

Manipulating practices

A critical physiotherapy reader

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CHAPTER 14

What's in a number? Progress and body shame in lifestyle programs for adolescents

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Abstract

There is frequent messaging in scientific and popular discussions that point to a childhood “obesity epidemic” worldwide. There have been significant responsive efforts to combat this (perceived) public health problem. These have primarily taken the form of individual, lifestyle interventions (i.e., diet and exercise). In this study, we considered the experiences of adolescents enrolled in a lifestyle intervention (aimed at weight control) organized by a specialized health service in Norway. We drew on interviews with two young women to answer the ques-

tion: How do adolescents experience group-training sessions, regular weight screening, dietary counselling, and fitness testing? In this chapter, we critically analyse how the adolescents made sense of their bodies in relation to and through the lifestyle intervention. We focus on the practice of regular testing and show how feelings of shame emerged in relation to the testing. This was particularly evident when the young women did not achieve significant “progress”. In our analysis, we adopt a critical embodiment approach drawing from the work of phenomenological scholars, including Merleau-Ponty’s notion of the body as a primary means of experience and Luna Dolezal’s writing on shame in the clinical encounter. We integrate poststructuralist perspectives to challenge contemporary hegemonic ideas about weight (loss) and fatness. Considering our findings on how shame can be exacerbated as well as avoided, we argue that lifestyle interventions should be implemented with caution. Moreover, we suggest that physiotherapists should exercise care when employing body measurement tools in these contexts. Focusing on enjoyment, meaning, and fulfilment could offer alternatives to more traditional measures of progress.

Introduction

When considering the notion of shame in relation to weight loss interventions, it is easy to look to *The Biggest Loser*, an American reality television show that is now franchised across the globe. This popular series publicly shames people with obesity into changing their “lifestyle” – namely diet and exercise – with the ultimate goal of losing weight (Domoff et al., 2012). In this regard, many contestants are successful during the taping. However, the often-dramatic weight loss achieved by contestants has incited controversy – popular media has claimed that eating disorders and other health issues have resulted (e.g., Bricker, 2014; Evans & Elliot, 2015). Past contestants have also experienced weight re-gain and stated, “we are all

fat again” (Evans & Elliot, 2015). Body shaming at the core of the public weight loss journeys documented in *The Biggest Loser* aligns with contemporary neoliberal ideals of responsibility, self-control, body regulation and discipline (Lupton, 2013). The widespread popularity of the show reveals how entrenched these ideals are in our collective psyche.

Media representations of health, illness, and bodies create public perceptions of particular conditions and embodied realities (Lyons, 2000), including “obesity” (Boero, 2007). In this way, *The Biggest Loser* re/enforces popular understandings of fat bodies as problematic, deviant and in need to fixing, and normalizes shame as a means by which to “motivate” weight loss (Lupton, 2013). What is more, it shows weight reduction via lifestyle modification as achievable and “fun” when in fact research has confirmed that the exact opposite is true. That is, sustained weight loss through diet and exercise is nearly impossible (Weiss, Galuska, Khan, Gillespie & Serdula, 2007) and shame can result in worsened health among obese individuals and interferes with the success of weight loss interventions (Puhl & Suh, 2015, Rugseth, 2011). Nevertheless, frequent testing and weight screening persist as part of lifestyle-oriented programs in both public and private health care settings and there is little discussion of failure and shame in reference to such interventions (Dolezal, 2015). Clearly, there is a need for more focused research in the area, which can inform the creation of healthcare practices that better support individuals in achieving health and wellness (independent of body weight). This is of particular relevance for physiotherapists who are frequently involved in such anti-obesity programs (Snodgrass, Carter, Guest, Collins, James et al., 2014). With this goal in mind, we used a critical-embodiment lens to examine experiences of a lifestyle intervention for teens. We asked: what is the connection between measurement, testing, “progress,” and shame within this context?

Within the face-to-face encounter that occurs in the context of weight loss interventions, shame and failure are often unspoken, hidden, or repressed (Rugseth, 2011; Glenn, Raine, & Spence, 2015; Knutsen 2011). This is not to say, however, that they do not exist. As a participant observer in a lifestyle program for adults, Rugseth (2007) noted that shame was present in the room as a relational phenomenon, that is, there was a shared sense of discomfort and exposure that nobody talked about. This was particularly evident when weight was measured:

My sense of discomfort being part of another persons' weight screening was unavoidable. We shared and took part in the shame. We felt shamefully involved and at the same time curious as to the result of the weight screening. (p. 138, our translation)

The weight measurement described by Rugseth as a source of shame is also a prominent fixture in anti-obesity programs involving children and adolescents. Critical scholars have voiced concerns about calls for regular weight monitoring (among adults and children) as part of on-going campaigns against the “obesity epidemic” by health authorities across the globe (Gard & Wright, 2005). Concerns include the potential unintended harms caused by construction of an “epidemic” in relation to obesity whereby health professionals are expected to intervene in the management of people’s weight; particularly among people under 18 years of age who are thought to be the “responsibility” of the state (as well as parents). Interventions include the establishment of lifestyle programs designed to “help” young people categorized as overweight or obese.

Critical embodiment perspective

In this chapter, we take a critical embodiment approach to understanding adolescents’ lived experiences of various testing situations

that were part of a lifestyle intervention aimed at weight control. This involved questioning established weight control and measurement practices by privileging first-hand accounts and embodied experiences, as expressed and reflected on during interviews with the first author. Our goal was to unpack and challenge the potentially hidden effects of testing and weight control and highlight the role of shame therein. We were inspired by Merleau-Ponty's (1945/2002) phenomenology, which posits the body as central to all human experiences. According to Merleau-Ponty, it is through the body that we come to know, make meaning of, and relate to the world around us. For example, it is the feel of the breeze on our cheek rather than a description from a book that transforms an abstract idea like wind into something knowable and concrete.

Dolezal (2015) draws on these ideas to explore experiences of body shame. She writes that shame is an embodied and relational phenomenon that is likely to happen when individuals are concerned with how they are seen and judged by others:

Body shame can be understood to be shame that arises as a result of some aspect of the body or bodily management, perhaps appearance, bodily functions or comportment. It is shame that is centred on the body where the subject believes their body to be undesirable, inadequate, or unattractive, falling short of social depictions of the "normal," the ideal or the socially acceptable body. (p. 569)

At the same time, shame (as a self-conscious emotion) can affect an individual's sense of *agency* (i.e., the ability to inter-act with and on one's surroundings). Dolezal argues, "When faced with shame common reactions include hiding, escaping, disappearing from view and shrinking into the floor" (p. 569). In other words, people find their own ways of avoiding or relating to shame, which involves some kind of action.

Body weight has become a global obsession in the service of overcoming the "obesity epidemic" (Gard & Wright, 2005; Lupton, 2013).

Consistent with neo-liberal principles of individualism and personal responsibility, people are categorized and compared to putative norms via measurements (weight screening; i.e., “obese” or “overweight” based on Body Mass Index [BMI]). These are purported as necessary components of the “war on obesity” and often carried out under the supervision of health professionals (Guthman, 2013; Lupton, 2013). BMI categories are somewhat arbitrary since there is no clear relationship to clinically meaningful outcomes (Flegal Kit, Orpana, & Graubard, 2013). For example, in research conducted by Flegal and colleagues (2013), being “overweight” by BMI category was associated with a reduced all-cause mortality rate when compared to “normal” BMI, and “grade I obesity” had the same mortality rate as “normal” BMI. Drawing on Dolezal’s (2015) argument that shame is relational arising in and through our interactions with others, moments of comparison, such as those that occur in the context of anti-obesity programs, are ripe for the production of shame. Moreover, as noted by Lupton (2013), shame can also develop in socio-cultural contexts (e.g., healthcare systems), where “overweight” people are made to feel indebted to the citizenry because of the “cost” of their fatness on others. In what follows, we explore the embodiment of shame in reference to a weight control intervention and provide a vital, critical perspective to this burgeoning area of scholarship. To our knowledge, no prior research has questioned the impact of measurement and testing within the context of a clinical lifestyle program, among adolescents. We hope these findings will inform practice – to shift healthcare (including physiotherapy) away from potentially body shaming practices.

Context

We take as our analytic starting point the experiences of young women who participated in a group based lifestyle program for adolescents in Norway. The one-year program was publicly funded and ran at an out-patient clinic. Entry into the program was usually

via referral from a general practitioner or school nurse based on a BMI of more than 35 Kg/m². Participation involved attending two exercise sessions per week, as well as monthly nutrition sessions. The program was interdisciplinary, run by physiotherapists and dietitians. The first author conducted individual, semi-structured interviews with ten participants in the program. In the interviews, she asked participants to talk about the reasons they attended the program as well as their experiences within it. In addition, she asked about their experiences of physical activity and food and eating in other settings. Interviews were recorded, transcribed, and the first author translated relevant excerpts into English.

For the analysis, we drew on elements of Mattingly's (1998) narrative-phenomenological approach and Kvale and Brinkman's (2009) critical analysis. We carefully read excerpts from the transcripts related to the young women's experiences of participating in the program and of testing and measurement situations. We searched for recurrent or unique themes and discussed these to reach consensus. We then crafted narratives, borrowing from narrative-phenomenological writing traditions (Mattingly, 1998; Zaner, 1993). The narrative influence can be seen in the arc of the stories, the threading through time, and provision of contextual details. The phenomenological influence is apparent in the reliance on Merleau-Ponty's (1945/2002) embodiment (i.e., body as primary to experiences), which was reflected in the anecdotes (i.e., experiential moments) we crafted from the participants' stories (Mattingly, 1998; Zaner, 1993). Participant narratives were then subjected to critical interpretation, which involved contextualizing the stories in terms of existing critical scholarship on embodied fatness, weight loss and shame as well as prevailing cultural, social, medical, and institutional understandings (e.g., Boero, 2007; Dolezal, 2015; Gard & Wright, 2005; Lupton, 2013). We focused on two young women's stories/experiences because

they highlighted the complex and divergent ways the experience can be lived, and provided sufficient data to achieve a depth of understanding and experiential resonance, which was the aim this exploratory study.

Alva's story: I do not regard myself as overweight

Alva was 15 years old when a doctor recommended that she participate in the program. Reflecting on this conversation, Alva expressed surprise and anger directed at the doctor because she did not see herself as overweight. "I am not overweight. I am totally sure of that. . I hate being called that and I am not overweight. I do not regard myself as overweight." The discrepancy between her sense of her body and the doctor's assessment was upsetting. Alva said it made her want to scream, "I am NOT overweight!" However, in the clinical encounter with her doctor, she said she did not voice her dissent because she feared it would prevent her getting what she really wanted: a referral for breast reduction surgery. Imagine her surprise when the doctor told her she needed to lose weight instead:

I had to reduce my BMI to get breast surgery. And that is why the doctor referred me here. So that I could get help and guidance with regards to diet and exercise and things like that.

Alva said she reluctantly agreed to participate in the program even though she maintained she was not overweight. This notion was challenged again upon entry to the program, this time by one of the health professionals: "The first time I came here they told me that I was overweight and then I thought, 'am I really that big because I cannot see that myself.'" This led her to question, "Am I overweight?" After her first encounter with the group she concluded,

“No. I’m not!” Comparing herself to the other teenagers made her feel uncomfortable. She explained:

I recall coming here the first time, feeling like an outsider, that I did not fit in, because I am not overweight. . . I had tears in my eyes and things like that because I felt that I did not fit in at all. . . this is perhaps a bit mean of me to say, but there were many others there who were much bigger than me.

At first, Alva said she was ashamed to be part of the program, to be grouped with these “bigger” others, and kept it a secret from her friends. However, as the weeks passed, she described how she enjoyed participating in the group. In particular, she said she felt enthusiastic about the exercise sessions. She said that she found some activities more meaningful than others; she liked feeling strong and capable, and she frequently felt like this during weight-training. The physiotherapists commented on her efforts, and she pointed out: “I do get cred. They talk positively about me, because I am so strong. They find it sort of impressive.” Alva noted this experience was in stark contrast to her experience from physical education class at school. Compared to her school-mates, Alva felt less capable because she could not keep up. In that context, she saw her body as problematic, clumsy, and less skilled than the others. She found strategies to avoid participating. She explained: “So I rarely participate with the class. I exercise alone in the weight room.”

In contrast to physical education at school, Alva said she found exercise sessions at the clinic meaningful. She explained that she could sense that she was making progress and saw evidence of this in the biweekly testing, for which program participants were responsible. For example, during testing, the participants worked in pairs but kept track of their own results. The physiotherapist(s) did not conduct the tests, but were present, observing and

encouraging the participants. Alva emphasized feeling inspired by this encouragement:

About 2-3 weeks ago, I managed to lift 42 kilos. Which means I have improved, increasing my record by 2-3 kilos. And that is empowerment. And then I noticed that all my exercising has given me results. And I am a competitive person, so I want to do better every time.

By the end of the program, Alva said she had gained enough self-confidence to try exercising in a fitness centre, although, she said she would have preferred to stay in the program:

I am determined to start exercising at a local fitness centre near my new home. But I would have preferred continuing here. Because I do enjoy being here. The place and the physiotherapists – I have a bond with them. They are very motivating.

According to Alva, the physiotherapists were able to help her progress in her strength training by being positive and encouraging. “Yes you can do it, come on, great work, keep up the good work Alva,” were examples of the kinds of praise she received. She said they also supported her pursuit of other activities she found meaningful (like weight lifting). Alva also mentioned that she really appreciated that the physiotherapists never commented on her weight:

Nobody talks about us being overweight, they never use that word, and I am happy with that, because I am not overweight.

Alva's description of her experiences of the monthly weigh-ins was quite the opposite. Indeed, Alva said she felt she was scrutinized and mistrusted when she had not lost weight:

I do not lose weight no matter what I do – nothing happens. . . And I exercise a lot, I eat less and more healthy, but nothing happens. But it seems like [the nutritionist] is not really convinced that I have changed

my diet. But I have changed my diet, I have. I have made drastic changes actually. Previously, I used to skip breakfast or I ate some crappy stuff like yoghurt or stuff like that, not that it is crappy, but now I eat yoghurt with oil, nuts and spinach, and all of that, but it has been challenging and now I only eat salad with chicken or fish for lunch and we eat a healthy dinner, so I have really changed my diet. And my weekend sweets are frozen strawberries, and nuts, that is my candy, because when I feel like eating candy I eat that instead. So I am almost totally avoiding sugar.

Alva said that she had done everything she could have in terms of exercise and changing her diet. Nevertheless, rather than supporting her and emphasizing the progress she made, Alva highlighted that the nutritionist questioned whether she tried hard enough. Weight loss was the professionals' barometer of Alva's success in the program. Alva, however, discussed that she felt otherwise:

But muscles weigh more than fat. My muscles have grown significantly. So in that sense, I am satisfied with the result, because I have lost 10 centimetres around my waist since I started here. And 10 centimetres is a lot. I cannot sense that I have lost 10 centimetres there, but I saw it when I was measured around the waist. I saw the numbers. So that means that I have tightened up there, and I am pleased with that [change]. And I do not care how much the scale shows, how much I weigh, I only care about the way I look, my body shape in a way. Because, as far as I am concerned I might weigh 90 kilos as long as I am happy with my appearance and my body, because muscles are important to me.

For Alva, BMI and the numbers on the scale were irrelevant because she could feel progress in other ways – she finished the program with a fitter, stronger, and more muscular body. Her sense of achievement was tied to gains in strength and fitness – that is what she could do – as well as how she appeared, not how much she weighed. Nevertheless, Alva still reproduced the notion of “fat as shameful” even while she worked to reformulate what “counted” as fat.

She did this by claiming she was not overweight, nor one of the “big” people in the group. She also argued that her body composition and shape changes were positive because they marked a loss in fat even though her weight had not declined.

Hannah's story: The scale never lies

Hannah entered the lifestyle program because she was afraid of future illness. She discussed her fear of becoming diabetic because both of her parents had the disease: “I was worried and wanted to do the right things. . . So the school nurse was there as a support . . . she told me about this program and managed to get me in.” Hannah said she had lost and then regained weight during the program, which led her to seek advice from the nutritionist. Hannah was offered a detailed eating plan, yet she described that adhering to it was challenging. She discussed having “relapses” and described how getting on the scale every month caused her anxiety. Her fear was tied to the possibility of weight regain, or lack of weight loss. She explained: “The scale never lies. Unfortunately, it is scary, in a way, to think that you actually weigh so much, kind of . . . It seems a bit hopeless.” At the same time, she expressed ambivalence about the salience of numbers as an outcome or indicator of her (lack of) progress: “You get yourself so stuck on a number that it means everything, in a way, and I do not really want that.” Hannah said that stepping on the scale occasionally initiated negative thoughts, like considering making herself vomit. “*I could get rid of the bad food this way,*” she explained. This behaviour is consistent with advice in the literature on eating disorders, which encourages avoiding the quantification of weight as a measure of health (e.g., Burns & Gavy, 2004). Although we do not know if Hannah actually purged, thoughts of self-harming behaviour are concerning in and of themselves.

Hannah reported that she enjoyed the exercise sessions in the program and experienced them as “fun,” “entertaining,” and “artistic.” She found that the positivity and playfulness of the physiotherapists contrasted sharply with the demeanour of the nutritionists who conducted the weigh-ins. Hannah’s enthusiasm can be interpreted as a sense of pride. She could do much more than she had thought:

I like the exercise sessions here. I am very satisfied because I am able to do more than I thought I could do. Because the physiotherapists are so positive and you see in a way, I personally feel that the group is good for me, I feel good and I am very proud of it. It is kind of “exercising is super easy, it is super fun, it is entertainment art, I can do more with it”. The food is much harder, because then you are on your own. Then there is nobody holding your hand.

Hannah explained that she was progressing even when it was not visible on the scale. She *felt* better, she explained:

Even though you do not see the results with your eyes, or those eyes, it is in a way, it is because if you are going to see progress, I feel that I have better endurance and all of that, so I feel very good about that.

“Feeling” progress was not something that was quantitatively measured but rather embodied for Hannah. It developed not because of, but rather in spite of, stepping on the scale. Hannah also experienced changes in her everyday life: running to the bus, train station and school were suddenly easier. She explained:

And this is not how things used to be; then it was like, huff and puff, huff and puff (breathes heavily in the interview). It used to be like that; I used to breathe like that for about 15 minutes, and then get the rhythm back again.

Regardless of her felt experience of progress in terms of fitness, since starting in the program Hannah had become more focused

on and critical of her weight and appearance. She expressed disappointment in herself and continued to worry about developing diabetes. She indicated that a lot was at stake:

I feel for the first time in my life that I am dissatisfied with what I see. I think it is a bit harder now, not because they weigh me but because I focus on it, that I am actually trying to do something about it. Previously I was not disappointed over gaining weight. . . . But now that I want to do something about it is much more disappointing. . . . because I want to be better. It is the health aspect of it too. I do not want to become ill like my parents.

Hannah's account suggests a young woman who was very concerned about weight and the health related consequences. As such, a weight loss and regain, although only a few kilos, triggered feelings of failure, worry and sadness because she thought she had let down herself and the people caring for her. Hannah identified that "the numbers", that were central to the program's understandings of progress, rather quickly began to affect how she viewed herself regardless of her embodied experiences of wellbeing and progress. Although exercise sessions were associated with positive experiences, she noted a strong sense of disappointed that she did not lose the weight she wanted to lose.

The meaning of numbers

Our findings, from the exploration of two adolescent women's accounts of measurement within a lifestyle weight loss program, illuminate the potential impact of these forms of body scrutiny, and how responses can differ with regards to how shame is embodied, expressed, and resisted. In what follows, we draw on Dolezal's (2015) theorization of shame, which she builds on Merleau-Ponty's (1945/2002) ideas of embodiment to better understand how

measurement and “progress” within a lifestyle program can create opportunities for shame and pride among adolescent women.

Both participants made changes to their lifestyle in response to the program, although neither lost any weight. These two young women expressed quite different ways of making sense of their experiences. Through Alva’s account we saw agency and resistance in the way she redefined success on her own terms. While she complied with “disciplinary lifestyle choices and practices” (Dolezal, 2015, p. 572), Alva refused to judge her body based on weight (loss) and instead focused on the pleasures and pride she derived from movement and newly gained physical strength. Hannah, on the other hand, saw herself as failing to sufficiently comply with the requisite “disciplinary lifestyle changes” (Dolezal, 2015). Unlike Alva, Hannah openly discussed feelings of shame, particularly in relation to her experiences of being weighed within the program. We see in Hannah’s account that “although it can have a clear cognitive dimension, shame for the most part is an embodied response” (Dolezal, 2015, p. 570), which was exemplified through her urge to purge consumed food. There is also a self-protective dimension to her shame; for example, through non-disclosure of the challenges she faced with the program’s nutrition plan. Dolezal describes this dimension: “The individual feels exposed and this leads to a (paralyzing) inner scrutiny, a moment of extreme self-consciousness” (p. 569). Social encounters such as those in a clinical setting can trigger shame, particularly when they involve an explicit bodily focus (Dolezal, 2015). Hannah’s experience of shame may have been exacerbated by her sense of personal responsibility for having chosen to join the program, and the significance of weight loss to her as a way of avoiding future illness. Dolezal explains that the closer the connection between illness and personal responsibility for self-control (or lack thereof) the greater the potential there is for shame to arise.

While there were differences in Hannah and Alva's responses to being measured, there were also similarities. Both young women described being compared to a putative norm where they felt they, "did not measure up" (Gibson, 2016). Alva responded by moving the goal posts to make them consistent with her pre-program understanding of her body, she highlighted that improvements in her exercise capacity were more important to her than weight (loss). She described feeling pride rather than shame, regardless of the numbers or what others said. Given that Hannah came to the program with a very different view of her body (as an object of risk), it was perhaps not surprising that she had a different response. Her feelings of self-worth shifted according to the context – when she was being weighed she felt bad about herself, yet when she was moving in the exercise sessions she felt accomplishment and renewed confidence.

The differences between these two young women's experiences could be due, at least in part, to the internalization of discourses equating weight with health, and the acceptance of BMI and other medical categorisations as meaningful. Although Alva and Hannah both described gaining physical capacity and "feeling progress" through their abilities to do more, they were also aware that according to the primary goal of the program (i.e., weight loss) they had come up short. In contrast to Hannah, however, Alva put little value in losing weight because she rejected the program's conflation of weight and health as well as being categorized as "obese." This may explain her feelings of pride in her accomplishments even while "failing" to meet programmatic goals.

It is not surprising that neither Hannah nor Alva lost weight despite largely adhering to the program protocol. There is burgeoning literature that demonstrates the relative ineffectiveness of lifestyle programs (Doutketis, 2005; Franz et al., 2007). Given the lack of evidence to its efficacy, in addition to the blame and

shame involved in measuring weight, the ethics of recommending weight loss within the healthcare realm has been critiqued elsewhere (Glenn, 2013; Hoffmann, 2016), including within “lifestyle” weight loss programs for adolescents and children (Holm et al., 2014; Evans & Colls, 2009; Foresight, 2007).

Although the measurement of fitness appeared less traumatizing for Hannah and Alva than weigh-ins, it too could be interpreted as a practice that reduces the body to an object to be measured and compared to a putative norm. Other research with children and adolescents has shown that repeated body testing can result in diminished self-worth (Bjorbaekmo & Engelsrud, 2011). Moreover, measurement in a group setting unavoidably elicits comparison regardless of the sharing/not sharing of results (Evans & Colls, 2009). We see this in Alva and Hannah’s accounts where they compared themselves to others in the program. This, in turn can create a competitive and evaluative space where bodies can be compared to each other and/or a norm. Thus the stage is set for the possibility of success or failure (Evans & Colls, 2009). With the continued focus on testing, these young women learned to connect their sense of achievement and self-worth (at least partially) to *external* measures. Although they commented on how they felt stronger and fitter, they also focused on how much they had improved according to their monthly test scores and measurements (including waist circumference). One is compelled then to question the value and consider the potential risk of measurement within the context of lifestyle programs such as this one.

Instead of focusing on measurement and numbers on a scale, we suggest that these programs could be reimaged. Reflecting on Hannah and Alva’s experiences, we wonder what a program would look like that did not involve comparison to norms or quantified outcomes. We argue that programs could focus instead on the joy of movement, feelings of physical strength and endurance, and on

increased capacity to participate and enjoy activities that are part of everyday life (e.g., running for the bus, walking the dog, carrying the groceries up the stairs). A shift in focus such as this might provide an avenue to strengthen the body and one's self-worth. For physiotherapists, there are lessons here about the pitfalls of promoting bodily change that could ultimately do more harm than good. While the physiotherapists in this study did not measure weight, there are many that do, and this study shows that this should be undertaken with caution.

We also wish to bring attention to the potential negative effects of measurement *per se*. Alternative approaches might focus more on individual needs, desires, and preferences and build on what is valued and enjoyed while acknowledging fears and challenges. This diverges from following a set of standard approaches, norms, and/or outcomes. Such lessons are important to consider in physiotherapy practice and also curricula. Calls for less shaming approaches to obesity have been made in the context of training physiotherapy students and include: shifting the focus from diet and exercise as sole contributors to obesity, using collaborative styles of communication, and incorporating understandings of weight stigma (Setchell, Watson, Jones & Gard, 2015; Setchell, Watson, Gard & Jones, 2016). Physiotherapists could also benefit from critical reflection on the possible negative impacts of using weight-based outcome measures such as BMI on the people (particularly young people) who seek their care.

In conclusion, through a critical phenomenological examination of the experiences of two young women undergoing a group-based weight loss intervention, we have highlighted that such "lifestyle interventions" should be implemented with caution. In a current context of growing global stigmatisation of bodily fatness, shame is a key consideration. Physiotherapists and other health

professionals could use our findings to help attend to experiences of shame and how they might be exacerbated as well as avoided. In particular, we suggest that physiotherapists exercise caution when employing tools of body measurement in the context of lifestyle interventions. A shift of focus away from body weight or behavioural changes to considerations of enjoyment, meaning, and fulfilment could offer alternatives to more traditional measures of progress.

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