, and I don't now. I wouldn't allow it now. I was certainly much more a victim of the medical profession than I am now. I believed what they told me and I would follow the rules, and I did all the things that I was supposed to do, and felt very guilty, and very much a failure, because it didn't work. I deserved to have that treatment, obviously, look at me." [NAAFA A]

"I was bred to believe that I got what I deserved. And it was my fault for being fat. And that they [physicians] were only doing it for my own good, like when the parent hits the child and says this hurts me a lot more than it does you . . . I must be a really terrible person to cause them to do this. Nobody wants to be mean. I must be bringing it out in them." [NAAFA B]

"I thought they were trying to help me. I thought everything that everybody did that was so negative, and that was yelling at me, was really just trying to push me to do the right thing. Because it was really for my own good. When people yelled at me, I did deserve to hear that. It was really the only thing that was going to help me was if people yelled at me enough that they made me act right. You know, and I didn't deserve anything until I did act right. And they were just trying to hasten that day (laughs). The day that I would act right and be thin." [NAAFA B]

Most Important Action Participants Can Take to Improve Their Health

Participants were asked what they thought was the single most important thing that they could do currently to improve their health. This question resulted in a very clear distinction between the Weight Watcher participants and the NAAFA participants. While the Weight Watchers unanimously felt that losing weight was the single most important thing they could do for their health, only one in each of the NAAFA groups thought similarly. In addition, the one smaller NAAFA whose response was "losing weight" felt that weight loss *and* exercise were equally important, while not one Weight Watcher mentioned exercise. In fact, the only Weight Watcher to mention anything besides weight loss was one who felt it was important to improve her self-esteem, in *order* to be able to lose weight. The other NAAFA who stated that weight loss was the most important thing she could do for her health was a woman who had serious mobility problems. Other responses from the smaller NAAFA group to this question were: physical exercise, sleeping better, taking better care of diabetes, stopping smoking and eating healthier.

Four out of six of the larger NAAFAn said that both exercise and eating healthier were equally the most important things they could do for their health. In their responses, participants who said they should eat healthier made it clear that they were not referring to caloric reduction, but to making an effort to do things like eating more fiber and less fat, salt and sugar.

Attitudes Toward Physicians

General Attitude about the Importance of Physicians

In order to get a sense of whether any of the groups was more likely to be critical of the medical establishment in general, participants were asked how important they thought physicians were for prevention and for curing illness. The majority of participants felt that physicians were important as far as prevention is concerned, and all but one of the participants felt that physicians are very important for curing illness. The remaining participant, a smaller NAAFAn, felt that physicians have their role but are "perhaps not as important as they're touted to be." She was also the one person who did not believe that people's weight negatively affects their health. Overall, participants in the three groups seemed to believe equally in the importance of the medical profession to people's health.

Relationship with Current Physician

All participants reported that they have a regular physician who they would go to if they needed to talk over a medical problem. All physicians were male except one of the Weight Watchers' physicians. While almost all regular physicians were internists or general practitioners, two of the Weight Watchers and one of the smaller NAAFAn had a gynecologist as their regular physician, one from the former group had a nephrologist, and one from the latter group had an endocrinologist as a regular physician. Slightly more of the Weight Watchers had their physicians for a longer period of time than did the the smaller NAAFAn, however there was a tremendous discrepancy between the two smaller groups and the larger NAAFA group. Four of the latter group had their current physician for one year or less. The median amount of time that participants had been seeing their physician was 16 1/2 years for the Weight Watchers, 6 1/2 years for the

smaller NAAFA group, and 1 year for the larger NAAFAn. Most participants got their physician through a recommendation by a friend or relative, although several were referred by other physicians, or got their physicians through a clinic they attended. Three of the women had gotten their physicians through an HMO or through HIP, and the rest had private physicians. Participants discussed their feelings about their current physicians and expressed how comfortable they felt with him/her and how competent they thought he/she was medically. Overall, participants seemed to have very strong positive feelings about their physicians regarding both competence and comfortable feelings. Only one participant, the smaller NAAFAn who did not think physicians are very important, thought that her physician was not competent. This participant also did not feel comfortable with her physician. One of the larger NAAFAn also did not feel comfortable, and another woman in this group was not as comfortable as she wished to be, but in spite of the two latter women's feelings about comfort, they still felt that their physician was quite competent.

Participants were asked about what they thought their regular physician's philosophy was as far as responsibility for causing or curing fatness, in order to see how close the physician's philosophy was to their own. This turned out to be a very difficult question for many of the participants to answer. Many said that they had never discussed the issue of responsibility with their physician, particularly as far as cause is concerned, and that they didn't know. Differences between the groups on this issue were not clear, although there was a trend in the direction of the NAAFAn having physicians who did not think people are personally responsible for being fat, and who did not think that it was people's personal responsibility to lose weight. In addition, many of the NAAFAn in both groups stated during the interview that they were comfortable with their current physician and pleased with him because he did not make a big issue about their weight. In the smaller NAAFA group, this was particularly true of those who had once been much heavier. Whether or not a physician made an issue out of their fatness was something that was very salient to them in choosing a physician and continuing the relationship. While the Weight Watchers also were very aware and sensitive about the times that their weight was a central issue in their

relationships with their physicians, it did not seem to be a salient criterion on which they chose physicians, or continued relationships with them.

The Search for a Physician

Participants were asked whether they had seen a lot of different physicians due to dissatisfaction. Almost all participants said they did not. Only one Weight Watcher had seen quite a few because she belongs to a clinic, but she was pleased with most of them. One of the smaller NAAFA's who had once been heavier, and two of the larger NAAFA's said they had been through a lot of physicians, because of the physicians' behavior in relation to the participant's weight. One participant commented that she didn't go through as many as she should have:

"I wasn't brave enough or courageous enough all of my life to have left doctors easily. In the last couple of years I've been lucky enough to have found a doctor who treats me with respect. There have been many times I was abused or felt discriminated against by physicians, and I didn't have the courage to get up and walk out, when I'm the customer, buddy! . . . The typical situation every overweight person has had. You go to him, you got the flu, you're throwing up, and he's talking to you about your weight. Or you've got a sinus infection, or a hangnail, or something and he's always comes back to that. Everything is your weight problem. Or they just mention it. They bring it in. You know, 'listen, by the way, when you get over that flu, we certainly have to do something about that weight' . . . There were times when I liked myself enough that if I needed to get the care I'd put up with that garbage, and I maybe should have done more than I did" [NAAFA A]

This issue of complacency with physicians was brought up by several of the NAAFA participants. Several tended to stay with physicians for a long time even though they were extremely unhappy about the way in which their physician handled the weight issue:

"[Didn't look for a new physician even though unhappy because] I was complacent. I was complacent and I was comfortable. I didn't want to have to go looking for another doctor. I didn't want to have to start up with another doctor because I figured I was going to get the same rhetoric [about weight] from another doctor." [NAAFA A]

"I don't enjoy the feeling that I'm some kind of spectacle. He [her physician] is the only one who treats me disrespectfully, and it's a very important thing to me. He's disdainful. It's like -- he treats me like less than a person, . . . I don't really have a lot of faith in him, but I haven't really done anything about it . . . It's time to go, I know." [NAAFA A]

"I think that I compromised a lot and put up with a lot of shit from a lot of doctors that I shouldn't have had to. Even pretending to be dieting or trying to diet. Because even though they won't treat you as well if you're dieting and not losing weight, they will treat you better if they think you are dieting than if you are not . . . Even though I had a documented history of chronic ear problems, I could never just go in and complain about an ear ache . . . I was treated for it. But, you know, 'Well if you lose this weight . . .'" [NAAFA B]

"[Stayed with doctor she didn't like because] what it really had to do with back then was that I knew that I didn't like this guy, but I didn't know who else to go to. I was very nervous about looking for another doctor because I hated dealing with doctors. I think part of it had to do with my weight. I mean, I think part of it had to do with, you know, I don't want to find a doctor and focus in on my weight . . . When you have to find a doctor it is very difficult. It's very time consuming, it's costly and how do you know? You know, that's the thing. How do you know how he's going to treat you about the weight? There have been times when I thought of calling doctors prior to going to see them and saying to them 'look, I'm a large person. This is the way that I am. I'm coming to see you because my toe hurts. Are you going to hassle me about my weight?' I thought of doing that. I've never actually done it." [NAAFA B]

In seeking out new physicians, several of the participants expressed the belief that women physicians, or physicians who are fat themselves would be more understanding as far as weight issues are concerned. One woman in each of the three groups purposely sought out a woman physician because she believed that women might be more understanding; the 'Weight Watcher found this to be so, while the two NAAFA's had bad experiences after purposely seeking out a woman physician. Similarly, while not specifically seeking out a fat physician, several of the participants reported that they were relieved when they found out a physician they went to see was fat because they thought he/she would be more understanding. While about half the fat physicians acted similarly to the ways participants reported most of the physicians they had seen did, there were several fat physicians who were reported to be much more understanding, and who gave the person a feeling of having an ally. The larger NAAFA who is going to have surgery for an ovarian cyst is utilizing a fat woman anesthesiologist. When she went to see the physician for the first time, the participant said to her:

"I guess there won't be any fat jokes in the O.R., huh?' And she [the physician] said 'not while I'm there.' And it was just so wonderful, because it really did feel a lot safer." [NAAFA B]

Another woman happened to have gotten a fat woman lab technician, who caused her to have a similar feeling:

"I felt awkward when I went for the upper G.I., and the contortions you had to make on the table. And it was funny, it was 3 male technicians and a female technician, and the female was definitely zoftig, you know. And I made a remark to her because she was helping me position, and you feel like you're the largest person in the world. And they always give you these little tiny technicians. And I made a remark about that that was one of the few times I wished I was thin. And she looked at me, it was like a feeling of sisterhood, because she looked at me and she said to me 'they suffer worse -- they haven't got the padding!'" [NAAFA A]

Physicians and Dieting

Dieting Under a Physician's Care

Every participant reported having been spoken to about their weight by physicians and having had diets suggested to them. Only two of the Weight Watchers and two from the smaller NAAFA group had never actually attempted weight loss under the direct care of a physician. Two Weight Watcher participants, and four from each of the NAAFA groups reported that they had tried to lose weight under the care of a physician numerous times. Most participants reported that the methods chosen by the physicians were a particular diet (either low calorie, high protein or a liquid protein diet), and/or diet pills. Methods physicians used were very similar for the three groups. One person from each group reported that she had been given injections: one claimed to have been given shots from pregnant women's urine, one from monkey urine and another time pituitary extract, and one was not sure what type of injections she was given. Physicians whom participants attempted to lose weight with were usually their regular physicians (usually General Practitioners or Internists) or a physician specializing in dieting, although the former were much more common.

Several physicians chose to refer their patients elsewhere, rather than having the patient see them for weight loss treatment. Those physicians referred their patients to support groups such as Weight Watchers or to nutritionists. Only about half the participants had ever been told by a physician that they should increase the amount of physical exercise they get in order to lose weight. For those who had been told this, it was usually mentioned as being of secondary importance to diet:

"I think diet is more of an emphasis than exercise. I mean, maybe exercise has been mentioned, but it's more like a trailer kind of thing. You know, 'diet, diet, diet -- and, you know, exercise wouldn't be bad either.'" [NAAFA B]

Diet Pills

One of the most common methods physicians chose to aid participants in their weight loss attempts were diet pills, most commonly amphetamines, although some were also given

hormones and/or diuretics. Although most participants had been given diet pills at one time in their lives, there were clear differences in the diet pill histories of the NAAFans versus the Weight Watchers. While three Weight Watchers had never been given diet pills, only one participant in each of the NAAFA groups had never been given diet pills. The four remaining Weight Watchers were given diet pills by physicians when they were between the ages of 18 and 25, and one had taken pills twice in her life, the others once. In contrast, four of the smaller NAAFans had first been given pills at age 18, one at age 16 and one at age 8 (a woman who had previously been much fatter before weight loss surgery), and three of these women had been on and off diet pills many times throughout their lives. The five larger NAAFans who had been given diet pills by physicians were first given them between the ages of 6 and 13; three of the five had been given diet pills numerous times throughout their lives by physicians. Some of the participants specifically went to physicians to ask for diet pills, while others were simply given them at the physician's behest, especially those given pills as children. Those who sought diet pills often went to physicians who ran "diet mills", where the participant was given medication after only cursory medical information was obtained. One of the smaller NAAFans said that the one time she was given diet pills, at age 16, her physician lied to her and told her the pills were for another condition she had, so she took them unknowingly.

While most participants who had ever been on diet pills had lost some weight, not one person had anything positive to say about this common medical treatment for weight loss. Almost all remarked about two things: the fact that they gained the lost weight back with incredible speed (several even while still taking the pills) and the horrendous physical and emotional reactions they experienced from the pills:

"I felt like I was always going. I was smoking and just drinking coffee, and I wasn't eating and I was just up until 3, 4 o'clock in the morning, and I was just so hyper, and I just had to come off those pills. That wasn't me." [Weight Watcher]

"I once lost 130 pounds with a doctor. And gained it back in an hour (laughs). Immediately. Because he had me on pills." [Weight Watcher]

"The most weight I ever lost was 55 pounds, and that was, unfortunately, through the aid of a doctor that I was going for diet pills and I was going for injections. Unfortunately, because I don't think, really, to go to a doctor for something like that, you should go to, if

you can do it on your own without having any kind of medical or artificial help in that way. It was an appetite suppressant which I consider are uppers. God only knows what was in the injections that I was going for once a week . . . The weight didn't completely stay off. Once that drug is out of your system, you gain it back again . . . I don't really believe that the medication or the drugs or anything else like that should be introduced to a person who really wants to lose weight. I think they have to try to do it on their own without drugs, without pills, without steroids, suppressants or uppers . . . they make me feel ill, they also give me heart palpitations – I feel like my heart is gonna jump out of my chest. You feel like you're on a continuous high because you're taking them every day. And they last anywhere from 8 to 16 hours. So when it's time for me to go to bed at 10:00 I can't. I'm so keyed up. And it's pitiful, because I have to get up at 5:00 every morning to go to work." [Weight Watcher]

"it was a very sobering experience for me as far as the side effects go . . . everyone has a Dr. Feelgood someplace. It was like a factory, like a mill. They took a minimal amount of history on you, and testing and so on. Everyone got the same thing, 3 yellows, 3 reds, this, this . . . I'm sure some sort of amphetamine because I could talk until 3 in the morning. It was incredible. But what happened to me, what really frightened me, I was probably about 20. I remember sitting in the office and had overpowering depression come on me. I was in such a funk it was frightening. And I couldn't shake it, I couldn't analyze where it was coming from. The more I thought about it, I realized it was the pills. I never felt like that. Really. Really. So I stopped taking them. It scared me. I said, 'this is it'. Plus, you feel your heart just palpitating out of your chest, when you're 20, it does make for frightening, it was just frightening." [Weight Watcher]

"I was taking pills by the handful, you know, pills to go to the bathroom, pills to stop going to the bathroom, pills to sleep, pills to wake up, and I lost 80 pounds . . . It was diet mill. You went in, the nurse put you on the scale, you lost weight, she patted you on the head, Dr. H. would come in, look at your chart and pat you on the head, and hand you a new bottle or bottles of pills. And it was 'I'll see you on Friday.' They would pat you on the head, and then you'd go out. You'd go in and you'd say to the doctor, 'I'm not sleeping, I'm having trouble with my bowels, I can't go to sleep', at which point he'd go into his handy-dandy closet of all these multi-colored pills -- I used to call it his candy closet. And he'd take out another bottle of pills, and hand it to you and say 'take these and it'll correct the problem. That's another \$3, that's another \$2.' I wasn't happy, because I would sit up all night long and read, because I was on speed. Now I know what it was, it was speed. My grandmother would be in bed and I'd be cleaning the house. Cleaning the floor with one hand, and painting the wall with the other. Then I would sleep for 15 hours. I had reached a plateau where the weight wasn't coming off, and the boomerang started. I had reached, I guess, the lowest point that I could and the weight started to come back. All I remember is not wanting to eat, period. I would look at food or think of food and be violently ill." [NAAFA A]

"[Diet pills were] forced on me and it didn't last for a long time . . . the doctor had given medication to my parents to give to me. Five different pills, and one was a diet pill. He said this all was related to the condition that I had. I became very ill from all the medications. Real ill. I couldn't lift my head off the pillow without throwing up." [NAAFA A]

"[At 18 years old, weighing 121 pounds] I took dexedrine sulphate . . . that's what it was given to me for – for dieting. I was given diet pills anytime I went and asked for them. I wanted to be thinner. I was embarrassed about gym class. The doctor never questioned me. I was given them freely and readily. Always. I really consider that this ruined my life. I really don't think I would have been this obese. I was the one in the family with the diet pills, and *every* time I went, I got heavier. And the first time I gained a major amount of weight was after I lost the 20, and I gained like 60 or 70. And then 5 years after that, I gained 110 in one year . . . on the pills that I was taking, you could get up on a chair, and wash the walls of all the rooms in your house . . . I became speed-dependent." [NAAFA A]

"I got diet pills in high school from a doctor. I was speeding in high school, and I didn't even know it." [NAAFA B]

"I remember my mother loved it because she said that I was like cleaning, you know. I was down there with the scrub brush cleaning . . . I had major energy. You know, it was like I remember climbing up on top of the refrigerator and washing the wallpaper (laughs). It's like, you know, insanity. I was just, I was so hyped up and that's all I remember. I just remember being very hyper . . . And the doctor was like, you know, his drawers in his desk, you know, were filled with pills. And I remember he would give you this little like manila envelope and he would open up the drawer and he would take a handful of pills and shove it in. I was on Preludin from that horrible doctor at ten years old. I think I was always on diet pills. I was always on diet pills . . . I had to take sleeping pills because of them . . . The pills stopped working after awhile . . . As you can tell, I was a real pill-abuser." [NAAFA B]

One of the larger NAAFans who had been given diet pills as a young child remembered how it felt to take amphetamines from the age of 6:

"The rainbow pills of the 50's, you know, you take one color one hour, one color another hour. In first grade, I remember having to excuse myself to go to the water fountain to take my yellow pill, or my pink pill or whatever. It was real hard to get that straight when I was a kid. . . I remember being very embarrassed, having to go to the water cooler . . . [she would take 2 to 3 a day as a teenager, even though she was only supposed to take one because] they were great. I don't remember a lot of high school because of them, but I lost the weight." [NAAFA B]

Helpfulness of Dieting under a Physician's Care

Although a few participants seemed to feel that their physicians were of some help to them in trying to lose weight, many complained about either having gotten ill from their attempt while using methods suggested by their physician, or about how expensive it was, or about how unsuccessful the attempt ultimately was.

In addition to becoming ill from diet pills, many of the participants reported that they had gotten sick from other weight loss attempts that were medically supervised. Among the Weight Watchers, one participant reported that she kept passing out from being on a low carbohydrate diet and developed diabetes a short time afterward, although the diet was being medically supervised. Another Weight Watcher had elevated liver enzymes while being under a medically-supervised liquid protein diet. One of the smaller NAAFans had been given shots of pregnant women's urine from her physician and was passing out and developed low blood pressure. This same woman had been given intestinal bypass surgery and feels that all her current health

problems (phlebitis, kidney stones, and needing to take a blood thinner for the rest of her life) are linked to the bypass:

"The only problem I've ever had, medically speaking, was related to a surgical procedure I had for being overweight. Other than that I've always been healthy. So if I hadn't been a victim of all kinds of scientific advances I'd be extremely healthy. I think I was a Guinea Pig, truthfully." [NAAFA A]

Another woman who had bypass surgery also reported having experienced continuous health problems since she had the surgery performed.

Several suggested that physicians encourage weight loss because of its lucrativeness, particularly where liquid protein diets are concerned:

"Very impersonal. The whole Dr. Feelgood type thing. You were just another number while they lined their pockets. I think he could have really cared less." [Weight Watcher]

"My doctors are always telling me 'I'll give you a couple of packets, why don't you try this and see how this works?' Packets of powder, of powdered products, that they're looking to promote on their own to make a little extra cash, as if they don't get enough money. My doctor is definitely promoting a diet plan, in addition to just being a regular physician, that he wanted me to get involved in. But I didn't want to spend money for it. It was too expensive. I couldn't finance it. I think he was in on this with a couple of other people, and the proceeds were going to go toward developing this franchise that he was trying to build." [Weight Watcher]

"I don't think the medical profession can help at all with obesity, period. I don't think they have a way to help. Instead of just saying that, they continue to try or they continue to bilk us . . . There are an awful lot of very happy overweight people. Leave 'em alone. Don't make a problem where there isn't one. But the medical profession does. I think many weight loss doctors are making a fortune at the expense of someone who's very healthy, if they would just leave them alone. And they end up making them worse than they were before they started." [NAAFA A]

"The doctor monitors me [on my diet]. And he asks me how I am doing. But other than that he doesn't really contribute to me in any way, shape or form . . . He is very nice. But he gets paid a lot of money to ask me how I am doing." [NAAFA B]

"A lot of doctors nowadays have their own powdered-fasting things which -- I was amazed, like everybody's got to get in on the diet craze. And they make their own powdered stuff, and you buy it from them, and it's going to make you lose weight. I think it's just a great thing to make money, because they know most people aren't going to stick with it. I think they know that." [NAAFA B]

A few participants stated that their physician, at least for a short time, helped to motivate them because of their fear of his/her reaction if they were to gain weight. Others, however, saw this fear as detrimental, because it did not result in weight loss, and made them feel bad about themselves.

Regardless of how helpful participants felt their physicians were to them in losing weight, each one who dieted under her physician's care regained all of the lost weight and in many cases gained even more than was originally lost. Only the three NAAFAn who had weight loss surgery had kept off some of the weight, but even they have regained a very high percentage of their originally lost weight, ranging from 40% to 70% of the amount lost.

Discussing Weight with Physicians

Interactions with physicians about their weight was an issue that participants spoke at length about, and almost all had very strong feelings about this issue. The next section addresses the general feelings of participants in regard to physicians discussing weight with their fat patients, and the following section will address specific incidents that the participants reported they have had with physicians, and their reactions to the incidents.

General Feelings about the Role of Physicians in Discussing Weight

Each participant was asked whether, in general, she felt physicians ought to bring up the issue of weight and weight loss with their fat patients, and whether physicians really *knew* how to help their patients lose weight. While Weight Watchers were much more likely than NAAFAn to believe that physicians should bring up the subject, the overwhelming answer from all but one of the participants to the latter question was a resounding "no" -- physicians do *not* know how to help their patients to achieve weight loss. (One Weight Watcher was not sure whether physicians know how to help their patients lose weight, but did feel that a person who is dieting should be seeing a physician on an ongoing basis in order to have his/her physical signs monitored.) It did seem somewhat contradictory to believe that physicians should approach the subject but are then incapable of effecting any change, and participants were asked about this contradictory belief. Several did not seem to be able to resolve this inconsistency, although some suggested that once a patient is made aware of the problem, they might be referred elsewhere for help (e.g., support group, nutritionist) or the physician might have scared them into being motivated to go ahead and be successful on their own. Not one participant thought that a person's chances for

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successful weight loss would be improved by dieting under a physician's care rather than trying other methods or programs. In fact, all but two of the women felt that physicians would probably be *less* successful at helping a patient achieve weight loss than would other methods or programs that exist. Of the remaining two participants, one in the smaller NAAFA group felt that no weight loss attempts work, so physicians would be no better nor worse, and one of the larger NAAFAnS felt that for some individuals, physicians would do better, but it would depend upon the relationship between the patient and his/her physician. Most felt that support groups are better, because one can feel more comfortable and understood, one can get more personal support, and if people can choose the types of diets that best fit their lifestyles they might be able to stick to them better.

Six of the Weight Watchers felt physicians should bring up the subject of weight loss with their fat patients. The remaining person, who happened to be the one Weight Watcher who did not feel a personal responsibility to lose weight, felt that the physician should discuss it only if the patient brings it up first. Only one of the smaller NAAFAnS felt that physicians should bring up the subject and one felt it should be discussed only if the patient brings it up *and* the person's weight is affecting his/her health. Two of the women in this group felt that it is appropriate for the physician to bring up the issue of weight on a person's first visit only, and the remaining three felt that weight should be discussed by the physician only if the person has a medical problem that is clearly related to his/her weight. Similarly for the larger group, two felt that it was acceptable for a physician to bring the issue up with a fat patient, one felt it was acceptable only for the first visit, one only if it was related to a clear medical problem, while two did not feel that it should be brought up at all. Those participants in all groups who thought that weight should be brought up by a physician generally felt that a person should be at least 25 to 30 pounds overweight before a physician should discuss it. Most participants who thought the issue should be brought up only if it is health-related stated that, unfortunately, physicians too often tend to incorrectly attribute health problems to fatness. Most of the NAAFAnS and one of the Weight Watchers felt that once a patient states that he/she is not interested in losing weight the physician should drop the matter.

Several of the participants who felt physicians should discuss weight loss with their patients believed that hurting a patient's feelings or scaring the patient was a positive motivator, although one specifically stated that scare tactics would not work for them personally:

"Maybe they *do* have to hurt the person to make them realize that they have to lose weight . . . so I guess they have to, for your heart and your cholesterol and all that. I think they just have to." [Weight Watcher]

"[Having a physician bring up the subject] makes them aware of it. Some people say 'oh my doctor is going to kill me. I didn't lose the weight'. You know, reprimand. Like a father figure. It may make them stick to it . . . it doesn't scare me one bit. That isn't what would do it for me." [Weight Watcher]

"[You're going to keep gaining weight] unless you make a conscious effort or somebody says to you 'hey, you are overweight. Why don't you look into it?' Especially a health physician. [When a doctor says something] I think it scares the patient. 'Oh my god, if I don't listen to him.', you know. 'Oh my goodness, he really is right.' You know, he like really like sparks something in you that you really didn't think about before." [NAAFA A]

"[If it's a doctor mentioning weight] I think would scare someone more." [NAAFA B]

One of the Weight Watchers and one of the smaller NAAFAs were more skeptical about how well scare tactics work:

"When a doctor says that to me, it more or less makes me feel like, here's another person saying this to me -- he's no god. So the guy has an M.D., he has a license to practice to administer drugs and whatever. But I don't take it as any great quote-unquote holier-than-thou statement, than I would from you or my mother or anyone else. They're just people. I diet out of my own understanding that I need to do it. Not because my doctor said it . . . It doesn't modify my thinking. I don't go for scare tactics that quickly." [Weight Watcher]

"[How successful a doctor is] depends on how badly they can frighten the patient. They can do a great guilt trip on them. [It may work] for a period of time, and then they make the patient feel guilty if the boomerang effect happens and they start regaining the weight." [NAAFA A]

The majority of participants felt that under some circumstances, physicians' behavior regarding the discussion of weight loss is inappropriate and can do more harm than good, such as having a negative effect on the physician-patient relationship or lowering the patient's self-esteem. One Weight Watcher felt that a negative interaction with a physician over being fat might cause the patient to gain even more weight. Many participants commented on the inappropriateness of physicians discussing weight when the patient has come in complaining about an unrelated medical problem. Participants felt that physicians typically oversimplify the issue of weight loss, do not have a good knowledge of nutrition, and do not take into

consideration the individual's motivation, environment, psychological nature and genetic/biological makeup. According to participants, physicians tend to feel that by simply bringing the issue up, or perhaps by insulting or criticizing the patient, the person will then automatically be motivated to become thin, but participants believe that this is not so. The issue of losing weight is a complex one, and physicians often disregard all the factors involved other than simply reducing food intake. According to almost all of the participants in both groups, physicians need to change their approach to this issue. If physicians begin to take a more sensitive and enlightened approach to this issue, they may end up helping their patients more. Participants' responses about this critical issue will be quoted at length here, because of the depth of feeling they expressed about it:

"[A physician could approach the issue of weight by saying] 'Such and such a condition that you have is negatively affected by your weight. Should you choose to do something about it, I'm available for discussion.' Offer your services, don't try to cram them down their throat. If there's no health problem, the doctor shouldn't discuss it. Because I think people know what they weigh. I think they [physicians] should mind their own goddamn business. Because all they do is make people feel guilty, and then they go home and eat a gallon of ice cream. What good has that done? It's intrusive, it's offensive, and it has negative results. Because if they do *force* you to take off weight, they wreck your endocrine system, they make you feel like a piece of shit, and then you're going to gain more weight than you had to start with, so what good have they done? . . . I think doctors need nutrition information. Because they intrude on that part of your life and wreck it. The worst advice I ever got on how to diet was from doctors. I think they don't know what they're talking about. Everything they tell you is negative -- you can't, you can't, you can't." [Weight Watcher]

"I think they should [approach the issue of weight loss], but I think their approach should be very different. I think they should have more of an understanding. I think they should have more information about weight. I don't think that they've moved too far from where they were when they got out of medical school as far as their approach to people. They should be more aware of being sensitive to overweight persons' anxieties. No flip remarks . . . I think they should be more understanding of where you're coming from, and realize that it's that much more. I think every visit to a doctor, most visits to a doctor, are anxiety-producing for most people, and I think that this is kind of an added layer for overweight people." [Weight Watcher]

"I don't think any doctor, no matter how well or how little the patient knows the doctor, should be treated unprofessionally and should be treated that because they're heavy they should be treated as something below their dignity. They should be treated as any other patient, with dignity, with respect and in a professional manner. I don't care who they are . . . With a new doctor, I would expect to be spoken to in a professional manner . . . I think, in general, doctors are one of your greatest allies, when it comes to dieting. Because when doctors watch you, and know what to look for, and you have a good rapport with the doctor, I think they can be one of your biggest helps." [Weight Watcher]

"The finger-wagging makes you feel like a little kid, in the way you talk to little children, and it makes you feel it's sort of like a cheap shot -- it's something that I'm still embarrassed

about myself, and the doctor, a professional person, has picked up on one of my weaknesses, and sort of puts some salt in the wound -- and makes it worse. And I don't like that kind of professional relationship. I'd much rather be consultative. I'd like the doctor to consult *me* about what the process is that's already going on . . . I think it's sort of helpful [for the physician approaching the issue] to start in general terms. You can talk about people, in general. A doctor can very quickly intimate that they want to be involved in health as a total thing. And, of course, as we know now, quote-quote, this includes all of the stuff that you're doing in your life. The question is, how can you remain healthy? What's your activity level going like? What things might make you ill? What things can you do differently? What's your diet like? Are you getting checkups? In other words, you make a few comments -- very broad, to set the scene. And then make comments about dieting, or weight loss in that context." [Weight Watcher]

"I think doctors should listen to what the patient is telling them and not just come off like 'I am god, and I say this or that'. He's really got to listen to his patients, and see what's going on, and address it differently than it's just a matter of 'I'm going to give you this diet, you're going to go home, you're going to lose X-amount of weight.' It doesn't work like that. You have to look at the whole person. And build up some kind of rapport . . . really get to know the person, and then look at the weight issue also, along with that." [NAAFA A]

"[A physician can approach the issue to a person with a health problem by saying, for instance] 'You have a heart problem. I have a feeling maybe your weight is making your heart work too hard'. Or 'your cholesterol is too high and you're going to clog your arteries. Let's knock down your cholesterol, and the best way to knock down your cholesterol is to knock off some of the weight or some of the foods that you're eating. And it might do something.' But if they're examining what appears to be a fairly healthy person, I don't think it needs to be made a medical issue. If weight has to be addressed, it should be with the honesty of saying 'you need to lose weight, and I'm not going to be able to make it easy for you. Because we don't know how to get weight off of you in a safe, easy, more than 2% successful way.' They should admit the limitations of what medical science knows about weight loss, and until they do know how to get people to lose weight they should stay out of the territory that they can't do much for." [NAAFA A]

"I really think the emotional side should be addressed with anyone, in regard to medical problems. I think that that's the biggest contributing factor in all disease. Maybe the doctor should discuss how they feel about it first, rather than just saying 'you're overweight, and you have to lose weight.' You know, if the doctor would sit down and discuss how they felt about it, and why they felt they were heavy, then they might get better results, if the person really wanted to lose weight. In general, I think most are kind of hard line about it -- 'This is what you have to do, now just go ahead and do it.' They're not thinking about, you know, this woman has to feed five kids and a husband, and then worry about what to make herself, and, you know, by the time she's ready to go to bed it's 10:00 at night, because she's made sixteen different dinners. Like stuff like that has to be taken into account. The whole person, not just 'this is what most people eat to lose weight, so here.' It doesn't work for all people." [NAAFA A]

"[There's no way to lose weight] except to stop eating, and that is certainly going to be difficult, number one, and will probably make you very ill, number two. Doctors tell you nothing more than the same thing. Cut back, cut your calories. When you've been overweight for awhile, you know the calorie count of every item of food produced. You don't need the doctor to charge you to do that." [NAAFA A]

"They should bring it up, and ask the patient 'do you want to discuss this, or don't you want to discuss this'. And if the patient says no, you say 'fine, thank you', close the folder, and don't beat them about the head and shoulders about it every time they come in for a hangnail, or a strep throat or a dislocated shoulder." [NAAFA A]

"I think they should address it with an open mind. I think they should try to separate the issues of being healthy from being fat. I don't think that they need to assume in a blanket

manner that everybody who is fat is unhealthy. I think it would carry more validity if they came to it with that attitude. I think they need to be realistic. I think they really need to stress activity more than diet. I think it's important for anybody to be eating healthfully. Sort of, make sure somebody's eating a healthy diet. I think they should make sure everybody does that. But, sort of, helping people to be more holistic about it, and, you know, ways that they can exercise. And I don't think that it has to be exercise, I mean, just encouraging people to be more active, and make good food choices, with realistic goals." [NAAFA B]

"People are very individual, in the way they lose weight, and what helps them lose weight. In their calorie level. I think doctors don't recognize that. They give out a diet sheet, they think that everyone can eat 1200 calories a day, and all this kind of food, and lose weight . . . I think there's no interaction that makes sense between doctors and patients [for weight loss]." [NAAFA B]

"If there is a medical problem -- it's just like if you smoke -- you know, the doctor can say to you 'look, you know, you've got a bad smoker's cough, you should stop smoking.' That doesn't mean you're going to. It's the same thing with weight . . . Most doctors, I feel, just think you should cut down calorie-wise. But everybody's different. And I don't think they can make a general thing like that. Not one general diet on a sheet of paper is going to be right for everybody. And that's basically what they're selling. You know -- the sheet of paper at this many calories. But that's not right for everybody." [NAAFA B]

"I think that if a person goes to a doctor and they have a cut on their finger and they want to be treated for the cut on their finger, that it is inappropriate for him to tell you to lose weight. On the other hand if a person goes to a doctor and says I want you to treat me for the weight, you know, for obesity and I want to lose weight then that's fine. But I don't want to be approached when I go to a doctor, for whatever reason I'm going to a doctor, I don't want to be approached about it. I know that I'm fat. I don't need him to tell me, you know. I don't need him to tell me that I have to lose weight. You know, that's a choice. That's *my* decision and *my* choice . . . it can't be along the lines of 'you know, by the way, you're fat and you have to lose weight' kind of thing. It would have to be more along the lines of 'look, I don't know how you feel about this. I don't know what your experiences are with dealing with this, but I just thought I would mention it' -- you know, to put it in a way that is not 'you bad little girl'. You know, *not* that kind of thing. More in an adult-type manner. 'I'm giving you this option'-type thing. 'I'm just bringing this up for your knowledge, so that you can now take this and do whatever you want to do with this knowledge.' But not that 'you're fat and you have to do this -- I'm the doctor, I'm god, I'm telling you -- go on a diet and all your health problems will disappear' (laughs). I really think, more than the words, it's an attitude that a doctor has." [NAAFA B]

"I think that they should discuss their patient's physicality with them. I think it should be an *inquiry* rather than an interrogation or a lecture. I think they should address a patient by saying 'You're fat. Do you want to tell me about it? Have you dieted? Are you dieting? Do you want to lose weight? Is it a concern of yours? Tell me how *you* feel about it.' That's the way I think it should be handled. I think the doctor's first concern should be for the patient's concerns because that's a good indicator of how the patient handles anything and everything else pertaining to their health . . . And I think that by the doctor taking the time to understand the patient that he or she is going to have much greater access to the patient's confidence and the opportunity to give them much better care. *Total care* . . . And the doctor has to have realistic expectations too . . . It shouldn't be such a profound issue because that attacks people's self-esteem." [NAAFA B]

Reactions to Weight Discussions With Physicians

All participants but one (the Weight Watcher who weighs the least) reported that the issue of weight has been brought up by physicians continually throughout their lives, by the majority of

physicians they have seen. The reports of the larger NAAFAns gave the impression that physicians were particularly relentless with them in demanding weight loss. In discussing their personal reactions to physicians who have discussed weight with them, one clear difference emerged between participants in the groups: that of being angry about physicians discussing weight loss with them. Although most of the participants in all three groups were critical of the ways in which some physicians approach the weight issue, the overall trend was for NAAFAns to be angry about the interactions they've had, while Weight Watchers typically were not. All but one of the women in each of the NAAFA groups expressed anger about at least some of these interactions, as did one of the Weight Watchers (the woman who felt she was not responsible for losing weight, and who felt it was not appropriate, in general, for physicians to bring up weight loss unless the patient brings it up first). These types of interactions were referred to variously by the participants as carping, harping, haranguing, lecturing, hounding, harassing and interrogating. Two of these participants specifically stated that despite their anger about weight loss discussions, they did think their physician was justified in believing they should lose weight. Several of the comments already quoted in the above section illustrate the anger that some participants expressed during the interview about physician-prompted weight loss discussions.

Additional comments were:

"[I always tell him] 'Shut up. Don't bother me about my weight, or I will not come back'. He shut up. I don't want anyone taking any more control away from me. I want to take care of my own life and my own body." [Weight Watcher]

"It was none of his business. [What he said] went in and out. I just want him to just shut up already. It's enough. It's my life. I'm going to lead it my way . . . I know they're right. But that doesn't mean that it is going to happen overnight." [NAAFA A]

"I thought they had the right to then, I don't think they do now. For a long time I believed them, that weight was a medical issue. I don't believe it's a medical issue now. Or it doesn't need to be." [NAAFA A]

"You sit there and you listen to the lecture, like your training in school to keep your hands folded, and say 'yes, ma'am, no ma'am, I'll try ma'am', and you walk out the door and say 'I'm going to stop the payment on that check.' . . . you know, I am paying her my money, to do one thing, or for going for a specific cause, and she's going around the mulberry bush about something else that I don't want to hear about. And I'm paying for a service. It's my money." [NAAFA A]

"[Didn't want to go to physicians because] all they were going to do was tell me to lose weight and why should I have to pay them money to tell me what I already know I have to

do, but can't seem to for one reason or another. [They'd say] 'how could you live like that? You're killing yourself. You are buying yourself an early grave. You have such a pretty face and you are so intelligent -- no one is ever going to notice it if you don't lose some weight. And maybe it won't matter because if you don't lose the weight you are going to be dead anyway. I would like to help you but I'm going to tell you right now, you're going to have to help yourself and lose that weight before I can do anything for you.'" [NAAFA B]

"[The doctor] is not permitted to speak to me about it [weight] . . . He brought it up, and I said 'look, why don't you find something that has a success rate for 5 years that gets above the teens, and then we'll talk. Because there's nothing that's effective' . . . It makes me angry, that I should have an adversarial relationship with someone who's trying to take care of me. I'm very angry, all the time, at doctors. I used to try and educate them a lot, and now I don't. It was pointless in the past, because they're not different from other people. You can get them right up to the line. I mean, this doctor knows it. He's admitted he doesn't have anything with a good success rate, and he still says 'but, you know, I'd still like you to lose weight.' Well, *how?* *How* is that going to be accomplished?" [NAAFA B]

One aspect of weight discussions that particularly angered participants was when they had gone to see physicians about a medical problem that was unrelated to weight, and the physician used the opportunity to bring up the topic. Two dramatic examples of this were when a physician brought up the issue of weight loss to one of the larger NAAFans who was discussing her upcoming surgery for an ovarian cyst which had the possibility of being discovered to be cancer, and when one Weight Watcher who had been raped needed to get a gynecological examination:

"[While getting a second opinion about having surgery] I clearly communicated to him that I had made up my mind to have the surgery, but it was a matter of timing now, that I was concerned about. So he was talking about it and he said to me 'sometimes when people have difficulty making a decision, if you're going to get something more out of it it's easier for you to make up your mind.' And he said, 'while we have you open, have you ever considered having a stomach stapling done?' *That* was when I should have left. Right then was when I should have left. Because I sat there, and I was like nauseous. I couldn't believe this. And it upsets me that I can't do that. That I just sit there, and what happens is that I just pull back, that I can't say 'what the hell are you talking about? That has *absolutely* nothing to do with why I'm here. Why are you even bringing that up?'" [NAAFA B]

"I was raped, and the police took me to the hospital, because they had to take a sample. First they take you in for the specimen. The doctor said 'You really should lose weight.' I thought it was totally inappropriate, but I was in no condition to tell him. [Almost believed her weight caused her to be raped because] I went in because I had been raped, and he told me to lose weight. Now what connection does a vulnerable person, and rape makes you as vulnerable as a newborn infant, what connection comes in your mind? This doctor took me in a very vulnerable position and said you have been raped, you have to lose weight. What connection's going to be made in my 2-year-old mind? And doctors do that all the time. They are violent against people who are vulnerable." [Weight Watcher]

Other participants echoed the latter participant's sentiments about the role of vulnerability in interactions with physicians who seize opportunities to lecture a patient about their weight:

"You know, before I got my gynecologist the one that I have now, oh my god did I used to dread that, boy! That was the worst, you know? With being fat and getting some gynecologist telling you, you know, 'you got to lose weight' and this and that and spreading your legs on the table. Very vulnerable position to be in." [NAAFA B]

"It's just like, I'm going to expose myself to this person, and I'm going to be vulnerable to this person, and this person has power over me, and some of it's going to be negative, and I get like, you know, I don't protect myself, I'm sort of at their mercy." [NAAFA B]

"I just tell them don't talk to me again about it . . . the way I handle myself with doctors is I get obnoxiously eccentric, and it's just not worth it to them to go in after me again. And that's the only way I can handle it. And the problem with that is, when I'm sick I don't feel like that, I don't have the energy to act like that, and that's when you get it worse. When you're really feeling sick. It really feels like they prey on me. They wait until I'm really sick, and I really need something . . . If they sense it, they take an opportunity. And I think they have a lot of anger at me for not letting them, you know, feel like they can say what they want. So it's a way for them to get back at me." [NAAFA B]

Other instances in which participants reported that physicians had brought up the weight loss issue when they went in for other medical problems were the following:

"I went to a doctor for bronchitis and he told me that I had to lose weight. I mean, everything was connected to my weight. And that's shit. He was telling me I had to lose weight, and I'm thinking I'm having trouble breathing. Let's do something about the breathing, shall we?" [Weight Watcher]

"I got sick all of a sudden . . . They ended up rushing me to the hospital because I was just about passing out. And in the hospital the doctor that was assigned to me first was very rude and made a lot of derogatory comments . . . He started in about my weight . . . The first thing he wanted to do was put me on a diet. I said 'I haven't been able to hold food down for two days -- I don't care what kind of diet you put me on, I can't eat anything anyway.'" [NAAFA B]

"[Was in hospital to get a blood workup because of medication she was taking] and right away they suggested that I should lose some weight. And I spoke to them about my past, and said that even though they look at me and they probably think I eat a lot, I don't, and all that stuff, and they sent me to a dietician. It really, really annoyed me . . . They just said 'wait here. She's coming' . . . I had no choice in the matter. 'Just sit here, and she's coming.' That really annoyed me. She sent me home with this stupid diet." [NAAFA B]

While almost all the NAAFAs were angry about weight discussions with their physician, four of the Weight Watchers felt that their physicians act appropriately in discussing their need to lose weight, as did one of the larger NAAFAs, although several of these women remarked that it did make them feel embarrassed and uncomfortable. Additionally, although several participants believed that their experiences with physicians regarding the discussion of weight loss were positive ones, all but one gave no indication that these discussions had ever actually motivated them to attempt to lose weight for any significant length of time. Only one Weight Watcher participant reported that it had a strong motivating effect for her and that she is currently attending

Weight Watcher meetings because her physician told her to lose weight. Another participant, the Weight Watcher who weighs the least, claimed that physicians almost never bring up the issue of weight with her and that she really wished they would do so, because she believed it would motivate her:

"I always expected them to say something. And more often than not, they don't say anything. It really surprises me. I always expect doctors to make more of an issue of it than they do. I expect to hear it. I would like to hear it, because I think that would help me do something about it . . . and there's nothing wrong with that. I mean, it comes from a professional person, who is working with you, who's the expert on your health." [Weight Watcher]

However, at the same time, this participant also felt that these discussions are often "power plays":

"Because talking about weight between doctors and patients is sort of a power issue. It's something that you're very sensitive about as an overweight person. That's what I said when the doctor makes a sort-of finger-wagging comment, it's a kind of cheap power play, because it's making you feel bad or put-down at their own expense." [Weight Watcher]

Several of the participants stated that occasionally their physician's comments would motivate them for a very short period of time to diet, but the motivation would wear off quickly. Others specifically stated that their physician's comments did not motivate them at all as far as dieting is concerned.

Of the five participants who felt their interactions with their physicians regarding weight loss were beneficial, two participants (including the one NAAFAAn) related stories they interpreted as positive, in which their physician had made what seem to be inappropriate comments about their weight. When asked about the inconsistency of these comments and their interpretation of a beneficial discussion, both participants commented similarly that they had a long close relationship with their physician and that these types of comments were more acceptable coming from him:

"He told me I was a little overweight, and what the hell am I going to do about it. Because I've been with him for so many years I don't take it as an insult anymore . . . [He said her heart palpitations] are due to 'the lard that you're carrying'. I don't think anybody deserves to be treated negatively because of their weight by a doctor. Not under any circumstances. He is considered a professional, and he should act as such. The only reason my doctor doesn't act that way is because I'm family, he's like my family . . . He's more personal with me . . . from him, it just didn't come as an insult, the man is speaking his mind. He's telling me the truth. If it came from a new doctor, somebody I didn't even know, I would take it as a high insult . . . I would probably have punched him in his face, knocked him on the floor, and I would have told him to go find himself a new line of business to get into because he's got no business being a doctor with that kind of an

attitude. It's as simple as that . . . My own doctor can say 'hey listen, come on, let's lose some of this tub of lard' . . . The man is speaking his peace. He knows enough to tell me, 'hey, your tire's hanging a little lower. Let's get it off.' He'll use those exact words, but he's not being unprofessional about it. Not at all. I don't take it as unprofessional. Not from him. I've known him for so many years. He's good that way. He knows how to handle his people. He knows how to handle each of his patients. With the utmost care, with the utmost professional manner." [Weight Watcher]

"[I went to him for help in losing weight and] he said 'you look disgusting,' and I love this man. He's never been that bad. He said I look like a disgusting pig, or something like that. It was the first thing he said to me, and I cried . . . He was very nice. Very sympathetic . . . I was very shaky as it was. And someone saying you're a disgusting pig doesn't make you want to laugh. You know. I was coming for help. I felt hurt. I love this doctor. I don't think he's the type of doctor to say that to just about anybody. I mean, we have a special relationship. Maybe he felt that he needed to say it, to shock me or something." [NAAFA B]

Another Weight Watcher participant was somewhat disturbed at having taken her daughter to the physician, and having the physician remark about the *participant's* weight, even though it wasn't even her appointment. Yet, she also felt that her long relationship with her physician made a difference in their interaction, and that this mitigated the hurt somewhat:

"As soon as I walked into the door. As soon as I walked into his office to speak to him about my daughter, he said 'you're overweight and I've never seen you so heavy' . . . and he says 'I'm only telling you this for your own good.' I didn't like what he said. But he was right . . . When he said that, I was like stunned that he said that to me because I wasn't going there for a medical problem . . . I guess I was hurt that he said this to me. I thought he was my friend. You know, you get a doctor that you can talk to . . . when I left I said 'I think I'm going to have to do something about it' . . . I think he really shook me up . . . I feel that I have known him for so many years that I agreed with him when he said it to me. I did agree. I didn't say 'oh how can you say that?' or 'it's none of your business'. I agreed with him. I said 'you're right.'" [Weight Watcher]

Two of the Weight Watchers, while not expressing anger about their interactions with physicians regarding weight, did not believe that it was beneficial for weight to be discussed. Both felt that their physician was justified in believing that they *should* lose weight, but the physician mentioning it only made them feel bad about the fact that they were not being successful at losing it:

"I know it's going to be a repetitive or rhetorical statement. It's rhetoric already, and I didn't really want to hear it. They were going to tell me again, 'well, you know, you really should think about losing the weight. It can definitely affect different parts of your body.' A lot of times my internist would say that, and I knew I was going to hear it . . . I know it's something that I should take in hand, and I neglect it. I know I should be doing it for myself. It reinforces that I'm putting it off, and he sees me putting it off, and it shows on the scale." [Weight Watcher]

"I felt like he'd uncovered some terrible sore; honing in on your one big point, I mean that's how I felt. I think he made me anxious. It was like the worst affliction you could have.

That's kind of how I was interpreting it. It made me uncomfortable. But at the same time I said to myself, 'you know he's right, you know he's really right.'" [Weight Watcher]

Many of the participants who were angry about weight lectures also stated that these interactions made them feel bad, and commented on the extent to which these interactions could negatively affect one's feeling of self-esteem. Most of the women reported that their self-esteem had been affected only in the past, but others feel currently that their physician's behavior still has negative effects on how they feel about themselves. Participants reported that physicians' comments to them regarding their weight had resulted in their feeling rejected by him/her, believing they were failures and feeling like they were worthless people:

"[Physicians were] worse than not helpful. They were destructive. Because they convinced me that I was absolute shit. And I already had a bad self-image. They just added a bad body image to an already bad psychological image . . . By telling me that I was disgusting, by telling me that I was too fat." [Weight Watcher]

"Maybe they [physicians] try to make you a little more self-conscious so you'll look at yourself. They tell you 'look at yourself in a full-length mirror. Isn't that enough to turn you off? Isn't that *dis-gusting*?' I think it was mostly meant to motivate you to continue on the diet . . . All it did was increase my self-disgust. It didn't really motivate me to diet." [NAAFA A]

"[I believed] I was weak-willed, lily-livered. Because you get it always told to you. [I thought that] she knew what she was talking about because she was a doctor, had the degree, had gone all these years to school. A doctor is an authority figure. And you have doctors, and you have advertising, and you have the whole world in general telling you that you have something wrong with you because you're obese, and that you don't fit the norm. And that it's all self-controlled. And if you *can't* lose the weight and keep it off, there's something wrong with you because you're weak-willed." [NAAFA A]

"I think it made me very embarrassed, and worthless. One time I had gone in for a physical, and he put me on the scale, and the scale had been set up from the patient before -- he never put the things back down. And he had to raise it from that. And I remember him saying to me 'you weigh more than that pregnant woman that just walked out.' Of course it made me feel bad . . . I probably thought that I was very inferior because I couldn't lose." [NAAFA A]

"I've gone to doctors, for minor complaints, and come out suicidal. Because of what the doctor said to me. I mean many times. Not once, not twice. Many times, when I would go to a doctor, when I was even a kid. You know, someone, a doctor, a doctor really has the ability to make you want to die. In a lot of ways that are direct and indirect. In that it certainly makes you want to never come back, and ultimately, if you happen to have some disease process, *that* can kill you. And he can make you want to kill yourself, because some doctors are so incredibly insensitive. They treat being fat as such a volitional issue, that it should be so easy for you. 'Well, why don't you do it' or 'I know it's a little difficult, but just get some willpower', that kind of thing." [NAAFA B]

One of the smaller NAAFans described her self-esteem crumbling not from her physician's words to her but from his behavior toward her:

"I've never had a doctor who acted like 'yeesh, I can't touch you', until [current doctor]. He's fat-phobic. Once he came in about a year ago, I take my shoes off, I mean I'm perfectly clean, and he looks like he finds that distasteful or the fact of my feet . . . Any feelings of self-worth, this man could demolish in two minutes. He looks disdainful. Utterly disdainful . . . at any part of me he has to come in contact with . . . It was shades of why I wouldn't wear the leotard in gym again, which was a part of my life I thought I'd gotten rid of. It was shades of feeling unworthy, body-wise again . . . And I have not been embarrassed about my body with a doctor for so long, and that man has managed to do it." [NAAFA A]

Participants discussed other instances in which physicians were especially inappropriate, if not downright cruel, in their behavior toward them, which had particularly negative effects on participants' feelings about themselves. These incidents will be discussed further in a section addressing unprofessional and inappropriate behavior of physicians toward their fat patients.

Office Visits with Physicians

Anticipating the Visit

In anticipation of office visits, about half of the women in the two smaller groups reported that they have often thought about physician visits ahead of time, and have worried about how their weight would come into play in their interaction with their physicians. On the other hand, all of the six larger NAAFA women worried about this very often:

"It does make you not want to go. Anything that's going to embarrass, or bring stress, or make you feel uncomfortable. It's going to stop you, it's going to make you think. You're going to anticipate that visit for hours beforehand, and dread it." [NAAFA B]

"I usually dread it and I'm usually prepared for a fight, and I try to psyche myself up . . . I was terrified all the time." [NAAFA B]

Several of the participants reported being so worried about their physician's reaction to their weight that they have dieted right before an examination so they would weigh a little less by the time of the visit:

"A lot of times when I know I'm going to be going to the doctor or when I'm planning it somewhere's in the future -- like 2 months, 3 months, whatever, I'll deliberately go on a diet. You know, let's make this look better for the doctor." [NAAFA A]

"If I was supposed to be dieting, then I would be nervous that I didn't lose. I dieted right before I went to the doctor's office, and I used water pills, and that helped too. It takes away a lot of water. See, you take it the day before you go [to the doctor], and, for me, that can take off 8 pounds, 5 pounds, something like that. I did that the last time I went, three years ago, and also when I went on the rice diet I did that a lot. That's where I learned about it . . . Because if I didn't lose weight the doctor would kill me. I mean, 'what's the matter with you?' You know, 'you're failing.' Or, you know, 'you're a failure.' You know,

'stop eating.' I just don't want to hear about it. The water pills would take it off. I mean, that's not perpetual weight loss. It goes back on." [NAAFA B]

Another of the larger NAAFA's, as quoted previously, would lie and tell her physicians she was dieting because she felt the physicians would treat her better if they thought she was doing something about her weight.

Those participants who now have a physician who does not focus on their weight do not worry about this as much now, but did so in the past with other physicians they have seen. In addition, many of the women stated that they are much more confident and assertive now than they were when they were younger, and therefore have an easier time in their interactions with physicians because of their assertiveness and consequently worry less than they did in the past. This increased assertiveness was true for women in all the groups, and for situations which involved weight as well as those which did not.

Getting Weighed

All participants except one of the Weight Watchers, mentioned aspects of physician visits they found troublesome because of their weight, either with their current physician, or with previous physicians. The aspect mentioned more often than any other was being weighed on the physician's scale. Participants in all groups reported feeling embarrassment, not wanting their weight to be commented upon, worry about what the physician (or nurses, who often do the weighing) would think of them, concern that their weight would take attention away from the condition they came to see the physician about or worry about the unavoidable lecture that would ensue. The larger women often had the additional embarrassment of not being able to be weighed on an ordinary physician's scale, which, according to the participants, usually only weighs a person up to 300 or 350 pounds.

"Oh god, I hate it. I don't like it. I don't like getting on the scale. That's what I don't like. If it's anything else it wouldn't bother me. But getting on the scale, that would bother me. . . . The nurses, like I said, at the clinic would say something about putting on weight. Even if it was three pounds and I thought I was doing pretty good . . . *She* would be the one that would say 'oh, you put on weight since you've been here last'. I think I hated to get on the scale just because of her. She was a nice person. She was a nice nurse and everything. But just because I didn't want to hear her comments if I gained weight or if I lost weight."
[Weight Watcher]

"I don't like to get weighed in the office. I don't like to get on scales . . . I'm just talking about a twinge of embarrassment. I don't like to get on the scale and face what the numbers are. [For myself] and also for other people too. I don't want other people to know what I weigh, because I think people associate, they have sort of a value judgment that goes with a particular number." [Weight Watcher]

"He used to weigh me, and I used to say 'no, I don't want to get on the scale.' And we used to have this little game we used to play because I knew what he was going to say. He was going to look at the chart from the time before and say 'you're still the same -- lose the weight.' Or, 'you only lost a pound, lose the weight'. Or, 'you gained a pound, you should lose the weight.' It would have been the same thing. There were anxieties, but I would try and get out of it, and I would keep thinking to myself that I don't have to do this if I don't want to." [NAAFA A]

"Many a time I stayed away from a doctor because I really didn't want to get on that scale, and I wasn't going to him for that reason. I would avoid it. I would just avoid going. I had phlebitis, one time, for three weeks, before I went to the doctor. I kept hoping it would go away, and I really didn't want to face that again. Certainly flus. I had walking pneumonia one time, that I didn't follow up on as I should have because a doctor made an issue out of the weight." [NAAFA A]

"I object to going to a doctor that your arm is hanging out of the socket, and their immediate response is 'get on the scale.' You know, put the arm back in the socket, put on a cast, and then, maybe I'll get on a scale, but first take care of the condition." [NAAFA A]

"I've been asked, even recently, to get on a scale, and I asked them what the capacity is. And they tell me and I tell them I've recently been weighed and my weight was 410, 420 whatever it was. 'How do you know that?' 'Because I told you I was just recently weighed.' 'Well why don't you get on the scale?' I say 'no, because the scale will not weigh me. And I don't really think that it's necessary.' 'Well, let me see for myself.' And I have to put my foot down. And these are the kinds of things that go on all the time." [NAAFA B]

"I dread the moment that they say they want to weigh me. Because then I first have to tell them 'well, your scale will not weigh me'. And, you know, how they can't comprehend -- these are medical people okay and they have a scale that goes up to 300 pounds. And they don't know what 300 pounds is (laughs). And so, you know, I hate like this one doctor that I was going to before that I never liked, his nurses or whatever, the scale was like right there right outside the waiting room. And it's like 'okay, now it is time to get on the scale.' It was like right there [in the corner of the waiting room.] People couldn't see you getting weighed. But they could hear everything that was going on. And so I *hated* that. And it was like 'okay now let's get on the scale'. And it's like 'look you asshole. I don't get on that scale.' How many times do you have to go some place and explain it to them?" [NAAFA B]

On the other hand, there were several participants who did not mind getting on the scale. One wanted to get weighed because she was usually curious about how much she weighed, and another reported that in the past she was relieved to get on the scale so she could finally get the much anticipated and dreaded weighing over with:

"Once I got over the initial thing of getting on the scale and being weighed, it was a relief. It really was. To get on the scale, and then, 'now you know.' I mean, prior to going I'd be a nervous wreck. 'Oh god, he's going to weigh me' and you'd have to go for school for a yearly physical, and I'd gained 20 pounds, 30 pounds, whatever, it would make me not

want to go, but you knew that you had to, so you just went, and then once they found out, whether it be the doctor, or my mother or whatever, it was like 'Whew, now they know.'" [NAAFA A]

Getting Undressed

Several of the participants reported that they are uncomfortable having to get undressed at the physician's office, because of their weight. Several specifically mentioned feeling uncomfortable about gynecological examinations:

"I haven't had a pap smear ever since I had my last child. I hate going. I mean after having kids, I mean, you would think that you would just feel a little bit easier. They don't *embarrass* you while they are giving you the exam. It's just that I feel that my legs are heavy and they just think 'oh gosh, look at thunder thighs over here'. You know, I don't know. I just feel, you know, even my chest is too big (laughs). I just get self-conscious about these things." [Weight Watcher]

"I hate the gynecologist because when I lost weight, I wasn't as uptight. I knew I wouldn't feel as embarrassed being seen in the total buff with all this weight hanging over here and there, and to be fitted for your birth control [diaphragm]. Your whole body changes, inside as well as outside. Your uterus changes. Your cervix changes. Everything changes. I was more comfortable then [when thinner], than when I went to visit in January. I was uptight. Of course I was uptight, with all the fat . . . I was embarrassed in front of him. I didn't want the man to think 'this woman looks like a real pig.' I have all these thoughts in my head that people are thinking of this, and maybe they are thinking of it. You know? Why should I care? But I'm uptight about it." [Weight Watcher]

"It's not one of my favorite things to do. I'm not eager to go. I am very concerned about whether the lingerie is nice enough. I always wear my nicest lingerie when I go to the doctor, I mean, even nicer than what I would wear with a lover (laughs). I'm serious. I think that I want him to have a total picture of me that's based on that of a well-groomed attractive woman, and I know that most of them are not going to have this attitude no matter what I do . . . because of the fat stereotypes about cleanliness and the rest of it. So it's disturbing." [NAAFA A]

"I think for me there are two issues -- there's the one issue of being fat, but even more than that there's the issue of having large breasts, and I'm aware that many of my fears of being in a bathing suit or being in a hospital gown are not so much concern that everyone's going to see my big butt or my stomach, but that my breasts are large, and that they hang down, and that's not how they're supposed to look." [NAAFA B]

"Oh god it was awful getting a pap smear. I used to die a thousand deaths when I had to go to a gynecologist. A thousand deaths. Because you have to be *very* naked at the gynecologist. Very naked. And, he can see the bottom of my belly, and my thighs are so big, and how's he gonna get into my vagina? All these elaborate worries that I had. Never once thinking -- this is his *job*, he better think of something. You know, it was always my fault, my responsibility in some way." [NAAFA B]

Another aspect of the visit that was mentioned as being uncomfortable by several people in both groups was having to wear examination gowns which very often did not fit, obviously a much bigger concern for the larger women.

Inaccessible Equipment/Procedures

Additional aspects of the visit were mentioned only by NAAFA's, such as the inaccessibility of the office. Several NAAFA's, particularly from the larger group, mentioned issues such as the physical difficulty of getting up on the examination table, the fact that the table is often not sturdy and tips over, and the fact that the chairs in the waiting room are often too small to fit in comfortably, or at all. Inaccessibility of medical procedures was also mentioned by NAAFA's. Several of the small and large group mentioned that most physicians do not have a large size blood pressure cuff, without which accurate blood pressure readings cannot be taken on someone with a large arm. Two of the women in the larger group reported having the experience of not being able to be given important medical tests that were needed, or not being able to be evaluated properly, because the tests they took were not designed for people of their size. Others worried that this situation might occur for them at some future time:

"Oh my god, medical equipment is like the worst. You know, you can't have a cat scan at this weight. I needed a cat scan for something and I couldn't get it. And that pissed me off. When I originally was diagnosed as having arthritis in my knee I needed x-rays. When I went to get x-rays, they found a spot on the x-ray, and they needed a cat scan to find out what it was. Well I have never had a cat scan. It wasn't that I couldn't fit in. I don't know. We never got that far. The table is a computerized table and will only hold so much weight. And also when they were sending me through for all these x-rays and stuff like that, I went through hell because they were afraid the table would break or something, and they had to put me on the floor to take x-rays. And it was like the most embarrassing thing in the world . . . I never did get the cat scan done." [NAAFA B]

"[Had gall bladder infection that had gone misdiagnosed because] all of the test reports [ultrasound, x-ray, upper and lower gastrointestinal] made reference to the fact that they were difficult to read because of my size . . . Those tests aren't really designed for someone my size. And that's a shame. There's a lot of problems getting test results on somebody like me, because everything that people are taught in schools, stops at about 300 pounds. There are a lot of machines that I just can't fit into. I can't ever get a cat scan because I could never fit into that machine." [NAAFA B]

"The other thing I don't like is that I can't have a cat scan if I want one, because they don't have a machine for me. Isn't that ridiculous? What if I really needed one? I used to think that I had a brain tumor, because I had terrible headaches . . . I resent the fact that I can't have the right medical treatment if I want it, or if I need it. What if I had an accident? You know?" [NAAFA B]

Other Concerns

One of the smaller NAAFA women and one from the larger group said that physicians always have trouble finding their veins for injections or drawing blood because they are fat.

Another of the larger women said that she is very uncomfortable when she goes to a new physician and has to give her medical history:

"Talking to the nurse about your history, because it always included dieting history -- that was real difficult. It was always uncomfortable talking about it, because I always felt guilty. That was like a record of my failures that I was displaying for people. I really hated that." [NAAFA B]

One of the smaller NAAFAs who had previously been heavier related a story about a time when she was embarrassed at her gynecologist's office because of a social situation:

"The only time I felt uncomfortable [at the gynecologist's office] was when I was sitting in the waiting room and some woman said 'and how many months pregnant are you?', and you have to say 'I'm not pregnant', and they were all like 'gassssp!' You know, because then they're embarrassed, and I'm embarrassed, and everything, and that I don't like. Of course, nobody would like it. But there's a whole bunch of 5 or 6 pregnant ladies sitting around talking about having babies, it's a natural assumption. Although I was embarrassed, I wanted to run and hide, I did not take offense at it." [NAAFA A]

Physician Behavior Considered Inappropriate, Disrespectful or Unprofessional by Participants

Most participants reported that they had encountered unprofessional and inappropriate comments from physicians at one time or another because of their weight, particularly "put downs" intended to motivate the patient to lose weight. Many also reported encountering disrespectful behavior from their physicians. Overall, Weight Watchers seemed to be much more tolerant of such behavior from their physicians than were the NAAFAs. As already discussed above, one Weight Watcher and one of the larger NAAFAs interpreted similar behavior to be acceptable from their physician with whom they have had a long, close relationship. Overall, NAAFAs seemed to react much more negatively to these types of incidents. However, NAAFA participants were also more likely to report such incidents, and seem to have been the victims of particularly cruel comments and difficult interactions. The overwhelming impression NAAFA participants gave about these incidents was that they had a devastating impact on their self-esteem and for many it impacted upon their willingness to continue the relationship with the health care provider.

As children, only the larger NAAFAn and those from the smaller group who had once been much heavier remembered negative stories. One Weight Watcher did mention a somewhat negative comment, but it was not of the same intensity as those stories related by the NAAFAn:

"In general, he was very sweet. I vaguely remember some comment or implication that boys won't look at a girl who's overweight. There was some kind of phrase he used, and the implication was -- If I wanted to be more popular and more attractive, that I really ought to do this." [Weight Watcher]

The comments NAAFAn related often had a cutting and mean quality about them, perhaps designed to "shock" the child into losing weight, which often only resulted in the child feeling worse about herself:

"He was a doctor I had since I was 5 years old, and I used to like him too. He looked like Walt Disney. There were a couple of things that were turnoffs. Like I remember him saying to me, and I couldn't have been more than 10, 11 years old, 'if you don't lose weight, when you have a baby you could die.' How could a 10, 11 year old kid think about dying when you have a baby? I mean, ten years old, you might think about being mommies and daddies, or whatever, but, you know, you just don't say things like that." [NAAFA A]

"[When I was a child] I just remember them saying that I ate too much . . . They put me on diets, and I ate what I was supposed to, and did not lose what they thought I should have lost. They were sure I had cheated. The same thing I got from my father. 'Well if it's missing, you must have eaten it.' That kind of thing -- always assuming that I was not in control, not able to or not intelligent enough to follow a diet. It made me very angry at them. And a lot of times when you're very angry or upset, you tend to overeat. There's a guilt cycle there . . . [Went to see physician uncle in eighth grade] He was a very well-known doctor for heart problems. He didn't know a darn thing about overweight, but he managed to make me feel real bad. He told me how unhealthy it was, and how dangerous it was and what a slob I was. I was 'out of control' and it's ridiculous for somebody my age, and I had no self-control and that most people would consider it . . . a morality statement, judgment. I was 15 at the time. There were several instances of this with this uncle. And I started to avoid that side of the family." [NAAFA A]

"They [physicians] felt permission to yell at you. Some of them are yellers. The ones who aren't yellers, always have these sad faces, like you personally disappointed them -- which is every bit as bad. I hated being yelled at when I was a kid. I was terrified of other people. *Terrified* of them. I think I was so afraid of their reactions. Really, it's taken me a long time to get over it. I'm never really going to be able to get over it. Being afraid of people's reactions. And I think it's real cyclical, that a lot of it has to do with living my life being afraid of how doctors were going to react when I told them I gained weight . . . It's really hard for me to think of things that doctors said, because I used to try and forget them as soon as I could, because they were so painful. And also, there was a lot of, when I was young, you know, 'you're never going to have a life when you grow older.' You know, 'you'll die before you're thirty'; 'no one will want you'; 'no one will go out with you in high school.'" [NAAFA B]

"The very first doctor I ever went to, a pediatrician, I was about seven or eight. He weighed me and he said that I was fat, and that I weighed more than his wife. I thought that was horrible. I was very insulted. So, I never liked him. Nasty doctor." [NAAFA B]

"[Physicians would say to her mother] 'you are going to have to keep her on this diet. She has to lose weight.' They would say things, I guess kind of negative things, to try to motivate me, to maybe insult me and inspire me, and my mother. The doctor made comments like 'my nurses don't weigh that much'. And 'little fat kids don't have friends'. And 'nobody is going to want to pick you to be on their softball team'. Meanwhile I couldn't have cared less about softball. I was an artist. I wanted to read. I wanted to draw pictures. I didn't care about those other things. They tried to motivate me with negatives." [NAAFA B]

"When my mother died [a fat woman who had a massive coronary], my father was concerned because of my weight. And he wanted me to try and diet. That's the only time in my whole life that he said anything about it. And I agreed to go to the doctor . . . I can remember him making a few comments, when my father brought me in, that I would end up like my mother – which was a horrible thing to say to a 13 year old who just lost their mother. It was horrible. That was the worst I remember." [NAAFA B]

One of the women said that her physician's comments led her to attempt suicide at the age of nine:

"I had doctors, when I was a child, tell me I was going to be dead before I was 30, if I didn't lose weight. This was a guy who eventually drove me to try to commit suicide, when I was 9. I might have been ten . . . He just went off on me. He went crazy. He started *screaming* at me, about how, didn't I know that I was an animal, and who would ever want me, and I was a pig. Didn't I know how disgusting I was, and how disgusting I looked. I was nine, nine or ten. He was just awful. The trouble is, and this is always the trouble with doctors, is that what he says hits home, because it reinforces what everybody's been telling me in subtle ways all my life . . . It's very hard when you have a doctor who, as the authority, really just finalizes what everyone else is thinking, and he seemed to make perfect sense to me – 'well that's right, I guess. I'm a pig, I'm an animal, no one will want me.' He just told me to go and take the [diet] pills, and it would make a difference, and blah, blah, blah. So I just decided I would save my family the trouble (starts to cry) of having a daughter like me, that would never get married . . . And I went upstairs, and I thought 'it's pointless, it's all pointless'. I mean I'd been trying at that point to lose weight for like -- my god, 4 years old I was taken to diet doctors. I'd been on pills for three or four years. I just, obviously, wasn't going to lose it. So I had taken all the pills he had given me. I must have had a month's supply in there. And I laid down to die, on my bed, and I never even got sick. I never even got *sick*. And the first thing I thought was, 'He lied to me. These aren't amphetamines. He lied to me'. I mean, he had told me my appetite should have been suppressed by this pill. And he lied. He just lied to me. And that's when I really began to have a lot of cynicism about doctors and a lot of suspicion about them . . . I think I grew up a couple of years by the time I got up from that bed, because I knew he was a liar -- I just feel I was lied to. And part of me was angry, but it was sort of a resigned anger -- it felt like a hopeless anger, but at least it was anger. And that got me through it. It's a good thing that it didn't happen when I was older, and more competent. I would have gone down and taken other pills, probably." [NAAFA B]

As adults, again the NAAFAs related more stories about these types of comments than did the Weight Watchers. Here, even women in the smaller NAAFA group, who had never been a lot heavier, related stories in which health professionals said things to them that were inappropriate and which did not result in motivation to lose weight, but instead in lowering the person's self-esteem:

"[A diet doctor said to her] 'you're not going to get a husband, if you don't stick to my diet' . . . I had a psychiatrist tell me that I was much too self-indulgent. I said 'what gives you that idea?' And he said, 'well, you're fat!'" [Weight Watcher]

"[In the hospital for diabetic shock] one doctor acted like I was taking their time and had no right to be there. And I spoke to him about it. He said 'we're wasting our time, because there's no way *you* are going to stay with this [diabetic] diet' . . . [He was saying] it's ridiculous for you to be here. I don't know why the insurance company is paying for you to be here. He made a determination on what he was claiming was my personality, but what else did he have to go by, but my weight, that I would not stay on the diet, so what was the sense of monitoring me? He said 'well, you certainly don't look like somebody who could stay on a diet.'" [NAAFA A]

"I had a doctor say to me one time [as I walked into his office for the first time] 'whooooaaan, look at the *size of you!* My god, girl!'. And I should have walked right out again, but I didn't. I felt very bad. At that point, it was all my fault. I believed it be a lack of control on my part, or a lack of self-discipline . . . One doctor said to me 'all you need is sulfa. Sulfa-denial'. Another said 'best exercise in the world is pushing yourself away from the table.' Another one a doctor said to me was 'you know another meaning for the word dessert? Dessert the table!'" [NAAFA A]

"When I broke my ankle, after they put pins in, I went down to go and try and use the crutches, and I was in the physical therapy room . . . it was about nine days after I first fell, that I had been laying in a hospital bed after surgery . . . the physical therapist saw I was having a lot of difficulties. This was the first time I had been up [out of the bed] I was in tears when I, I couldn't do it, I just couldn't do it. I was having a very difficult time. And she said 'you're going to have to be carried up and down, you're going to have to learn how to do this', and she kept pushing me . . . I was practically in tears the way she made me feel . . . I read my own chart. She had written on my form for the day that 'patient cannot handle her own weight'. And I was in tears . . . what does the woman expect from me after laying in bed for nine days? And here she writes in my chart, in *big letters*, 'patient cannot handle her own weight'. And I was just totally shattered from that. I really was . . . And that was a devastating experience to me. That was really the first time anyone had ever totally wiped my confidence and my self-esteem out in one shot." [NAAFA A]

"She [her physician] carped on it. I mean at one point I remember her saying to me, 'one of these days I'm going to lock you in one of my examining rooms with two buckets – a bucket of water and a bucket to pee in, and leave you there for three or four weeks.' [She meant] that all she was going to give me to eat and drink was this bucket of water and that I would pee out into the empty bucket . . . It was always the things, you know, 'push away from the table', you know, or 'I'm going to sew your mouth shut'." [NAAFA A]

"[In the hospital a group of physicians] were so incredibly rude. They walked in. They were on rounds. And they walked in and I was just laying on the bed. And nobody said hello to me. Nobody even looked at me. One of them just grabbed my nightgown and pulled it up and started examining me and pointing and talking. They were talking about my weight in very unflattering terms." [NAAFA B]

One theme that came up over and over again was that of physicians believing the participants were lying, either about how much food they consume in general, or about how well they had been sticking to a particular diet. According to participants, if they were not losing as quickly, or as much as the physician felt appropriate, they were blamed and told they were lying:

"I did lose some [weight with physicians]. But I either didn't feel well, or they would make me feel that I hadn't lost enough. You know, I'd be dieting for three weeks and lose 4 pounds, and then they would insinuate that I was cheating. And I'd get mad at that and I wouldn't go back. I *wasn't* cheating. Why would I be paying him all that money and cheat? But they didn't believe that, they just didn't." [NAAFA A]

"Well, of course the doctors gonna tell you 'did you cheat? Are you watching your diet?' And it *really* hurts if you were watching, and you really were faithful and you didn't lose weight. That hurts, and to put yourself through that -- I think that's probably the worst thing." [NAAFA B]

"Doctors made me crazy. They'd tell me that I could eat like 1200 or 1500 calories a day and lose weight. And I couldn't. I just knew I couldn't, eventually. I tried it and it just didn't work. And they'd say, 'well you're cheating, you're doing this, you're doing that.' I would say 'no. No I'm not', and they'd look at me in this kind fatherly way and say 'well dear, you have to be. Because you should be losing weight.' They made me feel I was crazy . . . I developed this theory that I blacked out and ate candy bars during blackouts, because I couldn't explain it any other way . . . So you think 'I guess they're right, I'm doing this wrong, I must be fooling myself'. Or you think, 'well, I'm crazy'. There are not a lot of choices. Because the choice is never that the doctor's wrong. That was never an option. Until later in my life." [NAAFA B]

One of the smaller NAAFans reported that her physician didn't believe she wasn't dieting when she began to lose weight (a possible effect of her diabetes):

"Dr. B. makes me feel like less than a human being. He would say 'great' when I was losing the weight. And I'd say, 'it's not great, I'm not changing anything. I'm eating just the same way. And I'm losing it rapidly. So it's not normal.' And he never dealt with it. I'm sure he didn't believe it. I'm sure he feels that whatever I weigh or don't weigh is directly related to [eating behavior]." [NAAFA A]

The one Weight Watcher who was very critical of physicians regarding weight loss, told a story with a different twist on the theme of lying:

"I went to Dr. C. [famous diet doctor]. His diet worked very well, except that I kept passing out. [Went to new doctor who] said I had no sugar in my blood, absolutely no sugar at all, and that was what was causing me to faint. I went back to Dr. C. with this doctor's report and he said 'well, everyone cheats.' And I said 'well, I don't cheat, I'm a fanatic.' I did take off the weight, but it was the first time that I realized that doctors lie, that doctors deliberately lie. I couldn't believe it. He lied when he told me that I could live on the diet he set -- he was basing it on the fact that he said everyone cheats. And the cheating gives you enough sugar to keep you alive. If you don't cheat, you die on his original diet. He also wasn't paying any attention to me. I was telling him I was having problems and he wasn't listening. He was on the phone to his stockbroker all the time . . . I stopped because I realized that he didn't care, and he had lied to me. And he was certainly willing to kill me. He said 'everyone cheats, I depend on that.' I never did see him anymore. Because this is a totally immoral way to handle your life . . . I found him appalling and obnoxious." [Weight Watcher]

This same Weight Watcher and one of the larger NAAFans related incidents about physicians inappropriately giving them medication because the physician felt that their weight was the most serious problem they had. The Weight Watcher told her physician that she was not

supposed to take diuretics when he prescribed them for weight loss, and according to her, he said "it doesn't matter. You are so fat you're going to die from it anyway, so what's the difference?" The NAAFAAn complained to her physician that she was addicted to amphetamines which she had been taking for many years in order to lose weight. According to her, he prescribed them anyway, saying he didn't care about her addiction because "you'll worry about that when you're thin."

Participants reported stories of inappropriate behavior not only from physicians, but from other health care professionals as well. One participant reported visiting a dentist who was rude to her:

"I've had a dentist mention my weight once. I couldn't get into his chair one time. The arm wouldn't go down on the chair. I have a receding gum problem, which everybody does at this age. He said 'it's from all the cakes and goodies that you must eat.'" [NAAFA A]

One woman told a story about needing an x-ray, and having trouble fitting in between two plates in the machine, and about the resulting offensive report sent by the lab technician to her physician:

"I looked at it [the x-ray machine] and I said, 'I'm not going to fit in there.' And she [the x-ray technician] said 'oh yeah, you will.' And I said 'no, I won't'. And she's like 'yes, you will'. I said 'look, I'll show you', and I tried to squeeze in and I was nowhere near fitting in there. I said 'this is a problem.' And she said 'ooh, alright.' And she had me lay on the table, and she flipped the machine on its side, and it was fine . . . And the report that was written said 'after much pushing and poking and stuffing and shoving, this *extremely* obese patient was finally able to be laid on it.' It was unbelievably unprofessional. In the first place, that wasn't what happened. There wasn't all that stuff that went on, and *that* was offensive to me. In the second place, nobody cares, that's your job. You have to push and poke and shove other people too, and you don't put that in a report. Because I don't care what you have to do to get the results, that's not professional." [NAAFA B]

Another woman had been referred to a dental surgeon in order to get her jaw wired to prevent her from eating. Originally, the dentist used rubber bands, but the participant discovered she could remove them, which she did because she felt "claustrophobic" with her mouth closed, however she stuck with her diet anyway. She told the dentist this, and:

"The dentist, when he found out, he put wires in instead. He wired me shut. Instead of rubber bands, he wired it shut. He's a sadist . . . He wired it shut. And I cried in the middle of the doctor's office. The rubber bands were more stretchy. [With the wires] I couldn't move my mouth at all. It was scary. Because you can't scream. What if someone comes to mug you or something? You can't even *scream*! It was horrible." [NAAFA B]

One woman went to see a psychologist, who administered psychological tests to her. It happened to be a day that she felt particularly good, because she had recently lost some weight:

"I was really upbeat and feeling great, and he's asking me these questions, and he asked if there was any part of my body I disliked and I decided I would be honest with him and I told him my breasts. And his response to me was something like 'well, I can understand, having breasts like a forty year old woman' and I'm like 18 at the time. And again, I sat there and I like crumbled inside." [NAAFA B]

Another participant reported that she was treated disrespectfully many times by nurses; although she suspected that it was because of her weight, she did not really know:

"I've had not fabulous treatment, but I don't know if it's weight-related or not. I don't know if anyone's been overt about hating me because I'm fat, or stuff like that. When I was in [a weight loss program] they couldn't take my blood there. I was black and blue from like here to here (indicates whole length of arm). The woman acted like she had an icepick in her hand . . . And also, the nurse in my gynecologist's office. She was such a bitch to me. I thought she was a sadist. I'm serious. And, you want to hear a very embarrassing story? I went to the bathroom in the doctor's office, and it overflowed. I flushed the toilet and it overflowed. And she made me clean it up! They had me cleaning up *their* bathroom . . . she *made* me clean it up. I mean they have to have a handyman or something to clean. But I don't think that was *my* job. It wasn't *her* job, but they had to have somebody there to do it. She hated me for some reason, I don't know. I don't know if it was because of my weight but she wouldn't have made anyone else do it, I'm sure of it. It was horrible." [NAAFA B]

Ways In Which Actual Health Care Is Affected

Some of the ways in which health care is compromised for fat people have already been alluded to, including the lack of accessible medical equipment, and the emphasis on weight loss rather than on treating symptoms. Other factors that prevent fat patients from receiving the same level of health care as others who are not fat will be discussed in this section.

The Salience of Weight Prevents Proper Treatment

Several participants gave examples of incidents in which their physician's focus on their weight clearly got in the way of their receiving proper and appropriate medical care. In one particularly horrifying story, the NAAFA woman who was about to go in for surgery to remove an ovarian cyst reported that her surgeon suggested she have a complete hysterectomy as a preventive measure, because of her weight:

"So I'm in the stirrups, and while he's examining me, he's asking me routine questions that gynecologists ask you, like are you sexually active, and do you plan to have children, and somehow this very emotional question, at 38 years of age, lying there on the table, with my legs up in the stirrups, with him between my legs, was not an opportune time to ask or answer that question about having children . . . And he says to me, 'well, I think you should be aware that large women have a higher risk for ovarian/uterine cancer, because the fat cells hold estrogen, so there's a higher incidence. And we really would want to avoid doing any surgery in the future for you, so if you're *not* thinking of having a family, I

think you should make a conscious decision – you would want to think seriously about having the other ovary and the uterus removed as well, as a preventative measure' . . . And I was just like totally dumbfounded. I was in shock. I had talked about if I had *cancer* they would take it out. If I had cancer, whether I had a uterus or ovaries would sort of be the least of my worries at that point. But to just take it out, just in case, so in ten years I don't have cancer! It was preposterous!" [NAAFA B]

Another of the larger NAAFA participants reported that she was actually physically assaulted by a physician she was sent to in order to qualify for disability benefits after an accident involving her knee:

"He was rude and verbally abusive and even physically abusive. He *smacked* me on the leg. When I got into the examining room, he had a cigarette hanging out of his mouth. And he started asking me questions and I answered them, and I was feeling very meek. And he started getting rough with me. 'So it's your knee -- so how the hell am I supposed to examine you?' I didn't know if he was kidding or not. And without even thinking about it I said 'what do you mean how are you supposed to examine me?' 'How am I supposed to examine *that* knee?' . . . And he said 'you pig. You are disgusting. Just look at you. How can you walk around like that?' And he just slapped the side of my leg like that (demonstrates using the palm of her hand). Just like that. 'You're disgusting.' You know 'what's the matter with you? How could you be like this?'" [NAAFA B]

Another participant feels her medical problems are easily dismissed by physicians because of her weight:

"Somehow I feel that I get stereotyped. And certain people are easier to dismiss than other people. Like old nervous Jewish ladies (laughs). And I think fat people are easy to dismiss. It may be a combination of 'if you don't care enough about yourself to take care of, don't come bothering me' and 'we couldn't figure out what it is anyway, because of the weight and we couldn't do anything about it, so forget it.' What has helped me a couple of times is, you remember those little boys who used to throw sticks at you, and call you names when you were a child (laughs)? Well, they went to medical school! It's really true. They have the same prejudices everybody else does. And it may not be a conscious thing, except -- 'this patient I don't want. I don't want this person here.' And it's hard because you go in with this, like, distrust. Sometimes it seems too pervasive. I'm never sure about anybody, actually. I don't think it's good, but it's real. But even more with doctors. They have so much power and authority, or I allow them to have so much power and authority, that it makes me even more scared. I mean, if another person doesn't like me, big deal, but if this guy's going to be operating on me, and he doesn't like me, I'm in big trouble!" [NAAFA B]

Many of the participants had difficulty obtaining birth control from their physicians, because of their weight. This issue will be discussed in detail in a later section.

Misattribution of Symptoms to Weight

Most of the participants in all three groups had at one time or another reported symptoms to physicians who attributed the problem to the person's weight. However, at least some of these attributions were questioned by a majority of participants in the NAAFA groups and by two of the

Weight Watchers. In most of the cases where these attributions were questioned, the participant had some type of independent proof through which it was clear that weight was not the cause of their medical problem (for example, having a thin family member with the same medical problem or having been told that weight loss would solve the problem and when the person actually lost weight, the problem was still there):

"[My legs hurt] because I inherited that from my father [who was thin]. I have venous insufficiency. It means I have poor circulation. And also he has arthritis . . . I always go to her [physician] because I had a tendency towards cellulitis of the leg. It is an infection in the cell. She would say 'you know, if you lost weight it would help it a little bit. Maybe you wouldn't have a tendency to get this so much.' . . . I would like to prove it. I would like to see. You know, let's not give it lip service if I'm not sure until I lose the weight . . . So she said 'you know if you lost the weight maybe you won't have it anymore.' But who knows?" [Weight Watcher]

"They [physicians] have attributed the arthritis to my weight. Even when I'd tell them that my kneecaps were shattered [through an injury], they'd still say to me 'but it's really caused by your weight.' I'd think, idiot! The *bones* were broken!" [Weight Watcher]

"I have had a bad knee, a trick knee [from a fall]. And my doctor kept saying if you lose weight it will make it go away better. Bullshit! I did my leg exercises and I had to take medication and it went away itself. And I have gained weight since and the knee is still the same old knee." [NAAFA A]

"[During visit to physician after recently having gaining a lot of weight] the next thing he did was to look at my back. I have all of my life had a leathery spot in the middle of my back, it's called affliculosis (sic), for as many years as I can remember ever seeing it. It's a skin disorder of some type, and my family has lots of those, and it's in the center of my back. He said 'you have affliculosis (sic) in the middle of your back, and do you know what that's from?' I said 'what?' He had never even asked if I had ever had it before, which I had. And he said 'that's because you can't reach your back to wash it.' [After explaining she had had it for years he said] 'Nope. It's from that.' And he insisted it was from my weight . . . I was led to believe at the beginning of the diabetes, I was told 'it will be controlled, and if you lose weight, you'll probably lose the symptoms entirely.' And I lost the symptoms entirely without losing weight." [NAAFA A]

"[After having menstrual bleeding for six weeks straight, she went to a new gynecologist who said] 'It's because you're too fat'. And I said to him, 'I'd buy that, except that my mother, who was never fat a day in her life, has all the exact same problems I do' . . . He just decided that my whole menstrual problem was due to my being fat . . . He, as far as I remember, didn't even attempt to examine me. All's I remember him doing is -- he weighed me, and took my blood pressure, and that kind of thing. But he was just totally convinced that the whole thing was due to my weight." [NAAFA A]

"In my early teens, I had really bad menstrual cramps, and I was told if I lost weight they would get better. [Never got better when lost weight] and, like years and years later, I just had very severe cramps, and just never felt that anybody believed me -- that I really had bad cramps -- just that my pain tolerance was low, or I was nuts, or something. And then when Motrin came out and was helpful with it, and they discovered that women who have really bad cramps produce too many prostaglandins, which causes the uterus to contract, and can cause really severe cramping, I felt like vindicated! It had nothing to do with how fat I was! It had nothing to do with any of that. There's skinny people that that happened to too . . . I remember I had lost weight and it really didn't change it, you know, and I just

had these really bad cramps . . . And then I was vindicated – it wasn't in my head, it wasn't because I was too fat, it was because I was *in* a lot of pain." [NAAFA B]

"I had trouble with my back, and they told me if I lost weight, that it would be better. And I said to him [a rheumatologist] 'is this something only fat people get?' And he said, 'no, in fact I have a very thin patient I put in a brace last week.' So I said 'well how can you say that being thin is going to help me with it.' And he said, 'well, the less pressure you put on it the better' [he did not treat her further] . . . And what it finally turned out to be was that I had a lousy bed. And when I got a new bed, my back problems went away." [NAAFA B]

"I had gotten very tired at the last job I had and I went to this doctor and he said 'you know, you have sleep apnea', because I was very tired during the day at work. And he said 'you're probably not sleeping straight through at night. If you lost weight, that would make a difference.' And I thought to myself, 'he didn't run *any* tests, how could he diagnose that?' . . . and the funny thing is, a couple of weeks later I went to *another* doctor, and told him what had happened, and he said 'well, you can't rule it out.' The doctor suggested that I have my sister check on my sleeping in the middle of the night. It turned out that I *didn't* have it. It was just a lot of pressure at work, a lot of tension, and the fact that I just needed more sleep than normal." [NAAFA B]

Often, when the physician attributed the person's symptoms to weight, the problem itself was not treated at all, and the only action the physician took was to discuss the need for weight loss. One particularly dramatic example of this was when one of the larger NAAFAans was told that the constant severe headaches she was suddenly experiencing were the result of her being fat. After several months of being told this, she eventually began to lose vision from a detached retina which could have caused her to go blind. If it had been discovered months earlier it could have been repaired by a simple laser surgery procedure, instead of the more complicated surgery she eventually had.

Another woman in this group had been walking around with untreated mononucleosis for a year, because the physician she had gone to attributed her symptoms to weight:

"I was about 20. I was in college and I was getting these horrendous headaches, I was exhausted, tired all the time. And I went to a doctor, and he said, 'you're probably under tension because you're in school and it must be hard to be in college and to be your size. And that's probably a lot of the tension.' So he gave me diet pills . . . And I had mono, it was like advanced mono, in its final stages. It never was diagnosed while I had it, but a couple of years later I had a blood test, and they told me that I had had mono." [NAAFA B]

One of the smaller NAAFAans had a situation where she experienced terrible pain in her legs and was not even given an x-ray:

"I was in excruciating pain [and my regular physician] said that I should go to the emergency room for x-rays . . . and I'm on the gurney, and I'm dying, I am in such pain. It was undoubtedly a gout attack, which is what it was. And I had this stupid intern, and his comment to me was that I should lose weight. On the stretcher. Never gave me an x-ray, never examined me. If I'm not mistaken, he gave me 2 Tylenol III's and sent me home." [NAAFA A]

While participants reported that many of the physicians they have seen have attributed medical symptoms to the person's weight, many of the participants themselves have, at one time or another, chosen not to seek medical care because they thought their own symptoms were related to their being fat. Although none of the smaller NAAFAn reported that they did this, four out of the seven Weight Watchers and five out of six of the larger NAAFAn reported not seeking health care for certain symptoms that they attributed to their weight. The Weight Watchers mentioned not seeking care for symptoms such as heart palpitations, shortness of breath, fatigue, and aches and pains. The NAAFAn mentioned not seeking health care for aches and pains. One of the Weight Watchers reported having very bad heart palpitation symptoms but would not see a physician because of her belief that it was due to her weight:

"I had severe heart palpitations. I mean *severe*. My chest would hurt. It started one day and it continued on and on and on. I really thought I was having a heart attack . . . Pain would radiate throughout the whole body . . . I kept thinking, it's probably because I'm too goddamn fat. I decided to try to diet first before I did anything about the pain." [Weight Watcher]

Lack of Thorough Examinations

In addition to the lack of treatment because of symptoms being attributed to weight, participants reported that they did not get proper medical care for other reasons related to weight. One area already discussed is the inaccessibility of medical equipment, which has prevented some of the participants from getting needed medical tests.

Similarly, while the medical equipment machinery is not built to be accessible to bodies that are larger than the norm, it appears that physicians themselves are simply not trained to deal with the bodies of fat patients; therefore thorough physical examinations are often not available to these patients. This concern was addressed by women in each of the three groups, particularly in regard to gynecological examinations. The NAAFAn who is going to have ovarian surgery stated that, according to her physician, a woman with this condition is ordinarily given a laparoscopy rather than surgery; however, according to him, it is too difficult to perform a laparoscopy on fat patients, and that is why examining her requires surgery. Another woman in the larger NAAFA

group also had had an ovarian cyst; her condition went undetected because her physicians felt that they could not thoroughly examine her due to her weight:

"When I was examined by a gynecologist they would just, you know, poke around the lower abdomen and the groin area and say 'I can't feel anything anyway. I don't know if everything is where it is supposed to be' and because I was so intimidated and no one was very thorough, they said that that tumor had to have been growing there for some time to get that size. At *least* a year, probably more. And I had *been* under a gynecologist's care. But that's why I said he wasn't really thorough, I don't think. He should have detected that something was wrong. I had also complained of pains in the lower left quadrant." [NAAFA B]

Others echoed the experience of being told by their gynecologist that he/she could not perform a thorough examination:

"[Obstetrician/gynecologist] said something about it being hard to feel what he needs to when you're very overweight. That he might be missing a threatening problem. He said that when you're fat it's more difficult to detect certain problems . . . It does not feel good that somehow or another again you were creating this kind of problem; you could be setting yourself up for something that might not be able to be detected." [Weight Watcher]

"During the exam he [new gynecologist] said 'you know, you're just so heavy that it's difficult, with the fat, to find what I'm looking for, and everything.'" [NAAFA A]

"They said when they gave me an internal, a bi-manual, 'it's hard to feel around', I guess because of the flesh, the stomach and stuff. And also, I was pregnant twice, and to guess how big the fetus was, or whatever, it was hard because of my size." [NAAFA B]

"That's probably the hardest kind of exam to have, especially when you're heavy. It's hard to get up on the table, and put your legs in the stirrups. It's not an easy thing to do. Some doctors complain – 'how can I feel anything? You're too big, I can't feel anything.' 'I really can't feel anything. Everything *seems* to be normal'. You know, that kind of thing. Which is not a very good outlook for *you* -- when you say, well I'm not getting a very good exam, am I? That makes it really strange. I don't say that out loud, but I say it to myself." [NAAFA B]

One of the larger NAAFans insisted that it is not impossible for gynecologists to thoroughly examine a large woman, and they could learn how to if they were interested in learning:

"There is an issue about feeling my uterus. Some doctors have a really hard time feeling my uterus. But you know what? I once had a gynecologist who's a lesbian, who had a fat lover. And I was so well-trained then, I get on the table, and I start apologizing to her about how she can't feel my uterus. You know, 'I know you can't feel my uterus, I'm sorry about that, I know it's hard with someone my size.' And she goes, thump! 'What do you mean, I can't feel your uterus?' Thump! And I'm like 'Wooo! What's that?' 'That's your uterus.' And she told me, she said 'men just have no idea how to work with a fat body. Fat bodies are different, and there's no problem feeling your uterus, no matter what a person's size'. . . They can learn, but they don't want to. They don't understand what it's about." [NAAFA B]

One of the smaller NAAFA's believed that she was not getting thorough examinations because her physician never touches her. She feels that he is disgusted by her weight. One of the larger NAAFA's stated that she did not realize that the physician she had seen for years had almost never given her a physical examination until she changed physicians and now sees that her current physician gives her a physical examination every visit. One participant expressed anger about her physician not buying a large-sized blood pressure cuff for use with fat patients, and therefore never being able to give her a thorough examination:

"He never had a large cuff. This man *never* took my blood pressure. And every time when I went we went through the same scenario. 'Oh let me take your blood pressure'. I say 'oh? Did you get a large cuff?' 'No I didn't get a large cuff. All right I guess I can't take your blood pressure.' . . . In the beginning I wasn't angry. You know, in the beginning I felt he was just uneducated and, but then, afterwards you feel like, all right you have explained it to him. You are a patient. You're paying money just like everybody else and you are not getting the quality care. And so after you go to him . . . I mean this is over the course of years or however long. You know, you would think they would invest a few bucks on a cuff. And when they don't do it, it really makes you angry. You know, I mean it made me very angry. I felt that he was not -- he never got the clear picture. He never looked at everything. He couldn't. And so I felt that as a doctor he wasn't thorough, he wasn't complete. You know, it was like -- 'get in get out. Get in.' You know, 'let me get my money.' [NAAFA B]

Refusal of Surgery

Sometimes a physician's belief that surgery is dangerous for a fat person prevents them from getting needed surgery. One of the Weight Watchers has a dropped bladder and rectum which causes her to be somewhat incontinent. She would like to have an operation for it, but her physician has told her that it is dangerous to put a fat person under full anesthesia, and he does not want to perform the operation until she loses weight. In another case, a cosmetic surgeon refused to perform a rhinoplasty on one of the larger NAAFA's (who happened to weigh only 200 pounds at the time). While it is possible that he was worried about the dangers of surgery, his reasons seemed to have more to do with his prejudice toward fatness:

"When I went to the doctor about getting a nose job he said 'oh, but I think you should go on a diet and lose some weight first.' Because, he said, you know 'your bone structure, and your face, and the size of the nose.' I mean because if he makes me a small nose on a big face it's stupid, or a big nose on a small face, it's all relative. So he said, 'look, go home, diet, and then call me when you're finished, and we'll do it.' So I said okay, so I left, and after a few weeks, I said, this is me, this is how I'm gonna be. I'm not going to lose weight. I called him up and said 'do it now. This is it.' He said no, he wouldn't do it." [NAAFA B]

Difficulty in Receiving Proper Gynecological Care

Overall, participants seemed to have more problems with gynecologists than with any other type of physician. As discussed earlier, participants reported that they had trouble getting thorough physical examinations from gynecologists and many reported that they found these examinations to be the most embarrassing of all medical examinations. In addition, many of the NAAFA's, particularly the larger women, reported having tremendous problems obtaining birth control. Several of the fatter women had been told by their physicians that it was almost impossible for someone of their size to get pregnant (yet two of the larger women interviewed had had unwanted pregnancies):

"I can remember when I weighed a whole lot less than this, being told that I probably shouldn't bother [to use contraceptives], because it's real unlikely that I would get pregnant anyway. Unbelievable! On the other hand I've been told that I really shouldn't get pregnant because at my weight it would be really dangerous to give birth." [NAAFA B]

Many of the barrier methods of birth control are difficult for fat women to use because of reach problems, and birth control pills seem to be contraindicated for fat women or for women who have medical problems that are often associated with fatness (circulatory problems, high blood pressure, diabetes). Several participants had gone to a gynecologist for birth control and were not able to get any type of contraceptive:

"There's another thing too about being overweight. You really can't go to Planned Parenthood to talk about birth control, because they look at you, and they say 'you're fat . . . you don't have sex.' You know, people don't see fat people as sexual people . . . I just went to a gynecologist recently, and I was willing to give birth control pills a try, and she said 'because of your weight, I don't really think you should take them' . . . She said 'well, if you have a diaphragm, because of your size, it's hard to insert. You're not going to know if it's in place' . . . So it's more or less, she was telling me, 'well, there's really not much you can do -- there's condoms and there's foams and jellies', and I thought to myself, that's not what I wanted to hear. I felt terrible when I left there, and I thought to myself 'I'm going to end up pregnant, and that's not what I want.' That was very upsetting. She didn't offer me anything. I felt like I wasted my time on going to her. That's the biggest blow I've had as far as doctors are concerned. I went there for something and I got nothing. No satisfaction." [NAAFA B]

"I decided that I wanted to go on the pill. And so at first my gynecologist said no to me because I was smoking at the time. And so at first he said to me 'I will absolutely, as long as you are smoking, I will not give you the pill.' So I said okay, fine. You know, I understood that. And then I quit smoking . . . So after six months of not smoking I went to him and I said 'look I quit smoking. I want the pill. Give it to me now.' And he really didn't want to. 'No I'm really afraid of your weight.'" [NAAFA B]

"I had gone to Planned Parenthood to try and get on the pill because I was sexually active at the time. And they refused to give me the pill because of my weight and I must have high blood pressure. They took my blood pressure. They couldn't get an accurate reading because the cuff didn't fit right, but they still weren't getting a really high reading. And I tried to explain to them that I was in the process of losing weight. That I'd lost over 100 pounds already. They didn't want to hear a goddamn thing, and they said use condoms and foam. And they offered me some condoms from a big basket on the desk as you leave . . . I asked about a diaphragm too. And the guy said 'you probably won't be able to get it in. How are you going to reach to put it in?' That is what they said to me. So at that point I was frustrated and I was angry and I was humiliated. And I left." [NAAFA B]

The greatest difficulty with obtaining birth control seemed to be the abuse that the women were subjected to by their gynecologists who had difficulty believing the women were sexual:

"When I went to her [gynecologist] and I wanted some sort of method of birth control she said 'who are you going to get? Captain Ahab?' And I looked at her and I said 'I've come to you in the last several months twice for pregnancy tests, and it hasn't been by Captain Ahab.'" [NAAFA A]

"They say that women who are fat should be very thorough in taking care of their gynecological health. But the problem is too that there are a lot of doctors who are disinterested, disgusted, and prejudiced by fat, and don't perform the kind of examinations and offer the kind of care that's necessary . . . I was assigned to a female gynecologist [at a clinic], and she was a real bitch. I'm sure that my weight had more to do with it than anything else. I know that doctors in clinics are overworked but there was no other excuse for her behavior. And I asked her very timidly at that time -- I was like 21 -- about contraception. And she said 'what for?' And I felt 'yeah, she's right. It's probably not going to happen anyway'. I just never asked another thing. When the need arose, I bought over-the-counter preparations . . . [The worst things doctors ever said] were mostly from gynecologists. Their presumption that I was not a sexual being because I was fat and the inference that no one could possibly want me because I was fat. And since I was fat I was desexualized and defeminized by their statements and their actions -- that degraded me further and made me feel dehumanized. You know and that really ate away at my self-esteem. So I allowed myself at that point to become even more of a victim because of the things that they said and did. Because we are taught doctors and lawyers and people like that are just on a pedestal. [That doctor] kept me from wanting to go back to any other doctor for years. And it made me afraid to even consider sex. Never mind even a relationship, but sex! If a doctor, who knows all about the human body and all about people, can tell me that I'm disgusting and unappealing and non-sexual, how can anyone else *possibly* see anything more positive?" [NAAFA B]

One of the larger NAAFans reported that her gynecologist simply would not believe that she was sexually active, and ignored her protestations to the contrary:

"In this ongoing effort to get my period straightened out . . . I went to this gynecologist, and she was taking down the questions, and writing them down fast, and she goes 'and you're not sexually active now, are you?' And I said, 'well yes, I am sexually active'. 'Oh you are?' 'Yes I am.' So she goes, and she's examining me, and she's talking about this, that and the other thing, and then she says again, 'you know, if you were sexually active, I'd do this or that, or whatever', and I said 'well, I *am* sexually active. I'm *very* active now, sexually.' She was talking about my period, and how I didn't need it unless I wanted to get pregnant, but I'm probably not sexually active. And, I couldn't believe it. And she's like washing her hands, and I'm talking about trying to get referred to a clinic to get this or that

or the other thing, and she's doing my paperwork and she goes something about 'sexual activity -- none.' And I said, 'I'm going to tell you for the third time -- I have *two* lovers, right now. *Two* lovers! And I'm looking to get a *third* one. I am *very* sexually active. I'm concerned about this.' She just, like, dropped her pen, and then she wanted to hear like the whole story of my sex life. And that was the only way I could get her to pay attention." [NAAFA B]

At the age of 18, one of the larger NAAFA's had become pregnant, and would not go for an abortion because of her weight:

"As a matter of fact my best friend in high school wanted to go with me to Planned Parenthood to see about an abortion. And I refused to go because I told her that they wouldn't believe that anybody would want to fuck me anyway. I believed that they would humiliate me. They probably would do it [the abortion] eventually, but they would humiliate me very badly before. I was too embarrassed to even go." [NAAFA B]

Avoidance of Medical Treatment

Not only did participants report *feeling uncomfortable* visiting physicians because of weight-related reasons, but many actually delayed visits or avoided health care altogether because of these reasons. The majority of participants in each of the three groups reported that they had, at one time or another, avoided physicians because of their weight, even when they felt they ought to see one. Some of the weight-related reasons given by participants for avoidance included not wanting to be lectured about their weight, embarrassment about their size, having previously experienced disrespect from physicians, believing that physicians would misattribute their symptoms to their weight, and mobility problems and lack of access at the physician's office. Four of the seven Weight Watchers, five of the smaller NAAFA group, and five of the larger NAAFA group reported that they had delayed a physician visit because of their weight for amounts of time ranging from one month to seven years, with a wide range in each of the groups. An additional woman in the larger NAAFA group stated that she has avoided physicians, but not because of her weight. More than half of the women who put off needed visits because of their weight specifically mentioned that it was a pap smear/gynecological exam that they were avoiding:

"Having any kind of pap smear, *that* bothers me. I haven't had a pap smear ever since I had my last child. I hate going. I would just have to go back to *that* doctor [assigned clinic doctor], and I'm quite sure he would just tell me to keep on losing weight." [Weight Watcher]

"I put off the gynecologist for while. Maybe about a year [while waiting to lose weight]. Anyone can see all this stuff (points to thigh). No doubt about it . . . I wanted to go, because I'm not one to neglect myself. When it comes to my health, I want to get checked up. I want to know everything. [After waiting two years between paps, she felt]

disgusting! Like, how could you neglect your body because of your weight? Your health has to come first. Of course this affects your health, but your health has to come first." [Weight Watcher]

"I did not have a pap smear for 6 years. I don't go if I don't have a symptom. I don't think about it. It's not part of my daily life. I don't like internals . . . I don't like my upper legs any better now than I ever liked them, and that's the only part of my body I don't like." [NAAFA A]

"[Avoided gynecologists for four years because of the effect of previous visits.] I felt defeminized. I felt dehumanized. Because it all tied into my being a woman and part of what it is about us as women that makes us unique is the fact that we have something that men don't. We have a reproductive system. We have the capability of holding within ourselves another life and giving birth. And all of those things are very special. And they were desexualizing me. And defeminizing me by saying things like 'what would you need contraception for? What would you need it for?' And 'you don't need it'. And 'I can't find anything down there' . . . [this] kept me from wanting to go back to any other doctor for years." [NAAFA B]

One of the larger NAAFAn has put off getting a pap smear for seven years, even though there is a lot of cancer in her family:

"I haven't been to the gynecologist now, for seven years . . . because I'm just not into it. I'm afraid. What if I can't jump on the table, put my legs in those things. What if I get a cramp? I just don't want the abuse . . . I also think, what if they find something? There's cancer in my family like crazy, and I'm scared that they'll find it." [NAAFA B]

Several participants reported having avoided their regular physician for a time, until they lost weight. One Weight Watcher reported that she avoided a checkup for a few months until she lost some weight:

"I delayed seeing this doctor the last time, until I'd gotten on Weight Watchers. I said 'I will go on Weight Watchers first, then I will go see him for the checkup, because I want to report to him that I am on Weight Watchers.' I felt like I looked bad anyway, and I gained weight since the last time I saw him anyway, so I want something to sort of counteract it. I wanted him to praise me for it. I didn't want him to say 'now, now, you know you're going to have to do something about this' . . . I would delay an appointment because of anticipating feelings of embarrassment." [Weight Watcher]

Similarly, a NAAFAn reported that she will not see her current physician until she loses weight:

"I don't go to my current doctor, even though he's never mentioned it [her weight], if I'm ten pounds heavier than I was the last time I went. It's a fear, an avoidance thing." [NAAFA A]

Another Weight Watcher avoided seeing her chiropractor for a painful sciatica problem even though she knew that the visit would bring relief, because she was embarrassed about her weight:

"You know why I didn't want to go in? Because I'm embarrassed for him to touch my back, because I don't want him to feel all this fat, he's gonna see like all this flesh on my buttocks. Now, this is my health here! My back's been bothering me, my disk is inflamed a

little bit . . . I just go through these stages where I'm very insecure about being undressed in front of somebody. This is a doctor. This is a man who's trying to help me . . . I just didn't want to go because I was embarrassed. I was honestly feeling like the man was going to have to, like he was going to touch me and see all these craters on my buttocks." [Weight Watcher]

Some of the larger participants had had various symptoms which turned out to be serious illnesses; despite the severity of the symptoms, their weight kept them from seeking health care. One of the smaller NAAFAns who had been much larger stated that she had once had phlebitis, and another time had been walking around with pneumonia, because she did not want to face having a physician make an issue out of her weight. One of the larger NAAFAns had had chronic bronchitis and would not see a physician about it until she ended up in the hospital:

"It had almost become pneumonia. I couldn't face going to a doctor, because I'm sitting there and wheezing and practically coughing up blood and all they want to know is 'how much do you eat' and 'how much do you weigh' and 'do you realize how fat you are?' That kind of thing. The lectures. And it got to the point where, you know, I thought I would just try to suffer in silence. Because it just wasn't worth it." [NAAFA B]

One of the larger NAAFAns had been walking around with a thyroid deficiency which was causing her to sleep a lot, even during the day. She avoided seeing a physician until she was so sick that a friend physically forced her to a physician's office. She had avoided seeking health care because:

"I just didn't think that they would take it seriously, I didn't feel like there was anything much they could do . . . I think at that point I just had so much anger toward doctors, I just didn't want to deal with it. It was so hard for me to just get up all the strength that I needed to go into a doctor, and not be trampled. I think that's really what it is. It takes so much psychic energy to do that, and not die. And sometimes it's just not worth it." [NAAFA B]

The same woman, as a teenager, experienced severe stomach pain, and refused to see a physician:

"When I was 14, I woke up one night, in the middle of the night with tremendous stomach pain, and I just made myself go back to sleep. The next day was Saturday. I could have gone to the doctor's office, he was open on Saturday -- I didn't want to go, I had gained weight, and I just didn't want to see the doctor. So I went on a camping trip with my family, and it turned out, Monday morning, they finally dragged me to the hospital -- I had a ruptured appendix, that had gotten gangrened. And I wouldn't go. My mother physically dragged me out of the house. And the reason I would finally go was, she called the doctor, and he said 'take her to the emergency room'. So I figured they wouldn't know what I weighed before, at the emergency room, and they wouldn't know I gained weight, and I still have time to lose weight before I saw my [regular] doctor . . . I almost died, I really almost died, because I was terrified of my doctor, and getting on a scale, and having gained weight." [NAAFA B]

The larger NAAFAn who would not go for an abortion because she felt the clinic staff would humiliate her, later experienced a miscarriage and refused to seek help:

"I had a spontaneous miscarriage. And it was months before I even went to a doctor about that. I was at home when it happened. And there was blood everywhere. And I cleaned it up myself . . . I thought I was dying. A friend said 'you have to go to the doctor.' And I wasn't going to go. I just wouldn't go. I continued bleeding for, I don't know, like two or three weeks, something like that. I wouldn't go. It finally subsided and it wasn't until months later that I went to the doctor. I was just so humiliated I couldn't do it. And then I was humiliated by my ignorance, my refusal to go. I felt humiliated by that, that somebody as smart as me should have known better and should have just given them all the finger and said 'take care of me'. I hid out in my room virtually for months. I just stayed in my room all day. I was weak and I was sick." [NAAFA B]

Interestingly, while many of the NAAFAs claimed to be much more assertive with physicians currently, and to feel much more positively now about seeing physicians, the majority of them told a *current* story about avoidance and delay in seeking health care.

Severing Relationships with Physicians

In addition to reports that they had avoided physicians because of interactions they have had regarding weight, the majority of NAAFAs had at one time severed a relationship with a physician because of weight-related issues. None of the Weight Watchers reported having done so. Four of the larger NAAFAs, all three of the smaller NAAFAs who had once been larger, and one other of the smaller NAAFAs reported that they had stopped seeing at least one physician because of an issue related to weight. Three participants said they stopped seeing a physician after gaining weight. Two others stopped seeing a physician who misattributed their medical problems to their weight, and the remaining participants severed the relationship because of the physician's attitude toward them regarding their weight. One participant who had experienced relatively few weight-related problems with a family physician she had since childhood, recently decided to choose a physician with a more enlightened attitude about the causes of being fat. Another participant remained in an uncomfortable relationship with her physician for a full twenty years before discovering that there were physicians she could see who would not continually focus on her weight.

Solutions

Educating Physicians

Several of the larger NAAFAn expressed the view that the main problems with health care situations for fat people could be solved if health care workers took the time to become more aware of the issues involved:

"Like with transferring patients. A lot of it is just sort of ignorance on the nurse's part, in that they don't really learn how to transfer problem patients that well, so they wind up like having six people in the room to get someone into a wheelchair, when maybe two people or maybe a third person, for a fat patient, would be okay. They overreact to any situation, so they see a fat person, they don't know how to handle it. And they just call in the troops. And it's probably more embarrassing and more unwieldy to have six people who don't know what they're doing trying to get somebody out of bed." [NAAFA B]

"When I went to the gynecologist there was a nurse in there, and I asked her [for help in getting up on the table], and she said 'sure, no problem. I never thought about it.' I think that a lot of the thing is, the reason is, people just don't think. They're not being mean and cruel. They just don't think." [NAAFA B]

"I feel that they have to be educated. And if I'm going to be meek and sit back and not educate them, then they are never going to learn." [NAAFA B]

Finding Physicians who Deal Well with Weight Issues

Despite all the negative things that participants said about physicians, many of them reported having positive experiences, particularly those who, after searching for a medical doctor they feel comfortable with, finally are pleased with their physician. Most of the positive things participants had to say about their physicians were weight-related, probably a result of the nature of the interview, although several physicians were praised for being caring and for taking a personal interest in the participant. The majority of positive comments that were weight-related had to do with how the physician approaches the issue of weight loss, if at all. Four of the seven Weight Watchers, four of the seven smaller NAAFAn and three of the six larger NAAFAn all said that they had physicians currently who either did not discuss weight with them, or discussed it in a mature, caring manner. *

Three of the NAAFAn reported experiences where they had gone to a physician with a symptom that easily could have been misattributed to their weight, yet was taken seriously. One of the smaller NAAFAn had complained to her physician about back pains, and the physician

investigated the symptom carefully by taking x-rays. One of the larger women went to her physician with diabetes which he did not attribute to her weight, but to a side effect from a medication she had been taking. Another of the larger women went to her physician complaining of pains in her chest, and her physician was very thorough and performed many tests. He asked her about what types of physical activity she was involved in and discovered that she had strained a muscle during basketball.

Several of the larger NAAFAs mentioned experiences at the physician's office where the procedures were either made more accessible to them or where the staff helped to make the standard circumstances more comfortable for them. One participant mentioned that her physician had bought a large-sized blood pressure cuff to use on her. Another participant has found a gynecologist whose staff is very helpful:

"All her nurses are wonderful. The most incredibly compassionate people in the world. And never a negative comment about my size or anything else. And the only question is, like, 'do you need help to get up on the table?' 'I need some help.' 'Okay. What is the best way for you to do this? What do you want me to do?' That kind of thing. And they don't try to make me wear paper gowns that don't fit." [NAAFA B]

One woman had this experience at a hospital:

"I fell on the ice, and I really wrenched my back and hit my head, and had a mild concussion. And again, here's this thing. I'm not mobile, and how are people going to manage me? And so I have to get up on the exam table and get down off the exam table. And I could sort of do it, and there was one person with me who sort of helped position me, so that I could do it myself. And then, when they put me on the stretcher to take me to x-ray, it's like the whole time I'm like really nervous. And they were wonderful. The woman who was pushing me, just very nonchalantly asked somebody 'could you give me a hand,' and didn't make like a big deal out of it. I wasn't embarrassed, I didn't feel really bad." [NAAFA B]

Two other participants had had positive hospital experiences. One woman had to stay in the hospital for some time and her physician ordered her a special wide bed with a thicker mattress.

The staff of a hospital put two beds together and reinforced them for another participant.

Two of the larger participants reported that they found physicians who were able to perform procedures that previous physicians were unable to. Both were able to find gynecologists who were able to perform thorough internal examinations, and one of the two participants reported finding a physician who was able to perform tests to diagnose a gall bladder

problem, although several previous physicians had told her that it could not be done on someone her size:

"[She told the physician] 'I'm concerned that you're going to go in for surgery not knowing if something's there, because I know that you can't get good test results on someone my size.' He looked at me like I was crazy. He said 'I can get test results.' He said he can tell from the ultrasound, and if not, there's an alternative test that's conclusive." [NAAFA B]

One of the women reported that she is so pleased with her physician, after having suffered a lifetime of bad experiences, that:

"I've actually been considering moving out of state and one of the things that keeps me from really considering it seriously is what would I do without Dr. L? I would never go through the search again. That's how I feel." [NAAFA B]

Finding Solutions to Specific Problems

Many of the participants reported specific solutions by which they have attempted to make physician visits easier for themselves. Several NAAFA participants mentioned bringing their own gowns or robes to the physician's office because they know the physician's gown will not fit them, or wearing two of the smaller gowns at once, one facing forward, one backward. One of the larger women stated that she now brings with her to her physician's office a 16-ounce plastic cup to urinate in when she must have a test done requiring a urine sample, since the tiny cups at the physician's office are too difficult for her to use. One woman has learned that if she holds her stomach up with both hands away from her genital area, her gynecologist has a much easier time examining her. The woman who is going in for surgery shortly has tried to educate herself about the surgical procedure and about what she might do to help in her own recovery. After much research, she discovered that an abdominal binder might support her stomach and keep it from pulling on her incision, which may give the incision a better chance to heal. While she was able to discover this with a lot of effort on her part, she had this to say:

"But you know what sort of nags at me? It's like, what if I didn't know to think about this? Who's watching out for this? Who's taking care of this? So, what other things are there, that I don't have the knowledge to know about, and that they do, or that they don't either, because they don't know. They just don't know. Because nobody's thought about it; nobody's come across it." [NAAFA B]

Changing Behavior Toward Physicians

Several participants mentioned that their behavior with physicians has made their interactions more comfortable and fruitful as far as getting good health care. One of the larger participants mentioned humor as a way of trying to "soften up" the physician. For instance, in one situation where a physician stated that he did not know how he was going to examine her, she responded, "Oh god! You're not going to tell me you were absent that day in medical school, are you?"

Almost all the NAAFA's in both groups, and one of the Weight Watchers mentioned becoming assertive with their physicians as a way in which they receive the type of medical care they need. These participants reported having learned to stand up for their rights in the physician's office, and demanding to be treated with respect. Most of the participants said that this assertiveness has come with age, as well as with a change in attitude. The most common circumstance in which participants asserted themselves had to do with being told to lose weight, and getting weighed at the physician's office. These participants have told their physicians that they do not wish to discuss weight loss or that they do not wish to be weighed, and have stood up to him/her if their desires were not met. Other ways in which participants reported expressing their assertiveness included: finding new physicians by screening them on the phone about weight-related issues before going to them; telling the physician's staff what their needs are regarding office procedures; insisting on getting a new physician in hospital/clinic settings when the original physician is not acceptable; and bringing a "fat advocate" with them to the physician's office so that they do not have to face the situation alone.

Starting Informal Referral Networks

One participant who feels she found a competent physician with comfortable attitudes about weight referred many of her friends to him; in this way an informal referral network was set up so that, in time, the physician began to have a practice with many fat patients who also referred *their* friends. A beneficial cycle was started whereby the physician learned more about fat patients and was therefore in an even better position to help other fat patients.

Given the current medical atmosphere, it is likely that these referral networks are one of the few ways in which fat people can be assured that the physician they are going to see will treat them with respect, and give them proper, appropriate health care without being overly influenced by their weight. As one of the participants said:

"I wish it could be different. I think that's the bottom line. I wish that the medical profession could all get fat. Maybe if they could walk in those shoes, a little bit, there would really be a dramatic change in the way they handle obesity. They would realize that it's not a medical problem. And maybe they would be a little more empathetic, that fat people do have feelings. That's the message they give loud and clear -- 'if you're fat, you must be out of control, and if you're that out of control, you must be stupid, and if you're that stupid, then you must not have feelings, and therefore I can do and say whatever, and treat you like a piece of dirt.' And that seems to be the cycle that I found myself in. And if you are *not* out of control, and if you are *not* stupid, and you *do* hurt, then you go home to a great deal of pain and live your life either hiding or angry or a combination of both. The medical profession has probably made an awful lot of people's lives much more miserable, much more painful than they need to be. Life is tough enough, without a doctor making it worse." [NAAFA A]

Discussion

Weight and group membership had little effect on the extent to which participants delayed or avoided physician visits currently and on how satisfied participants were with their regular physicians, although those who weighed less had a more positive general attitude toward physicians and those who were members of NAAFA (National Association to Advance Fat Acceptance), the group whose philosophy tends toward the belief that people are not responsible for causing or curing their fatness, tended to have had their current physicians for a shorter period of time than those who were members of Weight Watchers, a diet group whose philosophy tends toward the belief that people are responsible for both cause and cure of fatness. Most participants who were not happy with their previous physicians sought out a physician with whom they felt comfortable, and most eventually found one; because of this, there were presently few differences evident. However, past experiences seemed to be greatly influenced by these factors, particularly by weight – those who were heavier tended to avoid physicians more, and to have reported having greater difficulty in obtaining proper medical care because of their weight. Group membership also had some influence on the physician-patient relationship. NAAFA members tended to be angrier about interactions with physicians concerning weight and weight loss, tended to report having been subjected to crueler comments from their physicians, and tended to have severed more past relationships with physicians because of weight.

Weight philosophy was clearly related to group membership -- those who belonged to Weight Watchers tended to feel more responsibility for the cause and cure of their fatness and to feel they had more control over it than did those in NAAFA, and there was some tendency for individuals to have found physicians who were in agreement with their philosophy.

Participants in general tended to have strong negative feelings about discussing weight with physicians, although those in the Weight Watcher group were much more likely to think that weight is an appropriate topic for a physician to discuss, while the NAAFA members tended to be

angry about these interactions. Participants in general felt strongly about physicians' lack of knowledge and ability regarding weight loss, although all had been subject to these types of discussions with physicians. Most participants reported that at one time or another they had had their presenting symptoms attributed to their weight by a physician, and, as a result, the symptoms were not directly treated. The majority of participants reported having delayed or avoided health care because of their weight, particularly with regard to gynecological examinations. Almost all participants felt that there is a connection between fatness and poor health. Almost none of the participants felt that their inability to lose weight had ever prevented them from engaging in other health-promoting behaviors.

Self-Esteem/Weight Philosophy

As expected, those participants who are Weight Watcher members tended to believe that they had more responsibility and control over the cause and cure of their fatness than did the NAAFA members. It is notable, however, that there was quite a bit of overlap in the attributional orientations of the participants. Interviews with participants demonstrated that while there are some Weight Watchers whose orientation is similar to that which NAAFA espouses, and some NAAFA members who have a similar orientation to Weight Watchers, patterns based on philosophy were observable. Despite the overlap in philosophy between the two groups, the trend was for the overall orientation of participants in the two groups to be fairly dissimilar. Participants' political leaning was also related to their weight philosophy, particularly for the NAAFA members. Those who consider themselves more conservative tend to take the more conservative, established point of view concerning responsibility for weight, while those who are politically more liberal tend to have a more radical philosophy about their responsibility. For NAAFA members, those who are conservative may be people who tend to be generally satisfied with things as they are, while the liberal individuals are those who question the status quo and who strive for social change.

There seemed to be no apparent differences in self-esteem between the groups, despite major differences in their dieting and weight backgrounds, most notably that the members of NAAFA had typically grown up in families where, as children, their weight was treated in an extremely negative manner, where they were forced to diet at an early age, while those in Weight Watchers tended to be brought up in families that were either fairly supportive around the issue of weight or where the child's weight was not made a major issue.

This difference in the way respondents were brought up as children was one of the largest differences between the Weight Watchers and NAAFAns interviewed. It is not clear what effect, if any, this difference in upbringing might have had on NAAFAns developing a philosophy where they do not attribute responsibility to themselves. It is also not clear whether the differences in upbringing caused NAAFAns to eventually weigh more than the Weight Watchers, or conversely, whether they started out, as children, weighing more, which caused the difference in upbringing. Since presently the NAAFAns tended to be heavier than the Weight Watchers, it is possible that the effect of the NAAFAns' families' harping may have caused a greater weight problem in some of the respondents. Several had indicated that their parent's emphasis on dieting and on the foods they couldn't eat caused them to have a difficult relationship with food to this day. In addition, literature has shown that continued dieting eventually lowers the body's metabolism, often causing greater weight gain in the long run (Apfelbaum, Bostjarron & Lacatis, 1971; Bennett & Gurin, 1982; Smith & Fremouw, 1987; Zegman, 1983).

The finding that all of the Weight Watchers had come from families that were supportive about their weight was surprising, particularly in light of the fact that almost all of the NAAFAns had themselves been members of Weight Watchers at one time, and most of these people had come from families that were negative about their weight. While it may be possible that the effect of their families emphasizing the issue caused them eventually to become fatter, perhaps the difference in philosophy about weight between the participants in these two groups caused them to interpret their families' behavior differently, when looking back on it. That is, parents who encourage their child to lose weight might be seen by someone with a Weight Watcher

philosophy to be supportive of them, because they are encouraging them to do what they should do, while someone with a NAAFA philosophy might interpret the same behavior negatively, because the child is being pushed to change something that she should not have to. Because of the small number of participants selected for interviews, and the biased information gotten when people think back retrospectively to childhood, it is impossible to tell whether the families were truly different. A longitudinal study, starting when participants are children would clarify whether non-supportive families are more likely to produce children who will grow up fatter, or will grow up to reject society's view of fatness as being personally caused, and personally curable.

It was not possible to determine whether the families of the NAAFA participants were more negative because the participants, as children, were fatter. Rather than being able to give actual numbers, most of the smaller participants were only able to provide sketchy and subjective information about how fat they were as children, although most stated that they were the fattest child among their friends and peers. It is possible that the families of NAAFAns were more negative about their weight simply because the NAAFAns were much fatter children. Again, in order to thoroughly explore this possibility, this type of issue would need to be investigated while children are still young, or perhaps by conducting an intensive study utilizing childhood photographs and reports by parents and other family members.

One puzzling finding was that while the Weight Watcher members who were interviewed tended to come from families that did not treat the respondent's weight in a negative manner, these were the women who tended to talk most disparagingly about their weight and their bodies. The NAAFAns who were brought up in families that made their weight a central issue did not tend to speak in the same disparaging manner about their bodies. One possible explanation is that the latter women think of their bodies as a part of themselves, and therefore by disparaging their body they would be directly assaulting their self-esteem. The Weight Watchers, on the other hand, may be able to separate their bodies more from themselves, and be able to disparage body parts without necessarily hurting their sense of self. They may feel that distancing themselves from their bodies, and thinking negatively about it, will help motivate them to continue losing weight.

This notion is supported by Allon (1973) who reported that group dieters tended to differentiate themselves from their bodies. Jones et al. (1984) assert that when a stigmatized person is able to fantasize a "possible self" (e.g., a fat woman who believes she can be thin one day), the person may be able to treat the body like a foreign object, separate from the mind.

The results of this study did not show self-esteem to be related to whether or not one was fat as a child. This seems to contradict other findings in the obesity field (Allon, 1982; Stunkard & Mendelson, 1967; Tenzer, 1989); however most of these findings come from clinical observation, while the general population is rarely studied (Jarvie, Lahey, Graziano, & Framer, 1983). Crocker & Major (1989) have suggested that for stigmatized people in general, it is those who become stigmatized later in life who are more likely to internalize negative attitudes. No such pattern was evident for the participants.

Interestingly, while this study showed weight perception to be the strongest predictor of self-esteem, actual weight did not seem to contribute to it. It would seem that since the negative attention fat people get is believed to affect their self-esteem (Allon 1982; Cahnman, 1968; Leon, 1982; Sallade, 1973), those who are fatter should be expected to receive more negative attention and hence have lower self-esteem as a result. However, Crocker & Major (1989) have found that individuals use many coping strategies, such as attributing negative feedback from others to prejudice in order to preserve their self-esteem. Jarvie, Lahey, Graziano, and Framer (1983) reviewed the literature on body image and self-esteem and found little evidence for pathology in these areas among fat people. In addition, Silberstein, Mishkind, Striegel-Moore, Timko, and Rodin (1989) believe that dissatisfaction with weight does not affect women's self-esteem because it is normative for women to want to be thinner.

This study did not address the question of whether the perception of weighing more lowers one's self-esteem, or whether having lower self-esteem to begin with causes one's self-perception of weight to be greater. Most likely the relationship works both ways, each contributing somewhat to the other. A particularly notable finding was that Weight Watchers and NAAFA's did not differ in their weight perceptions, despite the fact that the NAAFA's weighed,

on average, 100 pounds more than the Weight Watchers. This finding seems to support the literature showing that people tend to compare themselves to similar others (Crocker & Major, 1989; Dawson, 1988; Jones et al., 1984); it is likely that NAAFAs were comparing their weight to others in their group, while the Weight Watchers were comparing themselves to other Weight Watchers. Similarly, regarding perceived health status, the women in the larger group who were interviewed made it clear that they were comparing their health status to that of other very large women, or to the stereotypes of how unhealthy a person of their size is supposed to be, and in comparison they felt quite healthy. It is possible, however, that if the comparison group were those of normative weight, these women might have indicated that they feel that they are less healthy. In addition, one woman admitted that she tried to dispel myths about how unhealthy fat people are supposed to be by projecting a stronger image of her health status than perhaps she felt. Although the interviews revealed the NAAFAs to have a slightly lower perceived health status, the questionnaire results demonstrated no significant differences either on the objective or subjective health measures between the groups or for smaller versus larger women. The fact that the larger women in the study did not differ from the smaller women even on the objective health measures, indicates that their reactions to whatever illnesses they have results in similar illness behavior to the smaller women. Therefore, either the smaller and larger women truly have no differences in their overall level of health, or the larger women learn to cope with their everyday illnesses in a way that in spite of their ill health or mobility impairments, lets them function similarly to the smaller women. That is, while the smaller women might be more likely to stay home from work for a bad backache, the larger women might be more inclined to push themselves to work in spite of the backache. From the interview comments of the larger women, this is what seems to be operating.

One important finding of this study was that almost all of the interview participants wished to lose weight, and were unhappy that they are fat. Despite strong attempts not to internalize negative feelings about being stigmatized, it appeared that, in fact, most NAAFA participants were personally unhappy about their weight and wished that it were possible to change it. All had been

socialized to believe that it's not acceptable to be fat, and most still wished they could "fit in". The majority of the NAAFans interviewed seemed resigned to the fact that they will be unable to become thin, and have therefore learned to live as happily as possible, in *spite* of being fat. While there may be NAAFans who truly are happy and comfortable with themselves being fat, the interviews suggest that this was not a widespread feeling among the participants. Additional evidence for this comes from the questionnaire data, where approximately half of the NAAFA participants (29 out of 60) reported that they have reduced their food intake within the last year for the purpose of losing weight. The ambivalence that some of the NAAFA members feel about the contradiction between their public image and their private feelings about being fat is reflected in the fact that more than half of the participants who reported that they have attempted to reduce their food intake nevertheless report that they are not currently on a diet. While this discrepancy might be explained by the fact that the reduction of food intake could have taken place anytime over the past twelve months, and the person might not actually be reducing their food intake at the present time, several NAAFA participants who were interviewed did say that they were not dieting, yet went on to describe methods they actively use to reduce their food intake. Many of these participants did not believe that they would ever become thin, but hoped to either maintain or reduce their weight somewhat, and therefore may not have considered themselves dieting in the traditional sense of the word, since they were not aiming to become normative weight. From the interviews, it appeared that there may be some stigma within NAAFA around engaging in dieting. Perhaps the discrepancy in NAAFans' political/philosophical viewpoint about weight versus their personal feelings about it are more easily resolved if they believe that they are not truly on a "diet". It may also be easier to resolve this internal conflict by making small dietary changes that are not labeled as dieting. It is difficult for fat people to fight against internalizing the stigma they must face every day. In an effort to foster the growth of the social movement, it may be necessary for people to project to the outside world that they like themselves the way they are, in spite of internal conflicts, in the hope that these proclamations will have the effect of increasing their own self-esteem, and may influence those in the general public who are fat themselves to

begin to think more positively about themselves and their bodies. It is also an attempt to get those who are not fat to begin thinking about physical differences in a more accepting way.

Fatness, Health and Physicians

While most of the respondents wished to lose weight, all were quite skeptical about physicians' ability to help in this effort. Most participants felt that physicians are not knowledgeable about weight loss and almost unanimously felt that joining a weight loss group or trying to lose weight on one's own would lead to more weight loss success than dieting with the help of a physician. Research has shown that physicians themselves do not have a high expectation of weight loss success for their patients (Maddox, Anderson & Bogdonoff, 1966; Maddox & Liederman, 1969; Rothert, et al., 1984). Many respondents reported having gotten ill from weight loss attempts under a physician's care, and the majority of respondents had been given diet pills at one time or another, which caused uncomfortable physical symptoms and resulted in rapid weight gain after stopping the medication. Prescribing diet pills is one of the more common methods by which physicians attempt to help their patients lose weight (D'Amelio, 1976; Lasagna, 1973; Stewart & Brook, 1983). Physicians rarely emphasized physical exercise to the respondents, a finding echoed by D'Amelio (1976), and those who mentioned exercise put much less emphasis on it than they did on dieting. Zegman (1983) reported that physicians dealing with fat patients are more likely to give women patients diet pills while men are advised to exercise. Even the women interviewed who had chosen to have weight loss surgery found it very difficult to keep their weight off or experienced such bad physical symptoms that they had to have the surgery reversed. Several of the participants expressed their belief that many physicians are involved in certain weight loss regimes, particularly the currently-popular liquid diets, for the sole purpose of making money. A prospectus from one of the liquid diet manufacturers, Medifast, informs physicians that they can earn upwards of \$62,000 a year by seeing only 15 fat patients a month (Beck, 1990). The general feeling of respondents was that physicians oversimplify the problem of being fat, as DeJong (1980) also asserts, and that physicians believe that insults or

criticism work to motivate a person to lose weight. None of the respondents reported any interaction with a physician that seemed to aid them in losing weight for any period of time. While some participants, particularly the Weight Watchers, felt that physicians might be useful in that they can frighten the patient to lose weight, that method did not appear to actually be helpful to any of them personally. Bandura (1986) reports that fear appeals do not generally motivate individuals to engage in health-promoting behavior, because fear undermines people's beliefs about their self-efficacy to control health threats. Overall, respondents of all weights in both groups disliked talking to physicians about their weight and felt that under some circumstances physicians' approaches to the discussion of weight loss with patients can lead the patient to have lowered self-esteem and can have detrimental effects on the physician-patient relationship.

One surprising finding was that virtually every person interviewed believed that fatness negatively affects health, and that their own health in particular was either currently being affected or would be in the future. This was interesting in light of much recent research questioning the link between fatness and health (Bennett & Gurin, 1982; Ernsberger & Haskew, 1987). While NAAFA members seemed just as likely as Weight Watchers to believe their health was negatively affected, it is important to keep in mind that many of them were at much higher weight levels than the Weight Watcher members, and therefore may be reacting to much stronger mobility impairments and possibly to a greater number of health problems that are thought to be related to obesity. Despite the almost unanimous agreement that weight affects health, the NAAFA members were much more cautious in stating their beliefs about this connection; they seemed to have a greater understanding of how social norms have affected opinions about the link between obesity and health. Many stated that although they believe there is some connection, they don't think it is as strong as physicians seem to believe, and one NAAFA member questioned whether her belief in a connection between her health and her weight is based on reality or on having been successfully "brainwashed" by society's views. In addition, several NAAFA participants mentioned ways in which their history of dieting has had the biggest negative impact on their health. Interestingly, several of the NAAFA members seemed to feel privately that they had a lot of health concerns, while

publicly they made an effort to appear healthy to others. Breakwell (1986) has stated that people in social movements often try to change the characteristics associated with the group in order for the group to appear more acceptable to others; NAAFA's may attempt to disassociate the health issue from fatness for this reason.

A high degree of psychological problems were found among the participants in the interview phase of the study. Many suffered from serious psychological problems, and many of the women were currently in psychotherapy or had been in the past. The literature on the psychological health of fat people compared to those of normative weight has found that there are few differences (Jarvie, Lahey, Graziano, & Framer, 1983; McReynolds, 1982; Wadden & Stunkard, 1985). As stated in the results section, it may be that individuals who are psychologically-minded would be more interested in participating in a psychological study, and that is why such a high degree of psychological problems appeared among these respondents. However, the large women were especially likely to have reported psychological problems or to have been in therapy. While the numbers of people interviewed are too small for this to be conclusive, the findings suggest that perhaps more personality research should be conducted which seeks out very fat people, who are generally overlooked in these types of studies. It may be that the extreme stigmatizing effect of being so much above the norm puts these people in increased jeopardy of developing psychological problems. Jarvie, Lahey, Graziano and Framer (1983) have also suggested that degree of fatness may contribute to the development of psychological problems.

Obtaining a Regular Physician

The quantitative results revealed that Weight Watchers were more likely to have their current physicians for a longer period of time than were NAAFA's. The Weight Watchers interviewed seemed in general to be pleased with their physicians and, while discussions of weight made them uncomfortable, they generally felt their physician was justified in initiating the discussions. NAAFA's generally expressed more anger about their interactions with physicians,

particularly regarding having their presenting symptoms attributed to weight and being subjected to lectures about losing weight.

Many of the Weight Watcher participants seemed never to have given much thought before to the issue of how their weight interferes with their relationships with physicians. On the other hand, many of the NAAFA participants seemed to have given this issue a lot of thought in the past. Once the issue was addressed during the interview, the Weight Watchers had a lot to say on the topic, and several remarked that while they had not previously thought about the issue, our conversation was bringing to mind a lot of memories and incidents. Given a negative orientation towards something, the more one thinks about it, the more negative one becomes (Tesser, 1978). It is possible that the NAAFA members reported being more angry about incidents they have had with physicians simply because they have given more thought to those incidents over a period of time, having been oriented by NAAFA or other NAAFA members toward thinking of their weight as interfering with the physician-patient relationship.

The quantitative results revealed that while Weight Watchers who smoke were somewhat more likely to have seen a greater number of physicians over the past five years than those who do not smoke, the NAAFAs who smoked saw far fewer than those who did not smoke. The purpose of this question was intended to measure dissatisfaction. It was thought that, after controlling for health status, those who saw more different physicians would be those who were more dissatisfied with the physicians they had seen and were more willing to seek out other physicians for additional health care. Unfortunately, this variable does not take into consideration the fact that people who are dissatisfied may stop seeking health care altogether, therefore it must be interpreted with caution. It is possible that since NAAFA members tended to be much more aware of physician prejudice and the associated poor health care that fat people are often subjected to, those who have an additional stigma (smoking) would feel that it is futile to try to seek out an understanding physician, when the chances would be so slim that they would find one, given the two "strikes" they have against them. Another explanation for this interaction may be that fat smokers who do not believe they have control over their weight might have a resigned

or pessimistic attitude toward their health in general. This may lead them to be apathetic about their health care, which might result in their seeing fewer physicians in general. The difficulty of interpretation of this variable is supported by the fact that while the quantitative results showed that Weight Watchers were somewhat more likely to have seen a greater number of physicians, the interviews, which addressed interactions with physicians over a lifetime, revealed that the fatter NAAFA women had been more likely to have seen a number of different physicians over the years in an attempt to get better health care, and these women had been more likely to sever relationships with physicians for weight-related reasons.

The quantitative results also showed that participants who were fat as children were more likely to have seen a larger number of different physicians over the past five years. Interviews revealed that both Weight Watchers and NAAFAs who were fat as children had had their weight addressed by physicians from an early age, and the NAAFAs who are larger had been subjected to particularly cruel comments. Having been subject to this may have instilled in these people at an early age a feeling of mistrust in physicians, since no (interview) participant's weight had been successfully altered by any physician intervention after so many years, in spite of their physicians holding out the promise that it would do so. This greater mistrust of physician abilities may lead to a greater willingness to seek out other physicians when one is not satisfied with the level of care one is getting. Further evidence for this is the fact that participants who were fat as children have had their current physician for a much shorter period of time than those who became fat at an older age.

The vast majority of participants, regardless of weight or group membership, were likely to have a current physician. Interviews revealed that virtually everyone thought their doctor was highly competent and most felt fairly comfortable with him/her, although several of the larger women were still somewhat uncomfortable. A few of the larger women had gone to see many other physicians before finding their current one with whom they are fairly satisfied. It is a testament to how important doctors are to the lives of the people interviewed, that in spite of tremendous attitudinal barriers, many continued to seek better health care until they found a

doctor with whom they were comfortable. And, despite the odds, most of the individuals with a NAAFA-type philosophy *did* eventually find a doctor who, if not actually having a similar philosophy, was at least tolerant of that line of thinking. The fact that people continued to seek out good health care in the face of all the barriers to which they were subjected indicates that in spite of the stigma they faced, these people managed to preserve enough of a sense of self-worth to place a high value on their health and to act accordingly.

It is interesting to note that despite some correspondence between the weight attributions of the respondents and their respective physicians, none of the Weight Watchers interviewed, nor the NAAFAns, have successfully lost and maintained their weight in the past nor are doing so now. A strong emphasis by physicians on weight loss does not seem to result in a patient's weight loss, even among those who feel this approach is appropriate. Research has shown very poor weight loss statistics and a high recidivism rate for weight loss programs studied, including those that are medically supervised (Foreyt, Goodrich, & Gotis, 1981; Stunkard & McLaren-Hume, 1959).

Delay or Avoidance of Physician Visits

Neither weight nor group membership appeared to influence how long it had been since participants last saw a physician, nor how many times they saw a physician this year. Only health status was related to those two variables; those with the poorest health allowed less time to pass since seeing a physician and they saw a physician more times this year. These results are supported by Becker and Maiman's (1983) finding that the number of days someone is ill and their self-reported state of health contribute to the likelihood that they will use a physician's services.

While most of the respondents interviewed admitted that they either currently or in the past avoided physicians because of their weight, those who found physicians who deal satisfactorily with their weight report that they engage in much less avoidance now, although there is still some tendency to do so. For instance, one NAAFA participant admitted that she still will not see her physician if she gains weight; this is in spite of feeling very comfortable with him, and in

spite of his not making an issue of her weight. It is likely that the fear of being criticized about weight is deeply ingrained in the minds of many fat people who have been harassed most of their lives because of their size, and even with a positive health care practitioner the fear is still there.

The results of the quantitative part of the study revealed that those who are older are more likely to visit physicians for serious or non-serious symptoms. Since the older participants in this study were in their middle years, this finding is in line with data which shows that those in their middle years tend to utilize health care more often (Kirscht, 1983). No differences were found for weight or group. The interviews, however, revealed that in the past, the heavier women were much more likely to avoid physicians for both serious and non-serious symptoms. The discrepancy in the quantitative and qualitative findings may be due to the fact that most of the participants had a physician with whom they were now comfortable, and consequently would now actively seek treatment for symptoms.

Those participants who weighed more were more likely to name a greater number of weight-related reasons for having ever avoided a physician visit, while those who were older named fewer reasons. Similarly, age and weight had a significant influence even for non-weight-related reasons for not visiting a physician. One would expect that those who are older would have named more reasons over a lifetime to have avoided a physician. However, the stigma of being fat was probably not very strong within the medical community until the early 1960's, when an insurance study linking obesity with health risks was released (Ernsberger & Haskew, 1987). It may be that the older participants in this study were not subjected to the same behavior from physicians when they were younger, and perhaps now that they are older, physicians do not pressure them as much to look socially acceptable as they might with a younger person. This may explain why older people might have indicated fewer reasons for not visiting a physician. In addition, Maddox and Liederman (1969) found that younger physicians were more negative about fatness than were older physicians; participants in the current study who were older tended to have older physicians. Harris and Furukawa (1986) have demonstrated that elderly people over normative weight generally do not feel that physicians discriminate against fat patients, but the

authors caution that this may be because there is less pressure on elderly people to conform to appearance standards. Lending support to the notion that physicians may put more pressure on young patients is national data analyzed by Packer (1988) showing that older patients are less likely to be diagnosed as obese, despite an objectively greater number of fat individuals among those who are older. In addition, it may be that younger people are less trusting of physicians' abilities to improve health than are those who are older, and therefore find more reasons not to go to them for health care.

In regard to visits over the past year, participants fat as children gave fewer weight-related reasons for avoiding physicians and those who were older gave fewer non-weight-related reasons. It is not clear why those who were fat as children were more likely to indicate fewer reasons, however this particular variable was one of the weaker ones, and explained very little variance overall.

Whether or not one has a regular physician influenced the number of weight-related reasons given both currently and in the past, and also influenced the number of non-weight-related reasons given for the past year -- those with a regular physician indicated fewer reasons for avoiding a physician. Becker and Maiman (1983) and Bloom and Jack (1985) report that having a regular source of medical care leads to increased usage of physicians' services.

While those who are heavier had more weight and non-weight-related reasons for ever avoiding physician visits, weight was not related to the number of reasons for avoiding *current* visits. This is most likely the result of participants being fairly satisfied with their current physicians, while many, particularly the NAAFAn, had not been so in the past. In comparing the differences in the number of reasons participants indicated from the past to the current year, NAAFAn showed a much bigger decrease in reasons than did the Weight Watchers. This may be a reflection of Weight Watchers having had the same physicians for more years, while many of the NAAFAn are using physicians they have only recently begun to see.

Attitudes Toward Physicians

Participants who weighed the most had the least positive attitudes toward physicians. Interviews revealed that the fatter women reported having encountered the worst treatment from physicians, so it is not surprising that they had the least positive attitudes. While weight was an important variable here, group membership did not appear to have an impact on this variable. The group variable was important for the two questionnaire items which addressed the longevity of one's relationship with a physician, while the weight variable was important for items addressing the number of reasons for having avoided physicians in the past and having less positive attitudes toward physicians. These findings are reflected by the interviews which showed that both Weight Watcher and NAAFA participants had negative feelings about physicians in regard to their weight, and all had avoided physicians for reasons related to being fat, although this was even more likely for those who were heavier. On the other hand, it was mostly NAAFA members, both heavier and lighter-weight, who were more willing to sever a relationship with a physician because of his/her attitude about weight, while the Weight Watchers tended to be much more complacent. The NAAFA participants were much more likely to actively try to change or withdraw from the uncomfortable situations they found themselves in.

While many participants were critical of some of the actions of physicians, the respondents very strongly believed, as a whole, in the importance of doctors to improving health, particularly when it comes to curing people who are already ill, and most thought that doctors have a role in prevention, although they thought physicians could be doing more in this area.

Ways In Which Health Care Is Affected

Regardless of weight or group membership, almost all participants interviewed reported that they had had difficult interactions with a physician regarding their weight or had had presenting symptoms ignored because of their weight. A stigmatized characteristic is often the focal point of interaction because the stigma is seen as a master status (Allon, 1982; Goffman, 1963). Many participants particularly resented seeking out a physician's help for a problem

unrelated to obesity and having the physician make an issue out of weight. These data concur with Packer's (1988) finding that in one national study, the majority of individuals who did not seek out a physician's care for obesity were nevertheless given or referred for diet counseling. While many participants reported having had these types of experiences, NAAFans in general seemed to have been treated overall with more disrespect and those participants who were heavier had the worst encounters. It may be that the clash between the opposing weight philosophies of the physicians and the NAAFans caused these participants to have been subject to worse treatment. This supports the Brickman et al. (1982) model which theorizes that when the help giver and help seeker have different attributional orientations, helping is undermined. NAAFans reported that they were less tolerant of disrespectful behavior by the physicians they had seen and were more angry about having received inadequate health care. They may have been less tolerant of this behavior because they encountered it more often. It is possible that Weight Watchers encountered similar behavior just as often by the physicians they had seen, but interpreted the behavior differently, and therefore did not mention as many incidents during the interview. There is some evidence for this in that one of the Weight Watcher respondents related a story about physician behavior that might have been interpreted as inappropriate, yet the participant felt it was appropriate behavior for her physician because they had a long-standing relationship. Another Weight Watcher, while hurt by her physician's comments, also believed his behavior was appropriate because of their long relationship. Although one of the NAAFans felt similarly, the Weight Watchers tended to have longer relationships with their current physicians and may therefore be more likely to accept such behavior as justified. One would need to study the physicians themselves in order to determine whether they truly act differently with patients whose attributions for weight differ from their own, versus those with the same orientation.

Many participants in both groups reported that they thought about their interactions with physicians ahead of time, and worried about how their weight was going affect the interactions. Participants were almost unanimous in disliking having to discuss weight with physicians, and all were fairly critical of the way in which some physicians discuss the issue. Most reported that they

have avoided needed visits because of factors related to their weight, including feeling embarrassed about their weight, not wanting to be lectured about losing weight, believing their physician would misattribute their symptoms to their weight, mobility problems, and lack of access to proper medical care including the inability of some physicians to perform thorough examinations. This is an example of how stigmatized people withdraw from interactions with others as a way of coping with their stigma (Jones et al., 1984) and avoid circumstances where the disadvantages of their stigma are emphasized (Crocker & Major, 1989). Some participants refuse to see a physician until they lose weight. As DeJong (1980) reports, fat individuals who are perceived as trying to lose weight are seen more positively. Several respondents reported that their physicians would not believe them when they told the physician that they had followed a diet accurately and yet had not lost any weight or had not lost as much weight as had been expected. Bailey (1981) wrote about this phenomena of physicians disbelieving their patients, while Altshul (1981) and Stunkard and Reader (1958) have implied that it is the patient who is fooling him/herself about how much they have eaten, despite an abundance of literature indicating that fat and normative weight people tend to have similar caloric intake (Huenemann, 1972; Maxfield & Konishi, 1966; Rose & Mayer, 1968; Willmuth, 1986; Wooley & Wooley, 1979). Respondents reported having avoided a needed visit for as much as seven years, and many told about incidents where they experienced severe physical symptoms, but still did not seek help. Many participants reported that they themselves had attributed symptoms to their weight, and avoided seeking medical care because they believed that losing weight was the only solution to relieving the symptom. This supports Mechanic's (1978) assertion that before people will seek medical help, they will first take into consideration any possible competing interpretations for their symptoms.

Weight level seemed to have the most impact on problematic interactions with physicians and on the actual level of health care delivered by the physicians. The larger women reported that they had repeatedly experienced being treated in an insulting manner by physicians, and had experienced much poorer health care treatment. These findings serve to reinforce Maiman, Wang, Becker, Finlay, and Simonson's (1979) contention that health care professionals' negative

attitudes are likely to interfere with the type of medical treatment fat people receive. In addition, several authors (Breytspraak, McGee, Conger, Whatley, & Moore, 1977; Klein, Najman, Kohrman, & Munro, 1982; Mizrahi, 1986) have noted that groups toward which physicians hold negative attitudes are likely to receive poor medical treatment or no treatment at all. Many respondents reported in the interview that this was the case for them. In particular, when a physician attributed the cause of a symptom to the patient's obesity, he/she usually offered little if any ensuing treatment other than reproaching the person for being fat. Since people are unlikely to engage in health-promoting activities when they feel they will not be able to produce the desired outcome (Bandura, 1982; Becker & Maiman, 1983; Hayes & Ross, 1987; Janz & Becker, 1984; Safer, Tharps, Jackson, & Leventhal, 1979), it is not surprising that many of the respondents avoided and delayed physician visits after being subjected to a history of having their health care needs unattended to. Also, since there is much literature which shows decreased compliance and satisfaction with physicians when there is poor communication between physician and patient and when one perceives their health care provider does not like or respect them (DiMatteo, 1979; Elling, Whittemore, & Green, 1960; Krantz, Grunberg, & Baum, 1985; Rodin & Janis, 1979; Roter & Hall, 1989; Stone, 1979) it was, again, not surprising to find reports of much avoidance of physicians by participants.

The fact that the majority of physicians are men, and emphasis on weight loss seems to be directed disproportionately toward female patients (Ernsberger, 1984; Fullarton & Pasick, 1978; McBride, 1982), is further evidence that the emphasis on weight loss reflects more of an aesthetic preference (Allon, 1973; Maddox & Liederman, 1969; Mann, 1971) than a concern with health. The fact that the medical professionals with whom the fat women had the most problems were gynecologists seems to support this explanation. Visiting this professional was the most embarrassing for the women, and the women seemed to be treated most disrespectfully by gynecologists than by other medical professionals they visited. Respondents reported having the most trouble getting thorough examinations from this type of physician than from any other type, and they tended to report avoiding gynecologists more. Obtaining birth control was an

ordeal for many of the women, particularly those who were larger. Perhaps gynecology was the biggest problem for the women because of its connection with sexuality. Fat women are seen by many people as non-sexual, and certainly as sexually unattractive. This widespread prejudice may be playing itself out in the gynecologist's office, where the physician must relate directly to the issue of the woman's sexuality. Ironically, since fat women are more at risk for cervical cancer, it might be advisable for them to see a gynecologist *more* often than women who are not fat (Emsberger & Haskew, 1987), yet this is the one type of physician whom fat women report avoiding the most often.

DeAngelis (1988) reported that female physicians are more likely to listen to their patients and to have a collaborative relationship. Several of the respondents had thought that women doctors would put less emphasis on the weight issue and be more understanding, but many found this not to be the case. It should be noted that because women were educated in the same medical schools as the men, with mostly men as teachers, it is not surprising that many take on the same values as the rest of the medical profession. In addition, because weight is such a strong issue for women, women physicians might be motivated by their own self-esteem needs to react negatively to a patient's weight.

It is hypothesized in the literature (Ernsberger, 1982; Emsberger & Haskew, 1987; Hollis, Carmody, Connor, Fey, & Matarazzo, 1986) that fat people may become helpless about other areas of their health because of their repeated failures at dieting. It follows from Abramson, Seligman, and Teasdale (1978) that repeated attempts to diet met with failure might produce learned helplessness, whereby the person might make a global attribution about his/her attempts to improve health and therefore might give up. However, in this study none of the respondents acknowledged that they had "given up" on other areas of their health, although several suggested that it had been true of them at one point in their lives. Most participants, in response to being asked about a feeling of helplessness over improving their health, spontaneously mentioned specific health behaviors they do engage in, such as physical exercise or attempting to eat more nutritional foods. This supports Kirscht's (1983) finding that engaging in one type of

preventive health behavior is relatively independent of engaging in other types. Therefore, even if fat people have a tendency to feel helpless over their weight, it does not seem that this causes them to experience a global feeling of helplessness over their health in all areas. Similarly, it does not keep people from seeking good health care and eventually finding care that they are satisfied with.

The finding in this study that participants who have radically different philosophies from their physicians do not become resigned to those practitioners, but instead tend to seek out physicians whose philosophies coincide better with their own, has important implications for the Brickman et al. (1982) model. While help-giving may be undermined in the specific situation where attributional philosophies differ, the lack of help may eventually motivate individuals to go elsewhere for help. Rather than passively accept a less-than-adequate relationship, people who are motivated to get help may actively seek alternatives until a satisfactory solution is found.

Although this study design did not utilize a "control" group of normative weight respondents, the answers of the fat respondents were compared to national data norms on a number of different physician-related items. While there are some problems with directly comparing the present study participants to the national population (because of background differences, and the fact that the present study participants were more self-selected) it is possible to make some comparisons, and to speculate on how differences might be explained by background characteristics. The present participants seemed to have a very similar profile of physician utilization to the national population. Yet, given their demographic characteristics, they should be expected to utilize health care even more than the general population -- they are much better educated and they are all women, two characteristics that tend to lead to higher health care usage (Safer, Tharps, Jackson, & Leventhal, 1979). Additionally, the current participants tend to consider themselves less healthy than the population at large does, and therefore should be expected to use health care even more (Bloom & Jack, 1985; Mugge, 1983; National Center for Health Statistics, 1987). Although speculative, these findings lend some support to the idea that fat people may avoid physicians more than those who are not fat.

It is likely that the poor medical treatment that fat individuals receive from physicians and the negative behavior that is directed toward them ultimately lead to poorer health. The findings that fat people are less healthy than those of normative weight may be partly caused by physician avoidance resulting from the emphasis physicians place on weight. This study has confirmed that fat people do avoid physicians because of reasons related to their weight. They report that they are often unable to be treated for their presenting symptoms and are often treated in a disrespectful manner by their physicians. These situations are particularly common for women who are fatter and can be compounded when the patient makes external attributions for her weight while the physician makes internal attributions.

This study has implications for other groups who are blamed for their medical conditions, most notably smokers and people with AIDS. It is likely that negative physician attitudes also interfere with the medical treatment of people in these groups, and that this may lead to physician avoidance, possibly resulting in poorer health effects in the long run.

Ways the Study Could Have Been Improved and Future Research Directions In This Area

The two groups used for this study differed in many ways. The Weight Watchers were older, weighed much less, were slightly less educated, were less likely to be fat as children, and by their own self-reports tended to come from families that were not terribly negative about their weight. It is possible that these factors, as well as other possible differences between the groups might have affected the results.

One of the reasons that few differences were found on the question of delay and avoidance of physician visits was that most questions focused only on the recent past. Questionnaires usually benefit from asking about a relatively recent time period (Sudman & Bradburn, 1982) because participants tend to have difficulty remembering accurately further back in time, depending upon the salience of the events. For this study, the interviews revealed that almost all participants eventually found a physician, and most were extremely pleased with their

physician. Since the questions referred to the recent past, there were few differences between the groups or between people at different weight levels because most people were satisfied with their medical care at the present time. Most of these questions, however, did not measure differences over a possible lifetime of mistreatment by the medical profession. The inclusion of more questions concerning difficult interactions with physicians in the past might have produced stronger results.

An important question to consider is whether, at any point in time, choosing twenty fat individuals to interview would have yielded a sample of people almost all of whom have physicians they are satisfied with. In other words, why is it that now the respondents report being generally happy with their physicians when many of them were not previously? If the study had been conducted ten or fifteen years ago, would the results have been different? The interviews seemed to reveal a metamorphosis among the NAAFans which took a long time in coming, and it is possible that because the size-acceptance movement is a fairly young social movement, and its members are maturing with it, that ten years ago the findings would have been very different. Years of being exposed to a new way of thinking about fatness, and receiving social support from others who believe similarly may have led NAAFans to eventually become more accepting of their bodies as they are, and to come to believe that they are deserving of proper health care at any size. Over time, NAAFans may have had a greater chance of finding a positive physician because other members, upon discovering a medical professional they liked, would refer other members to that person. Additionally, it may be that the medical profession is slowly changing its view of obesity; as a result of the increase in research, there may be more physicians in practice today who are open to believing that fatness is in part due to genetic/metabolic factors, therefore making it easier now for patients with the same philosophy to obtain a physician with similar views.

The study would have benefitted from well-established scales measuring attitudes toward physicians and willingness to seek health care, had such scales existed. Unfortunately, the rare scales which address attitudes toward physicians are not well-tested, and hence are probably not that reliable. Many existing scales that purport to measure attitudes toward physicians measure

attitudes toward one particular physician (e.g., Linn & Greenfield, 1982; Wolf, Putnam, James, & Stiles, 1978) and even these are not well-tested. The use of well-tested and established scales showing good reliability and validity would probably have led to stronger statistical results.

This research studied the issue of interaction between fat patients and their physicians only from the viewpoint of the patients. Physicians themselves were not studied, and inferences about their behavior were drawn from the words and opinions of the research participants. It is possible that participants' feelings and perceptions about weight influenced how they view medical practitioners' behavior. While the point of view of the participant is the most important and valid way of knowing how the physician-patient interaction affects the feelings and behaviors of the patient regarding this relationship, it remains to be seen how veridical the participants' impressions are of actual physician behavior toward them. Research studying the physicians themselves might present a different picture. Research has already shown physicians' attitudes to be negative toward fat people (Blumberg & Mellis, 1985; Breytspraak, McGee, Conger, Whatley, & Moore, 1977; Goodman, Richardson, Dornbusch & Hastorf, 1963; Klein, Najman, Kohrman, & Munro, 1982; Maddox & Liederman, 1969; Maiman, Wang, Becker, Finlay, & Simonson, 1979; Mizrahi, 1986). It would be of interest to know whether physicians' *actual* behavior is different toward their fat patients. It is possible that, answering hypothetically, physicians feel great disdain for fat patients and do not want to treat them, but when confronted with a real person in their office they react with compassion, in a professionally responsible manner. Obviously, the strong correspondence between the findings of the interview phase of this study and that of attitude studies of physicians does not lend much credence to this possibility. Nevertheless, it would still be important to study actual physician behavior.

This study would have benefitted from a comparison with participants of normative weight. The results showing differences to be an effect of weight were most likely attenuated because only those above normative weight were included. It is likely that a significant result showing slightly fat people differing from very fat people would show even stronger significance levels if a wider range of weights had been included. This study, in essence, compared those who are

somewhat stigmatized with those who are very stigmatized. To measure the full effect of stigmatization on the physician-patient interaction it would be important to be able to compare stigmatized individuals with those who are not stigmatized at all. It is possible that those who are not fat avoid physicians equally, but for different reasons; that is, instead of weight being a reason that they avoid physician visits, normative weight people may state an equivalent number of other reasons for which they avoid physician visits. Research should also be conducted which reanalyzes national data on physician utilization, looking at weight as an independent variable.

While this study showed that Weight Watchers tended to feel that their physician's comments about their weight were appropriate, it would be important to know whether fat people who are not presently dieting, but who have the philosophy that they are responsible for their weight, would feel similarly. It may be the act of dieting itself, and not one's attribution of responsibility, that makes one more open to hearing about the importance of dieting on health from physicians.

Another way in which this study could have been improved would have been to have written study respondents with varying philosophies from the same population of participants, preferably a population not chosen from a self-help organization. In this way, an analysis of philosophy would have had fewer intervening variables by which people differed, and any characteristics that make group-joiners unique would be eliminated or be able to be controlled for. It is possible that individuals motivated to join self-help groups are those who are more likely to seek help of all kinds, including health care. In addition, people who are motivated to seek the support of a self-help group, whether to lose weight, or to get support from similarly stigmatized others, may be those who feel worthy of trying to improve their situation and therefore may be starting out with higher self-esteem to begin with than those who would not join a group.

Because the current study focused on women only, and included few minorities, it is important for future studies to investigate how fat men and fat people who are non-white interact with their physicians, and whether they tend to delay physician visits because of their weight. While fat men are less stigmatized because of weight (Allon, 1982; Dwyer, Feldman, & Mayer,

1970; Millman, 1980; Wadden & Stunkard, 1985; Wooley, Wooley, & Dyrenforth, 1979), they are believed to more at risk for health problems (Ernsberger, 1984; Zegman, 1983). It would be interesting to see how these two factors play out against each other in the medical arena. In the United States, more non-whites tend to fat than whites (Dawson, 1988; Najjar & Rowland, 1987). There is some tendency, at least among black women, to be content with one's body size at higher weights than whites are satisfied (Dawson, 1988). Studies might address what effect this higher satisfaction has on the physician-patient interaction, and whether the higher incidence of fatness among minorities influences the way in which physicians approach minority patients about their weight.

A crucial study in this area would be a longitudinal prospective study which examines whether fat people with current physicians who take their patient's needs seriously and who treat the patient with respect, actually show an improvement in health over time, in comparison to other fat people. Such a study might also examine whether supportive physicians who encourage lifestyle changes actually make an impact on their patients' health; that is, whether patients of such physicians would be more likely to engage in health-promoting behaviors such as exercise or eating a nutritionally-balanced diet for the sake of health, and whether their level of health actually improves as a result.

One area that was only peripherally addressed in this study was how individuals come to make the weight attributions that they ultimately make. Almost all of the NAAFA participants had been a Weight Watcher at some point in their lives, yet eventually became a member of an organization with a radically different philosophy. It would be interesting to study the process that people go through as they emerge from making internal attributions for their weight to making external attributions. Such a study would most likely have to be done retrospectively. It may be that people's weight philosophy orientation is not an entirely stable one; perhaps people fluctuate between internal and external attributions at various times in their lives depending upon their personal circumstances and the views of important people in their lives.

One might also study how it is that some physicians are more tolerant of a view of obesity that does not blame the patient. Examining how it is that some physicians come to feel this way while others are highly resistant to this idea would make an important and interesting study. The role of personal and familial weight history of the physicians and prior experience with fat patients should be taken into account in such a study.

It is imperative that the medical profession begin to focus energy toward viewing fat patients as deserving of appropriate medical care at any weight. Toward this end, it is important that accessible medical equipment be developed, and that existing inaccessible equipment be modified in order to increase accessibility to fat people. It is likely that efforts to make equipment more accessible to one segment of the population will afford others more access as well. For example, if an examination table could somehow be made easier to mount, for instance by using a pneumatic device to raise and lower the table, it would be easier not only for fat patients to get on, but also for individuals with various disabilities and for less mobile elderly people. If necessary, alternative equipment or procedures should be developed which would improve physical examinations of fat people. For example, perhaps using ultrasonography when necessary, in addition to palpation in gynecological exams of fat women, might prove worth doing. Efforts must be made to teach those in the medical profession *how* to examine fat patients appropriately, possibly using alternate methods.

Whether or not a patient chooses to or can successfully diet should not determine whether they get proper medical treatment; people over normative weight need proper health care, and deserve to be treated with dignity, regardless of their size. Prejudice against this stigmatized group should not be allowed to interfere with their getting appropriate medical care, delivered with respect, by knowledgeable physicians. Those in the health field must be made more sensitive to the needs of fat individuals, and to the futility and potential peril of waiting for a patient's weight loss before attempting to diagnose or combat a medical problem. The medical community must have up-to-date knowledge on what is known about the connection between fatness and health, the problems with various weight loss methods, the high recidivism rates

associated with them and the negative consequences with which they are associated. Medical professionals must be made to understand the psychological consequences of failed weight loss efforts, and their concomitant effect on a person's willingness to seek treatment for health concerns. If the medical profession is truly interested in improving the health of people who are above normative weight, efforts must be made at changing the way the profession deals with the issue of weight, rather than focusing on changing the patients.

Use of Different Methodologies

One of the most important strengths of this study was the fact that it utilized three different types of methodology to investigate the same question -- whether or not weight and attributional philosophy affect physician utilization. A questionnaire was used, followed by in-depth interviews of some of the questionnaire respondents. In addition, participant responses were compared to national norms. Each of these methods had different strengths and weaknesses, but together gave a more complete portrayal of the issue. The use of multiple methods is important in research because the use of only one method only may lead to false confidence in results (Webb, Campbell, Schwartz, & Sechrest, 1966). Using a mix of methodologies was particularly important in this study, because an attempt was made not only to simply see whether fatter people have lower utilization of health care, but to see what role their philosophical view of weight and responsibility had on this. The interviews were essential in order to understand how one's view of their weight impacted upon their relationships with physicians.

While the questionnaire gathered a large amount of data on many participants in a relatively short period of time, the interviews uncovered much richer data about what the lives of participants were like. By necessity, the questionnaire had to use pre-conceived ideas about what would be found, while the interviews left open the possibility of finding relationships that had not been previously anticipated. For example, while it had been expected that fat people would have had difficulties in dealing with physicians around the issue of weight, the interviews revealed that gynecologists in particular had been most difficult for fat women to deal with. Denial of

adequate birth control for these women was a strong finding from the interview phase of this study that had not been anticipated beforehand.

Since the interviews were conducted on relatively few participants, the results of the questionnaire helped to demonstrate that the behaviors and feelings that participants discussed during the interviews were shared by many of the people who filled out the questionnaire but were not interviewed. For example, the interviews revealed that those who were fatter had had worse experiences and interactions with physicians and appeared to have stronger negative feelings toward the medical profession because of these experiences. The questionnaire also found, overall, that those who were heavier had less positive attitudes. This lends more support to the finding, since it could be argued that the interview participants may have differed from each other in ways that were not controllable; by using multiple regression techniques on the questionnaire data, many of the background characteristics were able to be statistically controlled.

The interviews complemented the questionnaires by helping to explain some of the relationships and clarify some of the ambiguities found in the latter. For example, very few differences were found by weight or by group membership regarding avoidance of physician visits in the recent past. If only the questionnaire had been used, the conclusion would have been that no differences were evident. However, it became clear in the interviews that participants, particularly those who weighed more, generally had had very negative experiences with physicians; however, almost all participants eventually found a physician whom they liked. This interview finding helped clarify why no differences were evident on the questionnaire for the recent past, while there were some differences in length of relationship with physicians and attitudes toward physicians.

Although the questionnaire found differences between participants by weight and group membership, most of the findings were not very strong. The information that was shared by the interview participants, on the other hand, illustrated much more strongly the differences between participants, as well as the similarities. The qualitative data were able to give a much broader picture of what the lives of fat people are like, and what their experiences with the medical field are

like. Although the issue of physicians was specifically addressed in the interviews, using this methodology allowed a lot of rich data to be discovered regarding what it is like generally to live with the stigma of being fat.

The use of national data on health care utilization allowed some comparison between the participants in this study and the general population. Although the conclusions are speculative, this method allowed for comparison of those who are fat with those who, mostly, are not. It was discovered that while the study participants seemed to use health care about the same amount as those in the general population, the former perceive themselves to be less healthy, and therefore might be expected to use health care more. Comparing the study data from the questionnaires to these norms helps to further support the idea that the stigma of being fat may have an effect on physician utilization.

The use of various methodologies is important in attempting to broaden knowledge and get a more complete view of an issue. Those who conduct research on issues which may be affected by differences in people's ideologies would benefit from such a mix of methodologies.

Conclusion

This study has demonstrated not only that fat people's stigma interferes with their interactions with physicians, but that their philosophy about their stigma plays a role as well. While it appears that many fat people have experienced physicians being disrespectful toward them or ignoring their symptoms because of their weight, the person's viewpoint about this behavior impacts upon how they react to the behavior. Weight Watchers, who believe the fact that they are fat is their own "fault", tend to react to this behavior by feeling uncomfortable, yet still feel the physician's behavior is appropriate; NAAFA members are more likely to end the relationship when they encounter such behavior and to seek out another physician.

An interesting aspect of this research was the finding that the points of view of the stigmatized people seemed to be very different from the perspective of most of the people to whom they went for medical help. The fat participants live as stigmatized people, and understand

what having the stigma means to their lives. Almost all have tried to overcome the stigma, by losing weight, and have met with little success. Physicians, according to many of the participants, do not understand what it is like to live one's life as a fat person, nor do physicians understand the difficulties involved in attempting to lose weight. Physicians tend to oversimplify the issue, and to offer advice such as cutting down on calories, without a full understanding of what their patients' lives are like. Participants tended to feel that physicians do not understand much about weight loss, and have little success in helping their patients to lose weight, yet profess to be experts in this area. As outsiders, physicians are offering advice to people who understand the stigma from the inside. The philosophy about one's stigma mediates how people react to outsiders offering advice. The Weight Watchers, whose philosophy is similar to that of the establishment, tended to believe that the advice was correct, despite the fact that it does not work for them. These people continue to attempt to follow the advice, and to feel bad about themselves if the advice does not work. The NAAFArs, whose philosophy differs from the establishment philosophy, were more questioning and critical of the advice, and many eventually sought help from another source.

These findings could apply more broadly to other stigmatized groups of people who may have various outlooks on their stigma. For example, there is some controversy among disabled people about whether individuals with mobility impairments are better off working toward walking with difficulty using some sort of cane device, or using a wheelchair instead. Those who believe it is important to try to fit in with the mainstream, may feel it is worth the trouble and awkwardness to try to walk with a device to appear more "normal", while those who have a "disability rights" perspective are more likely to believe that a wheelchair is more functional, and would therefore opt to use one. If people with these two different perspectives were to be trained in a rehabilitation center where the emphasis might be on walking, it is likely that people with the philosophical outlook of the latter group would clash with that of rehabilitation personnel, and might lead to the rehabilitation needs of these people being ignored. However, similar to the way many NAAFArs left the physicians they were dissatisfied with, these disabled people might opt to find another

rehabilitation setting whose goals are more similar to their own. Future research might test whether these assumptions are true for this group.

Another example regarding disability is the clash in philosophies between people who believe that deaf people should be taught to use sign language versus those who believe deaf people should lip-read in order to fit in better with the hearing world. Despite the fact that it has been shown that even deaf people who are good lip-readers can only understand about one-third of the words that are spoken, this method of communication is emphasized in many education settings. Proponents of sign language should be expected to have more difficulty in a setting emphasizing the lip-reading method because their philosophy would clash with those of the educators. One situation was studied where deaf parents of deaf children banded together to fight a school system, in order to have their children educated using sign language, while other parents had been content to have their children learn to lip-read (Erting, 1985).

Among working women, some are more oriented toward a feminist point of view while others are not. Those who are feminist and find themselves in a work environment where men are favored with promotions and higher salaries will be likely to question this, and possibly to band together with other women to protest this treatment. Individually, feminist women who are unhappy in this setting may seek employment elsewhere. Other women, who do not have a feminist point of view, may believe that they are not being discriminated against because they are women; rather, they may believe that if they worked harder, or were more intelligent, they would be moving up in the organization. These women would be more likely to stay in the situation, and to continue trying to get ahead.

In all of these examples, there are people who belong to a stigmatized or minority group who accept the status quo and do not question the group in power, while others question the established methods and either remove themselves from the situation or attempt to change the situation, often by banding together with others who are similarly-minded.

Social scientists who study stigmatized groups, such as those discussed above, must be aware that individuals have different outlooks and ideas about their stigmas, and these views

mediate how they interact with others. Acknowledging the different viewpoints people have will greatly enhance these studies. If a researcher starts out with the assumption that the people in the group have a homogeneous way of thinking about their stigma, he/she will miss important information about how people's views affect their reactions to their environment. Research concerning people from stigmatized or minority groups must allow for these differences in perspective.

Table 1. Means and Standard Deviations for NAAFA Versus Weight Watcher Participants on Background Characteristics, and Associated T-values for the Differences Between the Means.

<u>Variable</u>	<u>NAAFA Participants</u>			<u>Weight Watcher Participants</u>			<u>T-value</u>
	(n)	(M)	(sd)	(n)	(M)	(sd)	
Age (in Years)	60	35.05	7.71	58	44.16	12.96	-4.66***
Personal Education (1 to 7, low to high)	60	5.55	1.02	58	5.09	1.49	1.98*
Mother's Education (1 to 7, low to high)	60	3.58	1.52	56	2.77	1.43	2.97**
Father's Education (1 to 7, low to high)	58	3.59	1.91	55	2.82	1.84	2.18*
Health Status (1 to 5, excellent to poor)	60	2.38	0.90	58	2.51	0.80	-0.85
Number of Days Ill Over Past Year ^b	59	19.73	54.93	55	9.73	20.88	1.27
Number of Bed Days Over Past Year ^b	59	8.83	21.20	56	5.39	9.48	1.11
Number of Hospital Days Over Past Year	60	2.18	11.68	55	0.84	2.57	0.84
Level of Health Insurance Coverage (0 to 3, low to high)	60	2.43	1.03	58	2.72	0.62	-1.85
Self-Esteem (10 to 50, low to high)	33	40.33	7.24	58	39.17	8.77	0.65
Political Leaning (1 to 9, liberal to conservative)	33	3.88	1.98	58	4.60	1.94	-1.70
Weight (in pounds)	60	300.38	67.69	58	201.93	31.38	10.08***
Body Mass Index	60	48.25	10.98	58	34.31	4.72	8.90***
Weight Perception (1 to 5, low to high)	60	4.80	0.51	58	4.74	0.48	0.64
Weight Philosophy (5 to 25, low to high responsibility/control)	33	13.36	5.06	58	21.34	3.35	-8.11***a

Table 1 (continued)

<u>Variable</u>	<u>NAAFA Participants</u>			<u>Weight Watcher Participants</u>			<u>T-value</u>
	(n)	(M)	(sd)	(n)	(M)	(sd)	
How Long on Current Diet (in days)	13	153.96	201.33	54	147.46	264.61	0.08
How Much Weight Lost From Highest Weight Ever (In BMI Units)	47	3.51	3.14	58	3.83	3.22	-0.51
Number of Days Restricted Food in Past Year	59	68.27	104.77	56	148.25	129.34	-3.65***
Age of Current Physician (in years)	27	44.30	10.04	47	53.00	10.20	-3.55**

*p< .05; **p<.01; ***p<.001

- a A separate variance estimate was used to determine the t-value, due to significantly different standard deviations between the two groups, in addition to dissimilar n's.
- b Note that while the numbers in this chart represent the true mean for this variable, subsequent regression analyses collapsed the highest numbers into one category, in order to minimize the inordinate influence of outliers on this variable.

Table 2. Means and Standard Deviations for Lower-Weight Versus Higher-Weight Participants^a on Background Characteristics, and Associated T-values for the Differences Between the Means.

Variable	Lower-Weight Participants			Higher-Weight Participants			T-value
	(n)	(M)	(sd)	(n)	(M)	(sd)	
Age (in Years)	59	42.78	12.74	59	36.27	9.17	3.19**
Personal Education (1 to 7, low to high)	59	5.20	1.46	59	5.44	1.08	-1.00
Mother's Education (1 to 7, low to high)	58	3.05	1.64	58	3.33	1.41	-0.97
Father's Education (1 to 7, low to high)	57	3.04	1.98	56	3.39	1.83	-1.00
Health Status (1 to 5, excellent to poor)	59	2.46	0.88	59	2.44	0.84	0.11
Number of Days Ill Over Past Year ^c	56	10.46	22.60	58	19.19	54.79	-1.10
Number of Bed Days Over Past Year ^c	56	6.96	19.39	59	7.34	13.56	-0.12
Number of Hospital Days Over Past Year	56	2.34	12.16	59	0.78	2.13	0.97
Level of Health Insurance Coverage (0 to 3, low to high)	59	2.75	0.60	59	2.41	1.04	2.17*
Self-Esteem (10 to 50, low to high)	56	39.84	8.53	35	39.20	7.81	0.36
Political Leaning (1 to 9, liberal to conservative)	56	4.36	2.00	35	4.31	1.95	0.10
Weight (in pounds)	59	198.63	24.71	59	305.36	64.44	-11.88***
Body Mass Index	59	32.98	2.44	59	49.82	9.66	-12.99***
Weight Perception (1 to 5, low to high)	59	4.66	0.54	59	4.88	0.42	-2.46*
Weight Philosophy (5 to 25, low to high responsibility/control)	56	20.41	4.52	35	15.31	5.73	4.72***

Table 2 (continued)

<u>Variable</u>	<u>Lower-Weight Participants</u>			<u>Higher-Weight Participants</u>			<u>T-value</u>
	(n)	(M)	(sd)	(n)	(M)	(sd)	
How Long on Current Diet (in days)	48	170.43	276.97	19	93.89	168.77	1.38 ^b
How Much Weight Lost From Highest Weight Ever (In BMI Units)	59	4.14	3.94	59	3.68	5.68	0.51
Number of Days Restricted Food in Past Year	57	149.00	129.72	58	66.16	102.67	3.80***
Age of Current Physician (in years)	46	51.91	10.88	28	46.39	10.28	2.16*

* $p < .05$; ** $p < .01$; *** $p < .001$

^a A median split was performed so that the 59 (out of a total of 118) participants having a Body Mass Index of less than 38.1 were considered to be in the lower-weight group, while the 59 other participants having a Body Mass Index of 38.1 or more were considered to be in the higher-weight group.

^b A separate variance estimate was used to determine the t-value, due to significantly different standard deviations between the two groups, in addition to dissimilar n's.

^c Note that while the numbers in this chart represent the true mean for this variable, subsequent regression analyses collapsed the highest numbers into one category, in order to minimize the inordinate influence of outliers on this variable.

Table 3. Means and Standard Deviations for NAAFA Versus Weight Watcher Participants on Physician-Related Outcome Variables, and Associated T-values for the Differences Between the Means.

<u>Variable</u>	<u>NAAFA Participants</u>			<u>Weight Watcher Participants</u>			<u>T-value</u>
	(n)	(M)	(sd)	(n)	(M)	(sd)	
Length of Time Has Current Physician (in years) [†]	45	6.35	7.22	47	9.45	8.27	-1.91
Length of Time Since Last Saw a Physician (in years) [†]	56	.61	1.03	50	.45	.81	0.92
Number of Times Saw Any Physician over the Past Year [†]	58	8.41	19.35	53	4.81	4.65	1.32
Number of Different Physicians Seen over the Past Five Years	60	3.32	2.35	56	3.23	1.78	0.22
Delay Between Time Thought Should See Physician and Actually Had Visit (in years) [†]	57	.14	.27	55	.31	.71	1.75
Likelihood of Visiting a Physician for Serious Symptoms (5 to 25, low to high)	59	20.52	4.98	56	22.41	3.75	-2.29*
Likelihood of Visiting a Physician for Non-Serious Symptoms (10 to 50, low to high)	57	20.60	8.99	52	22.27	8.68	-.99
Positive Attitudes Toward Physicians (7 to 35, low to high)	59	16.54	5.87	56	18.98	5.36	-2.32*
Negative Attitudes Toward Physicians (4 to 20, low to high)	58	13.26	3.61	57	13.26	3.45	-.01
Number of Weight-Related Reasons for Ever Avoiding Physician Visits	60	1.77	1.79	57	1.30	1.64	1.48

Table 3 (continued)

<u>Variable</u>	<u>NAAFA Participants</u>			<u>Weight Watcher Participants</u>			<u>T-value</u>
	(n)	(M)	(sd)	(n)	(M)	(sd)	
Number of Weight-Related Reasons for Avoiding Physician Visits Within the Past Year	60	.68	1.23	57	.79	1.25	-0.46
Number of Non-Weight-Related Reasons for Ever Avoiding Physician Visits	60	3.13	2.95	57	2.16	2.74	1.85
Number of Non-Weight-Related Reasons for Avoiding Physician Visits Within the Past Year	60	1.32	1.59	57	1.14	1.608	0.60

*p< .05; **p<.01; ***p<.001

† Note that while the numbers in this chart represent the true mean for this variable, subsequent regression analyses collapsed the highest numbers into one category, in order to minimize the inordinate influence of outliers on this variable.

Table 4. Means and Standard Deviations for Lower-Weight Versus Higher-Weight Participants^a on Physician-Related Outcome Variables, and Associated T-values for the Differences Between the Means.

Variable	Lower-Weight Participants			Higher-Weight Participants			T-value
	(n)	(M)	(sd)	(n)	(M)	(sd)	
Length of Time Has Current Physician (in years)^b	49	8.02	7.13	43	7.83	8.75	0.12
Length of Time Since Last Saw a Physician (in years)^b	51	0.45	0.83	57	0.62	1.02	-0.96
Number of Times Saw Any Physician over the Past Year^b	54	7.17	18.18	57	6.25	9.72	0.34
Number of Different Physicians Seen over the Past Five Years	57	3.18	1.84	59	3.37	2.30	-0.51
Delay Between Time Thought Should See Physician and Actually Had Visit (in years)^b	56	0.31	.70	56	0.14	.27	1.64
Likelihood of Visiting a Physician for Serious Symptoms (5 to 25, low to high)	56	22.36	4.35	58	20.57	4.51	2.15*
Likelihood of Visiting a Physician for Non-Serious Symptoms (10 to 50, low to high)	57	23.73	8.98	52	19.26	8.23	2.71**
Positive Attitudes Toward Physicians (7 to 35, low to high)	57	19.58	5.20	58	15.91	5.69	3.60***
Negative Attitudes Toward Physicians (4 to 20, low to high)	58	13.03	3.39	57	13.49	3.66	-0.69
Number of Weight-Related Reasons for Ever Avoiding Physician Visits	58	1.14	1.47	59	1.93	1.87	-2.55*

..

Table 4 (continued)

Variable	Lower-Weight Participants			Higher-Weight Participants			T-value
	(n)	(M)	(sd)	(n)	(M)	(sd)	
Number of Weight-Related Reasons for Avoiding Physician Visits Within the Past Year	58	0.74	1.21	59	0.73	1.27	0.05
Number of Non-Weight-Related Reasons for Ever Avoiding Physician Visits	58	2.09	2.65	59	3.22	3.00	-2.17*
Number of Non-Weight-Related Reasons for Avoiding Physician Visits Within the Past Year	58	1.09	1.52	59	1.37	1.66	-0.97

* $p < .05$; ** $p < .01$; *** $p < .001$

^a A median split was performed so that the 59 (out of a total of 118) participants having a Body Mass Index of less than 38.1 were considered to be in the lower-weight group, while the 59 other participants having a Body Mass Index of 38.1 or more were considered to be in the higher-weight group.

^b Note that while the numbers in this chart represent the true mean for this variable, subsequent regression analyses collapsed the highest numbers into one category, in order to minimize the inordinate influence of outliers on this variable.

Table 5. Percentages and Chi Square Values for NAAFA Versus Weight Watcher Participants on Selected Characteristics.

<u>Variable</u>	<u>NAAFA Participants</u>		<u>Weight Watcher Participants</u>		<u>df</u>	<u>Chi²</u>
	(%)	(n)	(%)	(n)		
Race					1	2.672
White	83%	50	71%	41		
Non-White or Mixed Race	17%	10	29%	17		
Religion					1	0.024
Christian	58%	19	59%	32		
Non-Christian	42%	14	41%	22		
Fat as a Child?					1	4.325*
Yes	82%	45	64%	36		
No	18%	10	36%	20		
Currently on a Reducing Diet					1	71.727 ***
Yes	22%	13	98%	57		
No	78%	47	2%	1		
Currently Smoke?					1	1.349
Yes	22%	13	14%	8		
No	78%	46	86%	50		
Ex-Smoker?					1	0.446
Yes	53%	18	45%	19		
No	47%	16	55%	23		
Has a Regular Physician					1	0.337
Yes	77%	46	81%	47		
No	23%	14	19%	11		
Regular Physician's Sex					1	0.100
Male	81%	35	79%	37		
Female	19%	8	21%	10		
Seen Other Types of Health Practitioners					1	0.084
Yes	37%	22	39%	22		
No	63%	38	61%	34		

*p<.05; **p<.01; ***p<.001

Table 6. Percentages and Chi Square Values for Lower-Weight Versus Higher-Weight Participants† on Selected Characteristics.

Variable	Lower-Weight Participants		Higher-Weight Participants		df	Chi ²
	(%)	(n)	(%)	(n)		
Race					1	0.048
White	76%	45	78%	46		
Non-White or Mixed Race	24%	14	22%	13		
Religion					1	0.001
Christian	58%	31	59%	20		
Non-Christian	42%	22	41%	14		
Fat as a Child?					1	4.325 *
Yes	64%	36	82%	45		
No	36%	20	18%	10		
Currently on a Reducing Diet					1	35.962 ***
Yes	86%	51	32%	19		
No	14%	8	68%	40		
Currently Smoke?					1	0.081
Yes	17%	10	19%	11		
No	83%	49	81%	47		
Ex-Smoker?					1	0.059
Yes	50%	20	47%	17		
No	50%	20	53%	19		
Has a Regular Physician					1	1.269
Yes	83%	49	75%	44		
No	23%	10	25%	15		
Regular Physician's Sex					1	0.179
Male	82%	40	78%	32		
Female	18%	9	22%	9		
Seen Other Types of Health Practitioners					1	0.278
Yes	40%	23	36%	21		
No	60%	34	64%	38		

*p< .05; **p<.01; ***p<.001

† A median split was performed so that the 59 (out of a total of 118) participants having a Body Mass Index of less than 38.1 were considered to be in the lower-weight group, while the 59 other participants having a Body Mass Index of 38.1 or more were considered to be in the higher-weight group.

Table 7. Regression Table for: **Self-Esteem**

Variables Entered^a	ΔR^2	F	B/Beta (t-value)^b
Age			.000/ .000 (t=-.001)
Mother's Education	.038	1.676	.948/ .155 (t=1.457)
Fat Child	.001	.116	-2.201/- .131 (t=-1.130)
Currently Dieting			1.501/ .089 (t=.739)
Weight Lost			.023/ .012 (t=.116)
Weight Perception			-5.346/- .349 (t=-3.106)**
Current Weight	.136	3.290*	-.045/- .066 (t=-.500)
Group Membership			-
No Significant Interactions ^c			-
R ²			.175
Adjusted R ²			.103
F			2.424*

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R² were included in the equation.

*p< .05; **p<.01; ***p<.001

Table 8. Regression Table for: **Weight Philosophy**

Variables Entered^a	ΔR^2	F	B/Beta (t-value)^b
Age			-.009/-.018 (t= -.212)
Mother's Education	.020	.860	.601/ .152 (t=1.954)
Fat Child	.005	.452	-.169/-.014 (t= -.164)
Politics	.078	7.215**	2.227/ .782 (t=2.736)**
Self-Esteem	.001	.058	.031/ .043 (t= .534)
Currently Dieting			-2.873/-.238 (t= -1.755)
Weight Lost			-.065/-.048 (t= -.620)
Weight Perception			-.109/-.010 (t= -.113)
Current Weight	.428	17.801***	-.043/-.088 (t= -.782)
Group Membership	.036	6.461*	9.507/ .819 (t=3.357)**
Politics X Group ^c	.026	4.849*	-1.042/-.770 (t= -2.202)*
R^2			.594
Adjusted R^2			.535
F			10.093***

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R^2 were included in the equation.

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 9. Regression Table for: Length of Time Has Current Physician

Variables Entered ^a	ΔR^2	E	B/Beta (t-value) ^b
Age			-.004/-.078 (t=-.610)
Mother's Education	.014	.562	.030/.083 (t=.748)
Fat Child	.078**	6.994**	.325/.265 (t=2.236)*
Days Ill			-.008/-.113 (t=-1.005)
Health Status			-.019/-.028 (t=-.244)
Insurance Level			.043/.064 (t=.600)
Has Regular Physician ^d			
Current Smoker	.029	.643	-.072/-.050 (t=-.444)
Currently Dieting			.478/.420 (t=2.474)* ^e
Weight Lost			.013/.109 (t=.951)
Weight Perception			.007/.006 (t=.055)
Current Weight	.008	.166	.004/.084 (t=.563)
Group Membership	.141***	13.943***	.790/.707 (t=3.734)***
No Significant Interactions ^c			-
R^2			.271
Adjusted R^2			.149
F			2.228*

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R^2 were included in the equation.

^d This variable was not included in this regression equation, because the dependent variable applied only to those with a regular physician.

^e This variable had a significant b-weight in the final equation, although the block was not significant. The regression equation was subsequently rerun, entering this variable alone in the block; it did not contribute significantly to the R^2 .

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 10. Regression Table for: Length of Time Since Last Saw a Physician

Variables Entered ^a	ΔR^2	F	B/Beta (t-value) ^b
Age			-.006/-.127 (t=-1.217)
Mother's Education	.042	2.167	.020/ .062 (t=.652)
Fat Child	.011	1.172	.052/ .047 (t=.494)
Days Ill			-.018/-.301 (t=-3.202)**
Health Status			-.129/-.215 (t=-2.274)*
Insurance Level			-.036/-.065 (t=-.718)
Has Regular Physician			.192/ .578 (t=1.727)
Current Smoker	.206	5.213***	-.122/-.095 (t=-1.015)
Currently Dieting			-
Weight Lost			-
Weight Perception			-
Current Weight			-
Group Membership			-
No Significant interactions ^c			-
R ²			.258
Adjusted R ²			.195
F			4.094***

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R² were included in the equation.

*p<.05; **p<.01; ***p<.001

Table 11. Regression Table for: **Number of Times Saw Any Physician over the Past Year**

<u>Variables Entered</u> ^a	<u>ΔR^2</u>	<u>E</u>	<u>B/Beta (t-value)</u> ^b
Age			.022/ .055 (t=.609)
Mother's Education	.034	1.788	.161/ .055 (t=.672)
Fat Child	.056	6.180*	-1.588/-.159 (t=-1.944)
Days Ill			.274/ .492 (t=6.052)***
Health Status			1.196/ .216 (t=2.644)*
Insurance Level			.244/ .046 (t=.588)
Has Regular Physician			-1.629/-.147 (t=-1.864)
Current Smoker	.354	12.193***	.659/ .057 (t=.708)
Currently Dieting			-
Weight Lost			-
Weight Perception			-
Current Weight			-
Group Membership			-
No Significant Interactions ^c			-
R^2			.443
Adjusted R^2			.397
F			9.552***

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R^2 were included in the equation.

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 12. Regression Table for: **Number of Different Physicians Seen over the Past Five Years**

<u>Variables Entered</u> ^a	ΔR^2	E	<u>B/Beta (t-value)</u> ^b
Age			.003/ .179 (t=1.727)
Mother's Education	.009	.473	.001/ .007 (t=.081)
Fat Child	.136	16.652***	-.162/-.352 (t=-3.716)***
Days Ill			.005/ .189 (t=2.055)*
Health Status			.039/ .148 (t=1.609)
Insurance Level			-.026/-.108 (t=-1.240)
Has Regular Physician			-.026/-.050 (t=-.576)
Current Smoker	.134	3.715**	.479/ .882 (t=3.310)**
Currently Dieting			-.078/-.184 (t=-1.311)
Weight Lost			-.005/-.117 (t=-1.246)
Weight Perception			-.015/-.034 (t=-.372)
Current Weight	.020	.677	-.001/-.079 (t=-.639)
Group Membership	.008	1.074	.413/ .982 (t=2.161)*
Smoke X Group ^c	.050	7.321**	-.268/-1.434 (t=-2.706)**
R ²			.356
Adjusted R ²			.260
F			3.717***

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R² were included in the equation.

*p<.05; **p<.01; ***p<.001

Table 13. Regression Table for: **Likelihood of Visiting a Physician for Serious Symptoms**

<u>Variables Entered</u> ^a	ΔR^2	F	<u>B/Beta (t-value)</u> ^b
Age			.125/ .302 (t=3.113)**
Mother's Education	.084	4.845**	.249/ .083 (t=.853)
Fat Child			-
Days Ill			-
Health Status			-
Insurance Level			-
Has Regular Physician			-
Current Smoker			-
Currently Dieting			-
Weight Lost			-
Weight Perception			-
Current Weight			-
Group Membership			-
No Significant Interactions ^c			-
R^2			.084
Adjusted R^2			.067
F			4.845**

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R^2 were included in the equation.

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 14. Regression Table for: **Likelihood of Visiting a Physician for Non-Serious Symptoms**

<u>Variables Entered</u> ^a	ΔR^2	E	<u>B/Beta (t-value)</u> ^b
Age			.197/ .246 (t=2.470)*
Mother's Education	.063	3.403*	-.103/-.017 (t=-.172)
Fat Child			-
Days Ill			-
Health Status			-
Insurance Level			-
Has Regular Physician			-
Current Smoker			-
Currently Dieting			-
Weight Lost			-
Weight Perception			-
Current Weight			-
Group Membership			-
No Significant Interactions ^c			-
R ²			.063
Adjusted R ²			.045
F			3.403*

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R² were included in the equation.

*p<.05; **p<.01; ***p<.001

Table 15. Regression Table for: **Positive Attitudes Toward Physicians**

<u>Variables Entered</u> ^a	ΔR^2	E	<u>B/Beta (t-value)</u> ^b
Age			.048/ .092 (t=.823)
Mother's Education	.026	1.376	-.173/-.045 (t= -.442)
Fat Child	.002	.247	-1.359/-.106 (t=-1.019)
Days Ill			.023/ .032 (t=.307)
Health Status			-.698/-.100 (t=-.996)
Insurance Level			.630/ .095 (t=.968)
Has Regular Physician			-1.311/-.094 (t=-.963)
Current Smoker	.065	1.417	-.666/-.046 (t=-.451)
Currently Dieting			-.278/-.024 (t=-.203)
Weight Lost			.192/ .152 (t=1.471)
Weight Perception			.538/ .043 (t=.424)
Current Weight	.087	2.513*	-.145/-.274 (t=-2.175)* ^d
Group Membership			-
No Significant Interactions ^c			-
R ²			.180
Adjusted R ²			.076
F			1.733

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R² were included in the equation.

^d Although this variable added significantly to R² and had a significant b-weight, the overall regression equation was not significant. The regression equation was subsequently rerun, entering this variable alone in the block. It contributed significantly to the R² ($\Delta R^2=.066$; $F=7.684$; $p=.007$), and the resulting R² for the equation was significant ($R^2=.159$; $F=2.055$; $p=.041$).

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 16. Regression Table for: **Weight-Related Reasons for Ever Avoiding Physician Visits**

<u>Variables Entered</u> ^a	ΔR^2	F	<u>B/Beta (t-value)</u> ^b
Age			-.006/-.214 (t=-2.223)*
Mother's Education	.063	3.626*	.017/ .086 (t=.891)
Fat Child			-
Days Ill			-
Health Status			-
Insurance Level			-
Has Regular Physician			.d
Current Smoker			-
Currently Dieting			-
Weight Lost			-
Weight Perception			-
Current Weight			.e
Group Membership			-
No Significant Interactions ^c			-
R ²			.063
Adjusted R ²			.046
F			3.626*

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R² were included in the equation.

^d This variable had a significant b-weight when all variables were entered, although the block was not significant. The regression equation was subsequently rerun, entering this variable alone in the block. It contributed significantly to the R² ($\Delta R^2=.035$; $F=4.189$; $p=.043$).

^e This variable had a significant b-weight when all variables were entered, although the block was not significant. The regression equation was subsequently rerun, entering this variable alone in the block. It contributed significantly to the R² ($\Delta R^2=.047$; $F=5.878$; $p=.017$).

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 17. Regression Table for: **Weight-Related Reasons for Avoiding Physician Visits Within the Past Year**

<u>Variables Entered</u> ^a	ΔR^2	F	<u>B/Beta (t-value)</u> ^b
Age			-.004/-.175 (t=-1.748)
Mother's Education	.014	.744	-.004/-.022 (t=-.229)
Fat Child	.043	4.923*	.116/ .215 (t=2.219)* ^d
Days Ill			-
Health Status			-
Insurance Level			-
Has Regular Physician			.0 ^e
Current Smoker			-
Currently Dieting			-
Weight Lost			-
Weight Perception			-
Current Weight			-
Group Membership			-
No Significant Interactions ^c			-
R ²			.057
Adjusted R ²			.030
F			2.155

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R² were included in the equation.

^d Although this variable added significantly to R² and had a significant b-weight, the overall regression equation was not significant.

^e This variable had a significant b-weight when all variables were entered, although the block was not significant. The regression equation was subsequently rerun, entering this variable alone in the block. It contributed significantly to the R² ($\Delta R^2=.056$; $F=6.726$; $p=.011$), and the resulting R² for the equation was significant ($R^2=.105$; $F=3.165$; $p=.017$).

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 18. Regression Table for: **Non-Weight-Related Reasons for Ever Avoiding Physician Visits**

<u>Variables Entered</u> ^a	ΔR^2	E	<u>B/Beta (t-value)</u> ^b
Age			-.010/-.354 (t=-3.792)***
Mother's Education	.124	7.643***	-.001/-.006 (t=-.064)
Fat Child			-
Days Ill			-
Health Status			-
Insurance Level			-
Has Regular Physician			-
Current Smoker			-
Currently Dieting			-
Weight Lost			-
Weight Perception			-
Current Weight			.d
Group Membership			-
No Significant Interactions ^c			-
R ²			.124
Adjusted R ²			.108
F			7.643***

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R² were included in the equation.

^d This variable had a significant b-weight when all variables were entered, although the block was not significant. The regression equation was subsequently rerun, entering this variable alone in the block. It contributed significantly to the R² ($\Delta R^2=.033$; $F=4.209$; $p=.043$).

* $p<.05$; ** $p<.01$; *** $p<.001$

Table 19. Regression Table for: **Non-Weight-Related Reasons for Avoiding Physician Visits Within the Past Year**

<u>Variables Entered</u> ^a	ΔR^2	E	<u>B/Beta (t-value)</u> ^b
Age			-.006/-.229 (t=-2.233)*
Mother's Education	.077	4.530*	.002/ .011 (t=.120)
Fat Child	.015	1.778	.072/ .118 (t=1.256)
Days Ill			.001/ .025 (t=.260)
Health Status			.023/ .069 (t=.737)
Insurance Level			-.034/-.108 (t=-1.198)
Has Regular Physician			.170/ .259 (t=2.852)**
Current Smoker	.103	2.625*	-.118/-.168 (t=-1.798)
Currently Dieting			-
Weight Lost			-
Weight Perception			-
Current Weight			-
Group Membership			-
No Significant Interactions ^c			-
R^2			.196
Adjusted R^2			.133
F			3.107**

^a Variables were entered into the equation in the order they are presented here.

^b Numbers in this column represent the unstandardized (b) regression coefficients, the standardized (beta) coefficients, and the associated t-value for the coefficient, with all variables entered in the equation.

^c Only interaction terms which added significantly to R^2 were included in the equation.

*p<.05; **p<.01; ***p<.001

Table 20. Relative Strength of Independent Variables *Weight Philosophy* and *Group Membership* in Predicting Dependent Variables, Based on Order of Entry Into Regression Equation

	<u>Order of Entry of Variables</u>			
	<u>Weight Philosophy^a</u>	<u>Group</u>	<u>Group^b</u>	<u>Weight Philosophy</u>
Self-Esteem	N.S. ^c	N.S.	N.S.	N.S.
Length of Time Has Current Physician	$\Delta R^2=.064^*$ $F=5.11^*$	N.S.	$\Delta R^2=.075^*$ $F=5.99^*$	N.S.
Length of Time Since Last Saw a Physician	N.S.	N.S.	N.S.	N.S.
Number of Times Saw Any Physician over the Past Year	N.S.	N.S.	N.S.	N.S.
Number of Different Physicians Seen over the Past Five Years	N.S.	N.S.	N.S.	N.S.
Likelihood of Visiting a Physician for Serious Symptoms	N.S.	N.S.	N.S.	N.S.
Likelihood of Visiting a Physician for Non-Serious Symptoms	N.S.	N.S.	N.S.	N.S.
Positive Attitudes Toward Physicians	$\Delta R^2=.081^{**}$ $F=7.71^{**}$	N.S.	N.S.	$\Delta R^2=.052^*$ $F=3.86^*$
Wt-Related Reasons Ever Avoided	N.S.	N.S.	N.S.	N.S.
Wt-Related Reasons Avoided Past Year	N.S.	N.S.	N.S.	N.S.
Non-Wt-Related Reasons Ever Avoided	$\Delta R^2=.063^*$ $F=5.95^*$	N.S.	$\Delta R^2=.069^*$ $F=6.56^*$	N.S.
Non-Wt-Related Reasons Avoided Past Year	N.S.	N.S.	N.S.	N.S.

^a *Weight Philosophy* is entered into regression equation first, followed by *Group Membership*.

^b *Group Membership* is entered into regression equation first, followed by *Weight Philosophy*.

^c Not Significant.

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 21. **Relative Strength of Independent Variables *Weight (Body Mass Index)* and *Group Membership* in Predicting Dependent Variables, Based on Order of Entry into Regression Equation**

	<u>Order of Entry of Variables</u>			
	<u>Weight^a</u>	<u>Group</u>	<u>Group^b</u>	<u>Weight</u>
Self-Esteem	N.S. ^c	N.S.	N.S.	N.S.
Weight Philosophy	$\Delta R^2 = .288^{***}$ $F = 36.06^{***}$	$\Delta R^2 = .208^{***}$ $F = 43.37^{***}$	$\Delta R^2 = .479^{***}$ $F = 81.74^{***}$	N.S.
Length of Time Has Current Physician	N.S.	$\Delta R^2 = .043^*$ $F = 3.97^*$	$\Delta R^2 = .081^{**}$ $F = 7.97^{**}$	N.S.
Length of Time Since Last Saw a Physician	N.S.	N.S.	N.S.	N.S.
Number of Times Saw Any Physician over the Past Year	$\Delta R^2 = .036^*$ $F = 4.08^*$	N.S.	N.S.	$\Delta R^2 = .039^*$ F is N.S.
Number of Different Physicians Seen over the Past Five Years	N.S.	N.S.	N.S.	$\Delta R^2 = .034^*$ F is N.S.
Likelihood of Visiting a Physician for Serious Symptoms	N.S.	$\Delta R^2 = .053^*$ $F = 3.30^*$	$\Delta R^2 = .045^{**}$ $F = 5.23^*$	N.S.
Likelihood of Visiting a Physician for Non-Serious Symptoms	N.S.	N.S.	N.S.	N.S.
Positive Attitudes Toward Physicians	$\Delta R^2 = .086^{**}$ $F = 10.63^{**}$	N.S.	$\Delta R^2 = .045^*$ $F = 5.40^*$	$\Delta R^2 = .042^*$ $F = 5.36^{**}$
Wt-Related Reasons Ever Avoided	$\Delta R^2 = .072^{**}$ $F = 8.99^{**}$	N.S.	N.S.	$\Delta R^2 = .055^*$ $F = 4.58^*$
Wt-Related Reasons Avoided Past Year	N.S.	N.S.	N.S.	N.S.
Non-Wt-Related Reasons Ever Avoided	$\Delta R^2 = .078^{**}$ $F = 9.79^{**}$	N.S.	$\Delta R^2 = .047^*$ $F = 5.66^*$	$\Delta R^2 = .034^*$ $F = 5.02^*$
Non-Wt-Related Reasons Avoided Past Year	N.S.	N.S.	N.S.	N.S.

^a Weight is entered into regression equation first, followed by Group Membership.

^b Group Membership is entered into regression equation first, followed by Weight.

^c Not Significant.

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 22. Summary Regression Table

Variables Entered ^a

	Self-Esteem	Weight Philosophy	Length of Time Has Current Physician	Time Since Last Saw a Physician	Times Saw any Physician	Number of Different Physicians Seen	Likelihood of Visiting for Serious Symptoms	Likelihood of Visiting for Non-Serious Symptoms	Positive Attitudes Toward Physicians	Wt-Related Reasons for Avoiding (ever)	Wt-Related Reasons (past year)	Non-Wt-Related Reasons for Avoiding (ever)	Non-Wt-Related Reasons (past year)
Age							::	.				::	.
Mother's Education													
Fat Child			.			...					.		
Politics	-	::	-	-	-	-	-	-	-	-	-	-	-
Self-Esteem	-		-	-	-	-	-	-	-	-	-	-	-
Days Ill	-	-		..	...	.							
Health Status	-	-		.	.								
Insurance Level	-	-											
Has Regular Physician	-	-	-							.	.		..
Current Smoker	-	-				..							
Currently Dieting													
Weight Lost													
Weight Perception	..												
Current Weight									..	.		.	
Group Membership		..	...			.							
Interactions		.b				..c							

^ap<.05; **p<.01; ***p<.001 (for the b and beta weights in the final equations)

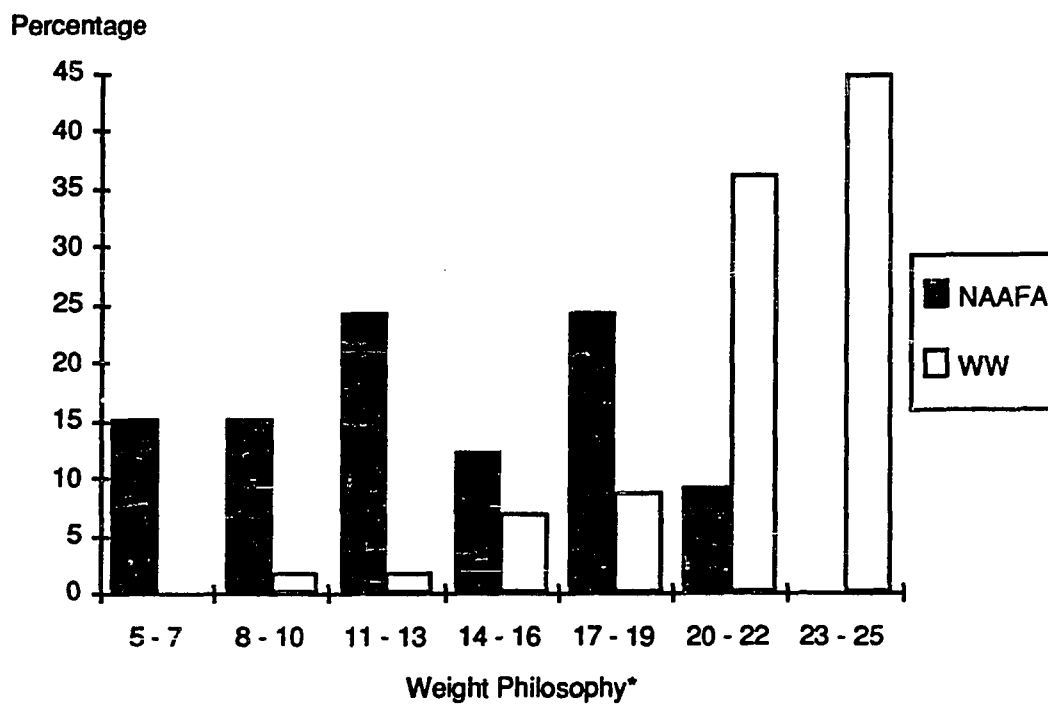
Table 22 (continued)

^a Variables were entered into the equation in the order they are presented here. Note that regression equations for the variables Self-Esteem and Weight Philosophy did not include the health-related variables; Length of Time Has Current Physician did not include Has Regular Physician; and Weight Philosophy did include the variables Politics and Self-Esteem, while the others did not. See text for an explanation of the inclusion or exclusion of these independent variables.

^b Politics by Group

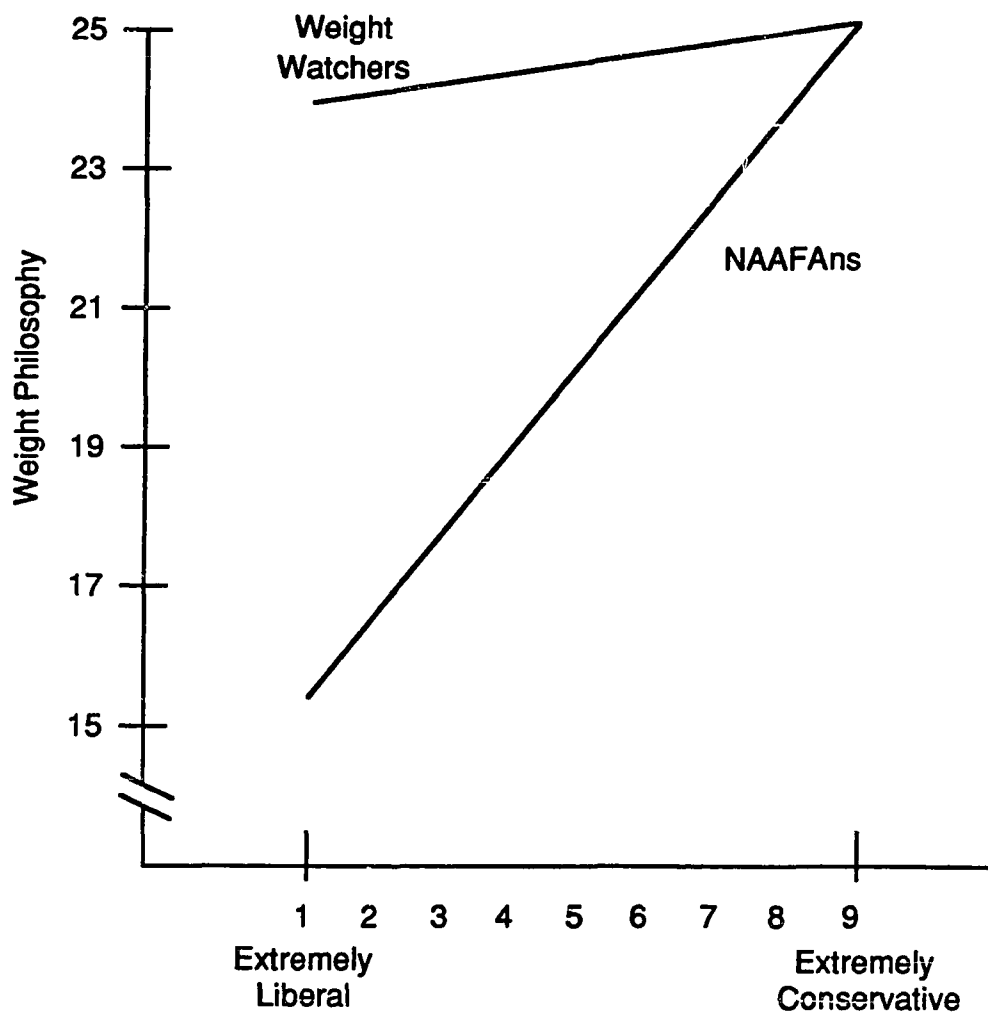
^c Current Smoker by Group

Figure 1. Percentage of NAAFA's Versus Weight Watchers By Level of Weight Philosophy



* Higher numbers indicate a belief of having more responsibility/control.

Figure 2. Interaction Between Group Membership and Political Leaning on Weight Philosophy*



* Higher numbers for Weight Philosophy represent a belief in greater personal responsibility and control over weight.

Figure 3. Interaction Between Smoking Status and Group Membership on the Number of Physicians Seen over the Past Five Years. (For the purpose of graphing, numbers assume participants to have been fat as children)

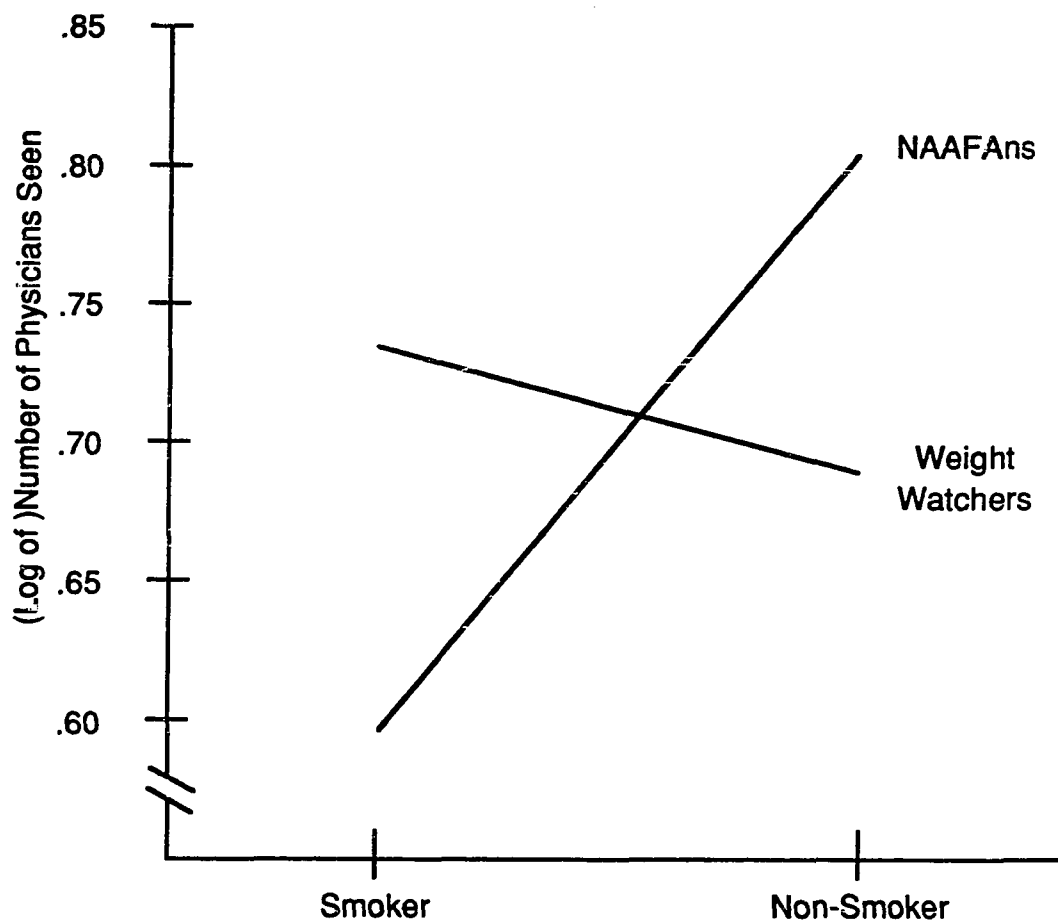


Figure 4. Percentage of Women in the General U.S. Population (National Health Interview Survey) versus NAAFAs and Weight Watchers Who Consider Themselves to be in Excellent, Very Good, Good, Fair and Poor Health



Appendix A - Final Questionnaire

This questionnaire contains questions about people's health, and about how people feel about visiting medical doctors. This questionnaire is voluntary and your answers will be kept confidential.

This research is being conducted as part of a doctoral dissertation by:

**Jaclyn Packer
Social/Personality Psychology Program
Graduate School of the City University of New York
33 West 42 Street
New York, NY 10036
(212) 642-2506**

Please answer the questions below by checking or circling the appropriate response, or filling in the information requested. All information on this questionnaire will remain confidential.

1. Would you say your health in general is:

excellent ☐
 very good ☐
 good ☐
 fair ☐
 poor ☐

2. Do you have a particular medical doctor whom you could call or visit if you needed medical advice or a checkup? (If this applies to more than one doctor, please answer this question for the doctor you have known the longest time).

Yes ☐ No ☐ (Go To Q. 3)

If yes:

What is your doctor's specialty? (For example: General Practitioner, Gynecologist, Internist, etc.) If you don't know, write "Don't Know".

Approximately how long has he or she been your physician?

Is your doctor male or female? Male ☐ Female ☐

What is your physician's approximate age? (If you're not sure, please make your best guess.) _____ years old

3. During the past twelve months, about how many times did you see any medical doctor about your health? (Count each visit separately, even if it was for the same problem/symptom). _____ times (indicate number)
4. About how long has it been since you last saw a medical doctor about your health? _____ years _____ months (indicate number)
5. For this last visit with a doctor, approximately how much time passed between the time you thought you ought to see a doctor until you actually saw him or her? _____ months _____ days (indicate number)
6. During the past five years, approximately how many different medical doctors have you seen about your health? _____ medical doctors (indicate number)
7. During the past five years, have you seen people other than a medical doctor about your health (such as a chiropractor, nutritionist, acupuncturist, nurse practitioner, midwife, etc.)?

Yes ☐ No ☐ (Go to Q. 8)

If yes, what types of people have you seen?

8. Do you have health insurance for yourself that covers:

medical checkups by doctors?	Yes ☐	No ☐
doctor visits other than checkups?	Yes ☐	No ☐
hospital stays?	Yes ☐	No ☐
health services by people other than medical doctors?	Yes ☐	No ☐

9. People frequently experience health problems or symptoms for which they might like to see a doctor, but do not for some reason. Listed below are some common reasons that people do not see a doctor, even if they have a problem with their health. Please indicate below whether each of these reasons has ever kept you from seeing a doctor and whether each has kept you from seeing a doctor during the past twelve months.

Ever Kept You From Seeing a Doctor	Kept You From Seeing a Doctor During the Past 12 Months	
☐	☐	I lacked confidence in available doctors
☐	☐	I didn't have time
☐	☐	I would be rushed in and out of the office
☐	☐	I felt it would cost too much
☐	☐	I had gained weight since my last visit
☐	☐	I couldn't get an appointment
☐	☐	I would have to travel too far
☐	☐	I didn't have a way to get there
☐	☐	I didn't want to get weighed on the doctor's scale
☐	☐	I was afraid of finding out what was wrong
☐	☐	I didn't have anyone to care for children or other family members
☐	☐	I felt I could get rid of the problem myself, by losing weight
☐	☐	I would have to wait too long in the waiting room
☐	☐	I didn't want to get undressed in the doctor's office
☐	☐	I was afraid of experiencing pain
☐	☐	I would be given unnecessary medical tests
☐	☐	I would be told to stop smoking
☐	☐	I would be told to lose weight
☐	☐	Other reasons not listed:
☐	☐	_____
☐	☐	_____
☐	☐	_____
☐	☐	_____

10. During the past twelve months, about how many days did illness or injury keep you from performing your normal activities (for example, work, school, homemaking)?
_____ days (indicate number)
11. During the past twelve months, about how many days did illness or injury keep you in bed all or most of the day?
_____ days (indicate number)
12. During the past twelve months, about how many days were you a patient overnight in a hospital?
_____ days (indicate number)

13. We are interested in how likely people are to make an appointment with a medical doctor when they experience certain symptoms. Listed below are health problems which people might experience. Imagine that you have been experiencing each of the following symptoms for one week. Please indicate how likely it is that you would call a medical doctor for an appointment. (Please consider each symptom separately.)

	<u>Very Unlikely</u>			<u>Very Likely</u>	
Pain in legs while walking	1	2	3	4	5
Shortness of breath	1	2	3	4	5
Blood in urine	1	2	3	4	5
Fatigue	1	2	3	4	5
Loss of sight in one eye	1	2	3	4	5
Back ache	1	2	3	4	5
Chest pain	1	2	3	4	5
Fever	1	2	3	4	5
Diarrhea	1	2	3	4	5
Sore throat	1	2	3	4	5
Headache	1	2	3	4	5
Fainting	1	2	3	4	5
Cough	1	2	3	4	5
Loss of feeling in an arm	1	2	3	4	5
Leg cramps	1	2	3	4	5
Trouble sleeping	1	2	3	4	5
Heat rash	1	2	3	4	5
Runny nose	1	2	3	4	5

14. For the following items, please indicate below how well each statement describes you:

	Doesn't describe <u>me at all</u>					Describes me <u>very well</u>				
On the whole, I am satisfied with myself.	1	2	3	4	5					
At times I think I am no good at all.	1	2	3	4	5					
I feel that I have a number of good qualities.	1	2	3	4	5					
I am able to do things as well as most other people.	1	2	3	4	5					
I feel I do not have much to be proud of.	1	2	3	4	5					
I certainly feel useless at times.	1	2	3	4	5					
I feel that I am a person of worth, at least on an equal basis with others.	1	2	3	4	5					
I wish I could have more respect for myself.	1	2	3	4	5					
All in all, I am inclined to feel that I am a failure.	1	2	3	4	5					
I take a positive attitude toward myself.	1	2	3	4	5					

15. Using the following scale, how would you rate your own political views?

Extremely Liberal	1	2	3	4	5	6	7	8	9	Extremely Conservative
----------------------	---	---	---	---	---	---	---	---	---	---------------------------

16. People say some good things and bad things about doctors and medical care. From your experiences, please indicate below how much you agree or disagree with the following statements:

	<u>Strongly Disagree</u>			<u>Strongly Agree</u>	
Doctors spend as much time as necessary with each patient.	1	2	3	4	5
Most doctors are able to improve your health.	1	2	3	4	5
Doctors should be a little more friendly than they are.	1	2	3	4	5
Most doctors do not care how medical procedures personally affect you.	1	2	3	4	5
Patients receive nothing but the best care from their doctors.	1	2	3	4	5
Many doctors don't care whether or not they hurt you.	1	2	3	4	5
Doctors don't care how long the patients have to wait.	1	2	3	4	5
Most doctors take a real interest in their patients.	1	2	3	4	5
When a doctor gets through treating you, you are likely to feel worse than before.	1	2	3	4	5
In an emergency, you can always get a doctor.	1	2	3	4	5
Doctors clearly explain what is wrong before giving you treatment.	1	2	3	4	5
Doctors teach patients how to prevent sickness and accidents.	1	2	3	4	5
It is easier to go to the drug store for medicine than to bother with a doctor.	1	2	3	4	5
Most doctors let you talk out your problems.	1	2	3	4	5

17. In comparison to the weight that most people in the United States consider the "norm" for your height, do you consider your current weight to be:

below the "norm"	☐
just about at the "norm"	☐
a little above the "norm"	☐
somewhat above the "norm"	☐
very much above the "norm"	☐

18. People have different ideas and experiences about their weight. Please indicate how much you agree or disagree with the following statements:

	<u>Strongly</u> <u>Disagree</u>				<u>Strongly</u> <u>Agree</u>
I feel personally responsible for whether or not I am above the "norm" on weight.	1	2	3	4	5
I feel personally responsible for getting down to a weight that is considered to be at the "norm".	1	2	3	4	5
I feel that I am able to lose enough weight to be considered at the "norm", and to keep it off permanently.	1	2	3	4	5
Being at the "norm" on weight is largely a matter of luck.	1	2	3	4	5
If I eat properly, and get enough exercise and rest, I can control my weight in the way I desire.	1	2	3	4	5

19. How old were you on your last birthday? _____ years
20. What is your sex? Male ☐ Female ☐
21. What is your race/ethnic background? Check as many as apply. (If none of the choices below represents how you identify yourself, please use the other category to indicate your race/ethnic background).
- | | | | |
|------------------------|--------------------------|------------------------------|--------------------------|
| Hispanic | ☐ | Black | ☐ |
| Asian/Pacific Islander | ☐ | Native American | ☐ |
| White/Caucasian | ☐ | Other (please specify) _____ | ☐ |
22. What is your religion? _____
23. What is your occupation? (If you are presently unemployed, or if you are a homemaker or student, please indicate this.)

24. What is the highest level of formal education you have obtained?
- | | | | |
|----------------------------|--------------------------|---|--------------------------|
| Elementary school or less | ☐ | Some college | ☐ |
| Some high school | ☐ | College graduate | ☐ |
| High school graduate | ☐ | Post graduate degree | ☐ |
| Vocational/Business school | ☐ | Other formal education (please specify) _____ | ☐ |
25. By the time you were 16 years old, what was the highest level of formal education your father had obtained? (If deceased before you were 16, indicate highest level ever obtained)
- | | | | |
|----------------------------|--------------------------|---|--------------------------|
| Elementary school or less | ☐ | Some college | ☐ |
| Some high school | ☐ | College graduate | ☐ |
| High school graduate | ☐ | Post graduate degree | ☐ |
| Vocational/Business school | ☐ | Other formal education (please specify) _____ | ☐ |
26. By the time you were 16 years old, what was the highest level of formal education your mother had obtained? (If deceased before you were 16, indicate highest level ever obtained)
- | | | | |
|----------------------------|--------------------------|---|--------------------------|
| Elementary school or less | ☐ | Some college | ☐ |
| Some high school | ☐ | College graduate | ☐ |
| High school graduate | ☐ | Post graduate degree | ☐ |
| Vocational/Business school | ☐ | Other formal education (please specify) _____ | ☐ |
27. How tall are you? _____ feet _____ inches
28. How much do you weigh? _____ pounds

29. If you have **ever** been heavier than your current weight (except while pregnant), how much did you weigh at your heaviest? _____ pounds

Approximately how long a period of time were you at that weight?

How long ago did you last weigh this amount?

30. Are you now on a reducing diet? Yes ☐ No ☐ (Go To Q. 31)

If yes:

How long have you been on it? _____

How much weight have you lost during this period of time? _____ pounds

31. Over the past year, approximately how many days (out of 365) would you say that you were attempting to reduce your food intake in order to lose weight? (If none, write "0") _____ days

32. When you were a child, did others consider you to be fat? Yes ☐ No ☐ Not Sure ☐

33. Do you currently smoke cigarettes? Yes ☐ No ☐

If yes: Approximately how many cigarettes a day? _____ cigarettes

If no: Did you smoke cigarettes in the past? Yes ☐ No ☐

Approximately how many cigarettes a day when you were smoking the most? _____ cigarettes

How long ago did you stop smoking? _____

Thank you for your time and cooperation!

Would you consider volunteering for an interview regarding health and the use of health care services?

Your cooperation would be greatly appreciated!

If you would be willing to consider volunteering for an interview*, please include your first name and telephone number below. By including the information below, you are under no obligation to participate in an interview if contacted later on, and are free to change your mind about participating at any time. All information will be totally confidential.

First Name _____

Telephone Number () _____ - _____
(please include area code)

* A modest payment will be given for interviews.

Thanks for your participation!

Appendix B - Purpose and Rationale for Questionnaire Items

- Q.1** This question was borrowed from two large national studies, the National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey (NHANES), and was used as a subjective indicator of health status for the purpose of matching for the interviews and as a possible covariate.
- Q.2** The stem of this question is adapted from NHANES and was used to compare the groups on whether or not they have a regular physician. Groups were compared on the length of time participants have had a relationship with their physician. Physician specialty, sex and age were included so that any differences could be taken into account.
- Q.3 - 5** These questions were included in order to get a rough measure of participants' willingness to see a physician. Question 3 was adapted from NHIS and NHANES, and Questions 4 and 5 were adapted from NHANES.
- Q.6** Controlling for health, this question provided a rough estimate of dissatisfaction with physicians--participants may have gone through a lot of different doctors before their current regular physician, or may have gone from doctor to doctor and still not have a regular physician.
- Q.7** This question was included in order to rule out the alternative explanation that one group sees physicians less because they see alternative medical professionals more.

- Q.8** Insurance information was collected to help rule out the alternative explanation that one group may see health professionals more often because they are covered by insurance.
- Q.9** This question was included in order to get a measure of whether people have actually avoided physician visits, and their reasons for avoidance. Many of the items included here are borrowed from a similar question on NHANES. Several weight-related items were added.
- Q.10-12** These questions were adapted from NHIS, and were used as objective indicators of health status for the purpose of matching for the interviews and were included to use as possible covariates.
- Q.13** The purpose of this scale was for participants to indicate how likely they would be to visit a physician for various symptoms. An effort was made to include very serious and very minor symptoms. This scale was changed somewhat after administering it to pilot test participants and conducting a factor analysis on the results (see Appendix C).
- Q. 14** This is the Rosenberg (1965) Self-Esteem Scale, adopted according to O'Brien (1985), who made a minor change to one of the items and used a 5-point Likert scale. O'Brien (1985) cites evidence demonstrating validity for using an additive scale rather than a Guttman scale. Rosenberg (1978) himself, later uses the additive method of scaling, rather than his original Guttman method.

Studies have shown this scale to have high divergent and convergent validity (O'Brien, 1985, Baker & Gallant, 1985) and to tap a unidimensional trait of global self-esteem (O'Brien, 1985).

- Q. 15** This measure of political leaning is similar to that used by Polley (1983), in his study of dimensions of political reality. It was included in order to examine the effect of political views on weight philosophy, and was also used to see if groups tended to differ politically.
- Q. 16** This scale was created and validated by Roghmann, Hengst, & Zastowny (1979), who found that the scale could be divided into two subclusters -- one positive, one negative, and that satisfaction, as measured by this scale, significantly predicted utilization of physicians. The original scale was changed somewhat after administering it to pilot test participants and conducting a factor analysis on the results (see Appendix C).
- Q. 17** This is a rough measure of weight self-perception. It was used to help rule out alternative explanations concerning whether the participants see themselves as fat or not, and was used as a covariate to see if weight perception affected physician utilization. The question is similar to one used by NHIS; the term "overweight" was eliminated and the wording was very carefully changed in order to be acceptable to people with widely varying philosophies about weight.

- Q. 18** The purpose of these items was to determine participants' attributions about their weight, and to determine how much control they feel they have over it. The first two items were developed to determine where participants fall in the Brickman et al. (1982) model, i.e., to what extent they feel they are responsible for cause and cure of their fatness. The third item was included to determine participants' level of optimism about dieting. The last two items were taken (with a slight wording change) from Saitzer's (1978) Weight Locus of Control Scale, in order to determine whether participants see control over their weight as coming from internal versus external sources.
- Q. 19-26** This is background data to be used as possible covariates and for the purpose of matching participants for the interviews. Several of the items were taken/adapted from Sudman and Bradburn (1982).
- Q. 27-28** Height and weight were used to determine the person's Body Mass Index (BMI), in order to determine which participants are more than 30% overweight by medical standards. BMI was also used for matching, as a covariate, and as an important independent variable.

While the accuracy of self-reported weight information is often questioned, research by Stunkard & Albaum (1981), conducted in a variety of settings, showed that people (including those in the higher weight categories) generally report their weights accurately. Seventy percent of participants reported their weight accurately within 2 kilograms (4.4 pounds). Weight self-reports were also found to be accurate in a large, representative Dutch sample (Seidell, et al., 1996). Preliminary data collected during a pilot test of the questionnaire demonstrated that participants were very likely to answer the weight question on the questionnaire, rather than leaving it blank, and tended to answer it truthfully (see Appendix C).

- Q. 29** This item was added to determine whether participants had lost a significant amount of weight which might have influenced their reactions to the physician issue, and was also used for matching purposes.
- Q. 30** Whether or not a person was currently dieting was thought to be an important independent variable that was explored in relation to physician utilization.
- Q. 31** This question was included as additional information to the previous question. Participants, when answering question 30, may have defined "dieting" in widely different ways. This question gets at the information in a somewhat different way. Answers to this question and the previous one were compared.
- Q. 32** This question was used for the purpose of matching participants for interviews, and was also included as an independent variable, since much of the literature on obesity draws a distinction between people fat from childhood or adolescence versus those who are not (Bray, 1973).
- Q. 33** These questions were adapted from NHANES. Information on cigarette smoking should be related to health status, as well as physician avoidance; whether a participant smoked or not was included for use as a possible covariate.

Appendix C - Pilot Test Results

During July, 1988 preliminary data were gathered on college students, mostly attending night classes, at Baruch College and at Hunter College, using a Pilot Questionnaire (Appendix D). Although data were gathered on a total of 165 students, those students under age 24 were eliminated from analysis, because concern over health would probably not be a salient issue for most young college students--concern should be greater among older people. After eliminating those under 24, as well as those who did not include their age, 70 people remained. The average age of the remaining participants was 32 years old (ranging from 24 to 68 years). Forty-five of the participants were women, and 25 men. Almost half identified themselves as white (33), a quarter as black (18), nine as hispanic and 7 as asian. One-third of these college students indicated that they were already college graduates.

I used the pilot data for two purposes: to factor analyze two scales included in the questionnaire, and to improve on the wording of the questionnaire. The pilot data helped to answer several questions of concern--it supported that people are very likely to answer the weight question on the questionnaire, rather than leaving it blank. Only 4 out of the 70 participants did not answer this question. Objective evidence was collected which indicated that people were fairly honest in their answers on the weight question--in a few cases, when a person was noticed who looked slightly heavier than the norm, a mark was made on their questionnaire; the questionnaire was later examined to see whether the answer to the weight question seemed appropriate. In every case it did. Also, importantly, the proportion of people willing to volunteer for an interview did not differ much by weight, health status, or attitudes toward doctors.

(Some additional data were also collected on 17 people attending a Weight Watchers meeting in New York--they were found to be only slightly less likely than the college students to volunteer to be interviewed. All 17 answered the weight question, and objective evidence indicates that those answers were also truthful.)

As a result of the pilot data gathered, these additional changes were made to the Pilot Questionnaire (see Appendix D):

Q.2: How one is to answer this question if it applies to more than one doctor was clarified.

Q.18-19: Several people had a problem answering this question because their parent had died before they were 16, so it was clarified.

Q.23: A question was added, asking when it was that the participant weighed more.

"Filler" questions, intended to distract college participants from figuring out that weight was the variable of interest, were eliminated. Since groups of fat people were being targeted, these additional items are unnecessary and would only lengthen the questionnaire.

Factor analyses for two scales on the college student pilot data were conducted, and Cronbach alpha coefficients were calculated. These are the results:

Q.12: A factor analysis was conducted using oblique rotation with listwise deletion. There were 63 individuals included in this factor analysis. Two factors emerged—one for serious symptoms and one for non-serious symptoms, accounting for 50% of the variance in scores. Using a cutoff of .30, all items except "ear ache" and "back ache" fit into only one factor. "Ear ache" was excluded from the final questionnaire because it correlated moderately with both factors. "Back ache" was kept in the final questionnaire because it loaded very highly on the non-serious factor although there was a moderate correlation with the serious factor.

Below are the loadings of the factors (above .30) on each of the symptoms:

	Factor 1 (Non-serious symptoms):	Factor 2 (Serious symptoms):
Cough	.83	
Headache	.82	
Sore Throat	.79	
Diarrhea	.71	
Leg Cramps	.67	
Heat Rash	.65	
Fever	.59	
Back ache	.58	.33
Trouble Sleeping	.57	
Fatigue	.44	
Ear Ache	.41	.32
Loss of sight in one eye		.88
Blood in urine		.86
Chest Pain		.77
Shortness of Breath		.67
Fainting		.47
Pain in legs while walking		.39

Two additional items were added to the scale on the final questionnaire, in order to test the two factors that emerged (serious--loss of feeling in an arm; non-serious--runny nose).

This scale yielded a very high Cronbach alpha coefficient (.88). When the scale was separated into two scales for non-serious versus serious symptoms, the alpha for the non-serious symptoms remained the same (.88), indicating some improvement since the alpha is based on 6 fewer items. (Removal of the additional item "ear ache" also did not lower alpha). The alpha for the serious symptoms was slightly lower (.78) (to be expected, since it was based on fewer than half the original items).

Q.13: This questionnaire was one taken from Roghmann, Hengst, & Zastowny (1979), which had been tested previously, and was found by them to contain a negative and a positive factor for attitudes toward doctors. I conducted a factor analysis using oblique rotation with listwise deletion. There were 60 people included in this factor analysis. As previously demonstrated, two factors emerged--one for positive attitudes toward doctors and one for negative attitudes, accounting for 39% of the variance in scores. Contrary to results previously demonstrated, not all the positively worded items fell into the positive factor. (Because the question items are so lengthy, they will be referred to as items 13A through 13N, in the same order they appear for question 13 on the attached Pilot Questionnaire.) Two items (13A and 13G) had moderate factor loadings on the positive factor but high negative factor loadings on the negative factor. Using a cutoff of .35, all items fit into only one factor. A decision was made to eliminate items with factor loadings of less than .40, in order to keep the final questionnaire from being too lengthy. Items 13C and 13J were therefore excluded from the final questionnaire.

Below are the loadings of the factors (above .30) on each of the symptoms:

	<u>Factor 1</u> <u>(Positive attitudes):</u>	<u>Factor 2</u> <u>(Negative attitudes):</u>
13K	.83	
13L	.78	
13D	.76	
13N	.63	
13I	.42	
13C	.37	
13E		.76
13H		.73
13G	.30	-.57
13A	.34	-.53
13B		.43
13M		.42
13F		.40
13J		.35

Two additional items were added to the scale on the final questionnaire, in order to test the two factors that emerged (positive--"Most doctors are able to improve your health"; negative--"Most doctors do not care how medical procedures personally affect you".)

The overall Cronbach alpha obtained for the scale as a whole was not very high (.48). However, when the scale was separated into positive and negative scales, guided by the factor analysis, much higher alphas were obtained (.73 for the positive scale and .68 for the negative

scale). Deleting items 13C and 13J has a minimal effect on alpha coefficients, yielding alphas of .75 and .66 respectively.

Appendix D - Pilot Questionnaire

This questionnaire contains questions about people's health, and about how people feel about visiting medical doctors. This questionnaire is voluntary and your answers will be kept confidential.

This research is being conducted as part of a doctoral dissertation by:

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New York, NY 10036
(212) 642-2506**

Please answer the questions below by checking or circling the appropriate response, or filling in the information requested. All information from this questionnaire will remain confidential.

1. Would you say your health in general is:

excellent ☐
 very good ☐
 good ☐
 fair ☐
 poor ☐

2. Do you have a particular medical doctor whom you could call or visit if you needed medical advice or a check-up?

Yes ☐ No ☐ (Go To Q. 3)

If yes:

What is your doctor's specialty? (For example: General Practitioner, Gynecologist, Internist, etc.) If you don't know, write "Don't Know".

How long has he or she been your physician?

Is your doctor male or female?

Male ☐ Female ☐

3. During the past twelve months, about **how many times** did you see a doctor about your health? (Count each visit separately, even if it was for the same problem/symptom).

_____ times

4. About how long has it been since you last saw a medical doctor about your health?

_____ years _____ months

5. For this last visit with a doctor, approximately **how much time passed** between the time you thought you ought to see a doctor until you **actually** saw him or her?

_____ months _____ days

6. Over the past five years, have you seen people **other than a medical doctor** about your health (such as a chiropractor, nutritionist, acupuncturist, nurse practitioner, midwife, etc.)?

Yes ☐ No ☐ (Go to Q. 7)

If yes, what types of people have you seen?

7. Do you have health insurance for yourself that covers:

medical checkups?	Yes ☐	No ☐
doctor visits other than checkups?	Yes ☐	No ☐
hospital stays?	Yes ☐	No ☐

8. People frequently experience health problems or symptoms for which they might like to see a doctor, but do not for some reason. Listed below are some common reasons that people do not see a doctor, even if they have a problem with their health. Please indicate below whether each of these reasons has kept you from seeing a doctor during the past twelve months. (Indicate whether each was never a reason, once a reason, or more than once a reason during the past twelve months).

<u>Never</u>	<u>Once</u>	<u>More Than Once</u>	
☐	☐	☐	I lacked confidence in available doctors
☐	☐	☐	I didn't have time
☐	☐	☐	I would be rushed in and out of the office
☐	☐	☐	I felt it would cost too much
☐	☐	☐	I couldn't get an appointment
☐	☐	☐	I would have to travel too far
☐	☐	☐	I didn't have a way to get there
☐	☐	☐	I didn't want to get weighed on the doctor's scale
☐	☐	☐	I was afraid of finding out what was wrong
☐	☐	☐	I didn't have anyone to care for children or other family members
☐	☐	☐	I would have to wait too long in the waiting room
☐	☐	☐	I didn't want to get undressed in the physician's office
☐	☐	☐	I was afraid of experiencing pain
☐	☐	☐	I would be given unnecessary medical tests
☐	☐	☐	I would be told to stop smoking
☐	☐	☐	I would be told to lose weight
☐	☐	☐	I knew how to cure the problem myself
			<u>Other reasons not listed:</u>
	☐	☐	_____
	☐	☐	_____
	☐	☐	_____
	☐	☐	_____

9. During the past twelve months, about how many days did illness or injury keep you from performing your normal activities (for example, work, school, homemaking)?
_____ days
10. During the past twelve months, about how many days did illness or injury keep you in bed all or most of the day?
_____ days
11. During the past twelve months, about how many days were you a patient overnight in a hospital?
_____ days

12. We are interested in how likely people are to make an appointment with a medical doctor when they experience certain symptoms. Listed below are health problems which people might experience. Imagine that you have been experiencing each of the following symptoms for one week. Please indicate how likely it is that you would call a medical doctor for an appointment. (Please consider each symptom separately.)

	<u>Very Unlikely</u>			<u>Very Likely</u>	
Pain in legs while walking	1	2	3	4	5
Shortness of breath	1	2	3	4	5
Blood in urine	1	2	3	4	5
Fatigue	1	2	3	4	5
Loss of sight in one eye	1	2	3	4	5
Back ache	1	2	3	4	5
Chest pain	1	2	3	4	5
Fever	1	2	3	4	5
Diarrhea	1	2	3	4	5
Sore throat	1	2	3	4	5
Headache	1	2	3	4	5
Fainting	1	2	3	4	5
Cough	1	2	3	4	5
Ear ache	1	2	3	4	5
Leg cramps	1	2	3	4	5
Trouble sleeping	1	2	3	4	5
Heat rash	1	2	3	4	5

13. People say some good things and bad things about doctors and medical care. From your experiences, please indicate below how much you agree or disagree with the following statements:

	<u>Strongly Disagree</u>			<u>Strongly Agree</u>	
Doctors spend as much time as necessary with each patient.	1	2	3	4	5
Doctors should be a little more friendly than they are.	1	2	3	4	5
Doctors try to have their offices and clinics in convenient locations.	1	2	3	4	5
Patients receive nothing but the best care from their doctors.	1	2	3	4	5
Many doctors don't care whether or not they hurt you.	1	2	3	4	5
Doctors don't care how long the patients have to wait.	1	2	3	4	5
Most doctors take a real interest in their patients.	1	2	3	4	5
When a doctor gets through treating you, you are likely to feel worse than before.	1	2	3	4	5
In an emergency, you can always get a doctor.	1	2	3	4	5
Many doctors treat the disease but have no feeling for the patient.	1	2	3	4	5
Doctors clearly explain what is wrong before giving you treatment.	1	2	3	4	5
Doctors teach patients how to prevent sickness and accidents.	1	2	3	4	5
It is easier to go to the drug store for medicine than to bother with a doctor.	1	2	3	4	5
Most doctors let you talk out your problems.	1	2	3	4	5

14. How old were you on your last birthday? _____ years
15. What is your sex? Male ☐ Female ☐
16. What is your race/ethnic background? Check as many as apply. (If none of the choices below represents how you identify yourself, please use the other category to indicate your race/ethnic background).
- | | | | |
|--------------------------------|--------------------------|------------------------------|--------------------------|
| Hispanic | ☐ | Black | ☐ |
| Asian/Pacific Islander | ☐ | Native American | ☐ |
| White/Caucasian (non-Hispanic) | ☐ | Other (please specify _____) | ☐ |
-
17. What is the highest level of formal education you have obtained?
- | | |
|---|--------------------------|
| Elementary school or less | ☐ |
| Some high school | ☐ |
| High school graduate | ☐ |
| Vocational/Business school | ☐ |
| Some college | ☐ |
| College graduate | ☐ |
| Post graduate degree | ☐ |
| Other formal education (please specify _____) | ☐ |
18. By the time you were 16 years old, what was the highest level of formal education your father had obtained?
- | | |
|---|--------------------------|
| Elementary school or less | ☐ |
| Some high school | ☐ |
| High school graduate | ☐ |
| Vocational/Business school | ☐ |
| Some college | ☐ |
| College graduate | ☐ |
| Post graduate degree | ☐ |
| Other formal education (please specify _____) | ☐ |
19. By the time you were 16 years old, what was the highest level of formal education your mother had obtained?
- | | |
|---|--------------------------|
| Elementary school or less | ☐ |
| Some high school | ☐ |
| High school graduate | ☐ |
| Vocational/Business school | ☐ |
| Some college | ☐ |
| College graduate | ☐ |
| Post graduate degree | ☐ |
| Other formal education (please specify _____) | ☐ |
20. How tall are you? _____ feet _____ inches
21. How much do you weigh? _____ pounds

22. Do you consider yourself to be:

underweight ☐
 just about right ☐
 a little overweight ☐
 somewhat overweight ☐
 very overweight ☐

23. If you have ever been heavier than your current weight (except while pregnant), how much did you weigh at your heaviest? _____ pounds

Approximately how long were you at that weight?

24. Are you now on a reducing diet?

Yes ☐ No ☐ (Go To Q. 25)

If yes:

How long have you been on it?

How much weight have you lost during this period
 of time? _____ pounds

25. Over the past year, approximately how many days (out of 365) would you say that you were attempting to reduce your food intake in order to lose weight?
 _____ days

26. When you were a child, did others consider you to be fat?

Yes ☐ No ☐ Not Sure ☐

27. Do you currently smoke cigarettes?

Yes ☐ No ☐

If yes:

Approximately how many cigarettes a day? _____

Have you tried to quit smoking cigarettes in the past? Yes ☐ No ☐ (Go to Q. 28)

When you have tried to quit, what was the longest amount
 of time you were able to keep from smoking cigarettes?

_____ (Go to Q. 28)

If no:

Did you smoke cigarettes in the past? Yes ☐ No ☐ (Go to Q. 28)

Approximately how many cigarettes a day when you were smoking the most?
 _____ cigarettes

How long ago did you stop smoking? _____

28. Do you currently smoke a cigar or pipe?

Yes ☐ No ☐

29. Do you actively engage in competitive sports?

Yes ☐ No ☐

If yes:

What type(s) of sports? _____

Approximately how many minutes per week? _____ minutes

30. Do you actively engage in exercise (other than competitive sports)?

Yes ☐ No ☐

If yes:

What type(s) of exercise? _____

Approximately how many minutes per week? _____ minutes

31. During the last six months, approximately how many alcoholic drinks did you have in a typical week? (Note that a glass of beer, a glass of wine, a mixed drink or a shot of liquor is considered one drink).

_____ drinks

Thank you for your time and cooperation!

Please indicate here how much time it took you to complete this questionnaire:

_____ minutes

If you had been asked to consider volunteering for a (possibly paid) interview regarding health and the use of health care services, do you think you would have included your first name and telephone number on the questionnaire, knowing that you would be under no obligation to participate in an interview if contacted later on? yes _____ no _____

Thanks for your participation!

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