Patient Perspectives on Weight vs. Health-Centric Messaging around Obesity Management

By

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Dalhousie University is located in Mi'kma'ki, the
Ancestral and unceded territory if the Mi'kmaq.
We are all Treaty people.

Table of Contents

List of Tables

List of Figures

Abstract

Individuals living with obesity are often subject to weight-centric messaging in obesity management and treatment, which has been identified as contributing to weight bias and stigma, as well as unreasonable pressure to lose weight as a means of improving health (Bombak, 2014; Nutter, 2020). Messaging from healthcare professionals that supports health rather than promoting weight loss could better support behaviour change. This study explored how individuals living with obesity understand the value of health-centric rather than weight-centric messaging in obesity management. To gain the patient perspective on health versus weight-centric messaging, in-depth, open-ended, qualitative interviews were conducted with 10 participants. Of the 10 participants, eight were women, and two were men, with two of them being a part of the Obesity Canada Public Engagement Committee. The interviews were transcribed and coded using NVIVO 12 and following Braun and Clarke's six-step model for thematic analysis. The study applied a Pragmatic Worldview approach, framed within the Social Ecological Model (SEM). There were four themes identified that were subsequently categorized into one of the five levels of the SEM. The themes were*, the 'weight' of words, unsustainable care, care without context,* and *think 'healthy' thoughts.* These four themes demonstrated that, while weight-centric messaging is more commonly used within the healthcare setting, health-centric messaging is preferred by patients and may be less damaging to their health and well-being.

List of Abbreviations Used

American Board of Obesity Medicine (ABOM)

Body mass index (BMI)

Clinical practice guidelines (CPG)

Edmonton Obesity Staging System (EOSS)

Health at Every Size (HAES)

Internalized weight stigma (IWS)

Patient engagement committee (PEC)

Qualitative description (QD)

Social Determinants of Health (SDOH)

Social Ecological Model (SEM)

Socioeconomic status (SES)

World Health Organization (WHO)

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Introduction

In Canada, approximately one in four adults are currently living with obesity and obesity rates are slightly higher in men (28%) versus women (25%) (Government of Canada, 2020). There are multiple factors that influence obesity, including geographical location, food security, genetics, sex, and gender (Government of Canada, 2020). Obesity is a complex, chronic disease that is characterized by excess adiposity that impairs health (Wharton et al., 2020). Obesity management in Canada is also limited due to the lack of programs, lack of healthcare providers with an expertise in obesity, long wait times, and high costs of programs and treatments (Wharton et al., 2020). Despite now being considered as a complex chronic disease, the prevailing societal narrative around obesity is that it is an individual issue that is easily resolved through weight loss and willpower (Puhl and Heuer, 2010). However, there is a growing recognition of the complexity of obesity that requires an approach to management that focuses on health rather than weight loss (Wharton et al., 2020). Unfortunately, people living with obesity are commonly faced with a more weight-centric than health-centric approach when seeking care for obesity management (Tylka et al., 2014). A weight-centric approach is one that encourages weight loss, intending to improve health, and in most cases, body mass index (BMI) is the tool used to classify an individual as having obesity (Hanan, 2021). Although a weight-centric approach appears more common in healthcare settings, a health-centric approach has been found to be less damaging to patients living with obesity (Mauldin et al., 2022). A health-centric approach considers patient goals and current health behaviours, instead of focusing on the number on a scale (O'Hara et al., 2015), whereas weight-centric messaging can perpetuate the narrative that individuals living with obesity are unhealthy even though healthy individuals

can be represented in any body type or shape (Nutter, 2020). Obesity has recently been redefined in the 2020 Canadian Clinical Practice Guidelines (CPG) as "a complex chronic disease in which abnormal or excess body fat (adiposity) impairs health, increases the risk of long-term medical complications, and reduces lifespan" (See Appendix A for full definitions) (Obesity Canada, 2022). This new definition challenges the notion that excess adiposity alone is a health risk. While BMI is commonly used as a proxy of adiposity, it is not a good measure as it does not consider factors such as sex, race, or muscle mass, creating a poor representation of the relationship between health and weight (Hanan, 2021). Instead, BMI uses a height-to-weight ratio when determining if an individual is classified as having obesity or not (Statistics Canada, 2019).

Rationale for this research

A lack of obesity management resources and treatments can leave individuals living with obesity without effective treatment options (Wharton et al., 2020). Compounding the problem, is the existence of weight bias and stigma which can limit access to effective care (Wharton et al., 2020). While a variety of different interventions are recommended for individuals living with obesity including, behavioural interventions (dietary, physical exercise therapy, cognitive behaviour therapy), pharmacotherapy, and bariatric surgery, clinical practice does not always reflect the best available evidence (Wharton et al., 2020). For example, bariatric surgery for example is only available to one in 171 adult Canadians living with severe obesity each year and those referred for the surgery can expect to wait up to eight years before receiving the surgery (Rehani, 2019).

Given the complexity of obesity, and the framing of management typically focuses on weight loss, there is a need to better understand patient preferences for obesity management approaches. One way to do this is to ask patients about their experiences of weight management and whether a weight-centric or a health-centric approach is preferred.

A weight-centric approach sees weight and health as equivalent, meaning it assumes an individual's body size can be used to predict an individual's health status (Mauldin et al., 2022). This conceptualization, although unsupported by our current understanding that obesity is a chronic disease, is how our current healthcare system typically manages obesity (Mauldin et al., 2022). According to O'Hara and Gregg (2010, p.433), a weight-centric approach can be defined as the six following beliefs: "(a) that weight is under individual control, (b) that weight gain is caused by an imbalance in caloric intake and energy usage, (c) that health status can be predicted by weight, (d) that excess body weight causes disease and early death, (e) that methods for successful long-term weight loss involve the modification of eating and exercise patterns, and (f) that losing weight will result in better health." Weight-centric messaging can be harmful to patients because it is linked with experiences of depression, disordered eating, and avoidance of healthcare which is why a health-centric approach to obesity management has been promoted in recent years (Vadiveloo & Mattei, 2017; Chen et al., 2021). Believing that weight is under an individual's control and that an inability to lose weight is the fault of the individual are flaws of the weight-centric approach (Mauldin et al., 2022).

A health-centric approach is different from a weight-centric approach as it focuses on health instead of weight as its primary goal, while trying to diminish weight bias by using people-first language which refers to putting the person before their condition and

understanding that there is no "ideal" body type (Nutter et al., 2016); (Raffoul, 2017). Health-centric messaging, also known as a health-centric approach, has been shown to improve relationships between patients and healthcare providers, yielding more positive results in management and treatment (Tylka et al., 2014). Health-centric messaging in obesity management challenges the notion of "eat less, exercise more" and instead considers patient goals and current health behaviours (O'Hara et al., 2015). Applying a health-centric-lens in place of a weight-centric one can help prevent disordered eating and reduce the weight bias and stigma often seen in obesity management and treatment (O'Hara et al., 2015).

Although research has been done on weight-centric messaging and how it could be harmful to those experiencing it, few studies have been published where researchers use patient perspectives to explore this impact of such messaging. One study by Giabbanelli et al. (2013), acknowledged that a weight-centric approach is not sustainable as many individuals do not stay on the same diet or workout routine long-term, and instead suggested that a health-centric approach that engages participants in understanding the need for long-term, health-focused behaviour change strategies, should be used instead. However, no lived experiences or patient perspectives were included in that study; instead, they used participants responses in educational virtual games to identify relevant psychosocial factors for the participant and suggest evidence-based steps for change based on their observed behaviour (Giabbanelli et al., 2013). Another study by Nutter et al. (2016), looked at weight bias from a health-centric, weight-centric, and Health at Every Size (HAES) approach using weight bias researchers' perspectives. The HAES approach has been described as a health-centric movement where researchers from all disciplinary backgrounds, "approach weight bias through the consideration

of weight and the position that societal obsessions with thinness and dieting are unhealthy and do not allow for natural body diversity" (Nutter et al., 2016, P. 5). Although this study found that all three perspectives recognize weight bias as an important social issue compounded by the belief that weight is within an individual's control, the weight-centric approach was the most harmful to patients as it was linked to experiences of anxiety, depression, stress, and binge eating (Nutter et al., 2016).

From this previous research therefore, it appears that patients are often faced with a more weight-centric approach to care (Tylka et al., 2014). This may lead to individuals living with obesity resorting to 'fad' diets to try and lose weight, which may have impacts on their long-term health as often these diets are unsustainable due to their high cost and strict rules (Tylka et al., 2014). Instead, it is possible that, if a health-centric approach was used, healthcare providers could work with the patient to create obesity management strategies that fit the individual's lifestyle and has a better chance of working long-term (Tylka et al., 2014). It is important to note that weight-and health-centric approaches are not dichotomous and both approaches can be used as obesity management interventions. For example, an individual living with obesity may focus on losing weight as their primary goal which would follow under a weight-centric approach, while introducing interventions that align with their current health behaviours, which would follow a health-centric approach (O'Hara et al., 2015). However, the lack of patient narratives in existing research suggests a need to better understand patient experiences of the two approaches, which provides the rationale for my study.

Research Purpose and Aims

The overall purpose of this study was to explore how people living with obesity understand the value of health-centric rather than weight-centric messaging in support of behaviour change. Providing individuals with the opportunity to explore how they experience health-centric and weight-centric messaging can help us to learn about the value of a health-centric approach in supporting people living with obesity. Often decisions are made from people without lived experience so hearing from people with obesity is important.

To achieve this purpose, my study has the following aims: 1) provide insight into the lived experiences of individuals living with obesity with respect to the value of health-centric versus weight-centric messaging in obesity management; 2) provide an understanding of how health or weight-centric messaging may shape an individual's view on obesity management; and 3) share how individuals living with obesity may be further impacted by their peers who may or may not be living with obesity.

These aims were addressed through conducting semi-structured interviews that posed a series of questions: "What type of health-care setting/ healthcare professional have you visited? What were your experiences? Was it easy to access this care?"; "What experiences in the healthcare system have you faced while seeking obesity management resources? Were they positive or negative?"; "What have these experiences with obesity management looked like and how did they impact your willingness to seek support?" Although prior to the interviews I was aware that a health-centric approach to obesity management is often seen as more positive in research, I sought to remain neutral in my approach to the interviews, allowing

participants to share their personal experiences and explain which approach they preferred after providing a definition for each.

The results section shares the findings from the interviews, including participant experiences and quotes. Themes were derived from the interviews and organized using social-ecological model (SEM). The SEM looks at the interactions between a health concern such as obesity and the different spheres of influence on a person's behaviours (Golden & Earp, 2012). These spheres of influence are intrapersonal, interpersonal, organizational, community, and public policy. The SEM is important to consider in research as it can help identify useful interventions at these different societal levels (Golden & Earp, 2012). The discussion section shares limitations from the study as well as considerations for future research.

I chose to research this topic as I have family members who are currently living with obesity, where I have seen first-hand the struggles, they have faced of trying to find reliable and available interventions to help with obesity management and wanting to learn more about what can be done to improve these resources across Canada (see also my positionality statement in the methods).

Summary

This section provided an overview of the study, what is meant by weight- and health-centric messaging and why it was important to consider these types of messaging in the present study. It provided the study's purpose and rationale. In the next section, the literature review will provide more detail on the thesis topic while connecting it with previous literature.

Literature Review

Introduction

The following section explores existing literature around how individuals living with obesity access obesity management care, along with the gaps found in existing literature. A literature review was conducted in the fall of 2022 as a part of the thesis proposal and then updated in the fall of 2023 to identify any additional research of relevance to the topic under study. Literature was identified using the Novanet document search application through Dalhousie University Libraries to search databases such as PubMed, Biomed Central, and Wiley. Other literature was found through official websites such as the Government of Canada, Obesity Canada, and The World Health Organization. The keywords used during this search process were obesity, obesity in Canada, weight-centric, health-centric, weight bias, weight stigma, and obesity management. Only literature that looked at adults (18 years and older) was included for this study to provide relevance to the study population selected.

Obesity

Obesity can be defined as "a complex chronic disease in which abnormal or excess body fat (adiposity) impairs health, increases the risk of long-term medical complications and reduces lifespan" (Wharton et al., 2020, P. 875). Obesity has traditionally been operationally classified as having a BMI exceeding 30 kg/m^2, BMI uses a height to weight ratio to determine an individual's body fat (Wharton et al., 2020). Obesity is now considered a complex and chronic disease because managing obesity is a lifelong process due to the body trying to "defend" its fat stores to maintain the individual's highest weight (Obesity Canada, 2022). According to Obesity Canada (2022), one in four adult Canadians are living with obesity, making it a disease that is

more prevalent than other diseases such as diabetes, heart disease, arthritis, chronic lung disease, or cancer. There can be health complications associated with obesity that include type 2 diabetes, hypertension, high blood pressure, anxiety, depression, and low self-esteem (Government of Canada, 2019). According to the 2020 Canadian Clinical Practice Guidelines (CPG), the root causes of obesity may include biological factors such as genetics, epigenetics, neurohormonal mechanisms, associated chronic diseases, certain medications, sociocultural practices and beliefs, social determinants of health (SDOH), environment, life experiences, and psychological factors (Wharton et al., 2020). Understanding that there are complex, inter-related factors that impact obesity is important when providing care to patients (Wharton et al., 2020).

Determinants of Obesity

There are several biological, behavioural, and societal factors that influence obesity including, genetics, physical activity, diet, and socioeconomic status (Government of Canada, 2011). Physical activity for example has been shown to have an impact on obesity due to an individual's lifestyle habits including, amount of movement, sedentary behaviours, and sleep (Government of Canada, 2011). According to the Government of Canada (2011), many Canadians get less than the recommended daily amount of physical activity. Sedentary behaviours such as screen time, reading, sitting during transit, and sitting during work also have been shown to have an influence on obesity (Government of Canada, 2011). According to the Government of Canada (2011), high levels of screen time (time spent on phone, watching television, or using a computer) are associated with a greater likelihood of Canadian adults and children developing obesity. Children and youth are recommended to have less than two hours

a day of screen time, however only 19% of are meeting this guideline (Government of Canada, 2011). Age, sex, education, socioeconomic status, and community influence screen time for both adults and children (Government of Canada, 2011). Diet along with physical activity are the two most common studied behavioural influences on weight and obesity (Government of Canada, 2011). Several studies have also found that environmental factors, lack of consumption of fruits and vegetables, and food insecurity have all had a negative impact on obesity (Government of Canada, 2011). Socioeconomic status (SES), education level, occupation, environmental factors such as neighbourhood and community also contribute to weight status and can be interconnected amongst each other (Government of Canada, 2011).

Obesity in Canada

In 2018, Statistics Canada (2019) identified that approximately 27% of Canadians aged 18 and older were affected by obesity with another 26% being considered overweight, as defined by BMI. Obesity, like other chronic diseases, can be effectively treated or managed (Obesity Canada, 2019). Over the past three decades, obesity rates have increased across the world including in Canada where obesity cases have increased threefold since 1985 (Wharton et al., 2020). On top of the rising number of obesity cases in Canada, healthcare professionals often feel ill equipped to provide care and support for individuals living with obesity (Wharton et al., 2020). In Canada, there is a profound lack of obesity management programs, a lack of access to healthcare providers with proper training in obesity, and a high cost for most management and treatment interventions (Wharton et al., 2020). The anti-obesity medications that are available are often not covered by provincial drug or Pharmacare programs across Canada, and the wait times for bariatric surgery are the longest of any surgically treatable

condition with some patients having to wait eight years before receiving surgery (Wharton et al., 2020).

Weight Bias and Stigma

Weight bias refers to "negative weight-related attitudes, beliefs, assumptions, and judgments toward individuals who are overweight and obese" (Alberga et al., 2016, p. 1). These views are widely held and lead to the development of stereotypes associated with obesity like "lazy", "sloppy", "unmotivated", "unintelligent", or "lacking willpower" (Pearl, 2018, p. 147). This becomes an issue when a person with obesity seeks care from the health system because weight bias and stigma are common in healthcare (Pearl, 2018). For example, it was found that healthcare professionals have less respect for patients living with obesity and believe they are unlikely to follow treatment recommendations due to their "lazy" and "unmotivated" nature (Pearl, 2018, p. 150). Weight bias and stigma are also experienced within education and employment due to the negative stereotypes associated with obesity (Almutairi et al., 2021). Individuals can also stigmatize themselves, a process known as internalized weight stigma (IWS), which refers to a type of stigma that is "characterized by self-devaluation and the fear of enacted stigma resulting from one's identification with a stigmatized group", in this case obesity (Almutairi et al., 2021, P. 1). IWS can be caused by the individual facing weight bias and stigma from their peers which then causes the individual to believe what their peers are saying leading to the individual stigmatizing themselves (Almutairi et al., 2021). IWS is even more concerning as it has been shown to contribute to poor psychological and mental outcomes such as low self-esteem, depression, anxiety, binge eating, and body image concern (Almutairi et al., 2021).

Access to Obesity Management and Treatment

According to the Canadian CPG (2020), a variety of different interventions are recommended for individuals living with obesity including, behavioural interventions (dietary, physical exercise therapy, cognitive behaviour therapy), pharmacotherapy, and bariatric surgery (Wharton et al., 2020). The way that healthcare professionals approach these interventions is important because many professionals see obesity as a lack of willpower, which can be stigmatising since this belief places the responsibility on the individual to address the problem (Wharton et al., 2020). As noted above, weight bias and stigma can negatively affect an individual and can lead to poor quality care, and avoidance of the healthcare system (Nutter et al., 2016).

Two common forms of obesity treatment are diet and physical activity, either together or separately. Any individual, regardless of if they are living with obesity or not could benefit from regular physical activity and healthy eating (Wharton et al., 2020). It is recommended that individuals get around 30-60 minutes of physical activity most days of the week, which can help with weight loss and improve well-being (Wharton et al., 2020). According to the World Health Organization (WHO, 2021), reducing the number of calories consumed from fats and sugars, and eating more whole foods, fruits, and vegetables instead can lower the risk of obesity in an individual.

Psychological and behavioural interventions offer another form of obesity management. These interventions look at the "how to" of change to allow health-related changes in an individual's life to be more sustainable and adapted to the individual (Wharton et al., 2020). These types of intervention vary from patient-to-patient but consider health goals in the

context of a person's everyday life (Wharton et al., 2020). Individuals living with obesity should be able to use healthcare professionals' expertise to help identify strategies that work for them to support behaviour change (Obesity Canada, 2021).

Pharmacotherapy is another form of obesity management and treatment recommended by the Canadian CPG. Obesity medications are shown to be effective for managing weight and are often combined with psychological and behavioural interventions (Obesity Canada, 2022). However, anti-obesity medications are not covered by any provincial or federal drug benefit programs, making it an expensive intervention for obesity management (Wharton et al., 2020). This intervention is recommended for individuals who have a BMI of > 30kg/m² or a BMI of > 27 kg/m² and who struggle with weight loss through behaviour change alone (Wharton et al., 2020). Individuals living with obesity should be able to access this form of obesity management with the goal of improving health (Obesity Canada, 2022).

Bariatric surgery may be used for individuals who have a BMI of > 40kg/m² or a BMI of > 35 kg/m² and who have at least one obesity-related disease (Wharton et al., 2020). Bariatric surgery can offer sustainable weight loss (20-30% reduction) with appropriate education, follow up and patient selection (Obesity Canada, 2022). Bariatric surgery, despite its success, is only available to one in 171 adult Canadians living with severe obesity each year and those referred for the surgery can expect to wait up to eight years before receiving the surgery (Rehani, 2019). An example of an obesity related disease may include type 2 diabetes, hypertension, or high blood pressure (Government of Canada, 2019). Bariatric surgery either reduces the amount of food you can eat or reduces the absorption of calories from the food that you eat, or both (Rehani, 2019). Although these surgeries have shown success in patients, maintaining healthy

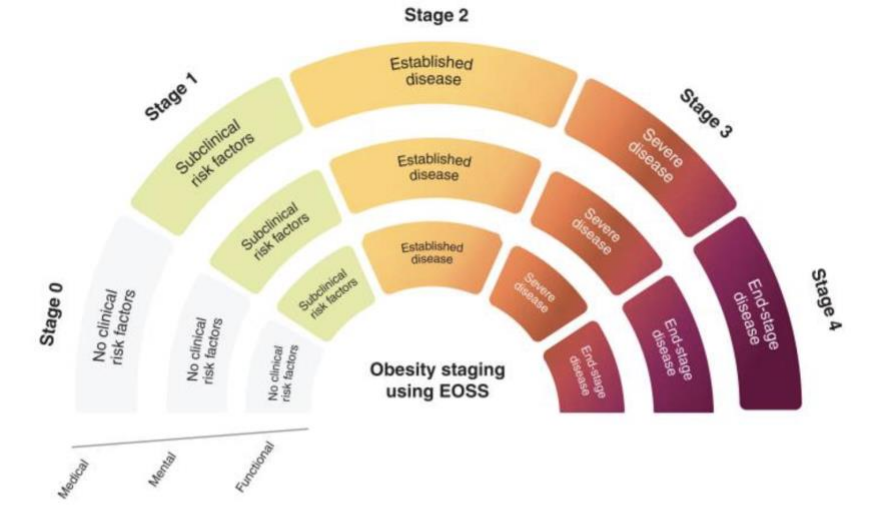
behaviours is still required to reap the long-term benefits (Rehani, 2019). This surgery can offer a 20-30% weight loss reduction with a reduction in morbidity and mortality and improvements in mental health and quality of life (Rehani, 2019).

Obesity Management Core Principles

One of the ways healthcare providers can assist their patients with obesity management is through the 5As tool. The 5As tool consists of five steps; ask, assess, advice, agree, and assist which can be used to help patients better manage their weight and other connected health issues (Obesity Canada, n.d.). Ask can refer to the healthcare professional asking permission to discuss weight and explore the patients' readiness; assess can be looking at risks and causes related to obesity; advise would be on obesity treatment options and health risks; agree can be on the agreeance of health outcomes and goals between the patient and healthcare provider; and lastly assist can refer to the healthcare professional assisting in finding and accessing proper resources and professionals (Obesity Canada, n.d.).

Another tool used to evaluate obesity or, more specifically, the stage of the disease is the Edmonton Obesity Staging System (EOSS) (Swaleh et al., 2021). According to the 2020 Canadian CPG there is a need for clinical assessment for individuals living with obesity which can be determined using BMI for obesity classification and the EOSS for the determination of the stage of obesity the individual is in (Wharton et al., 2020) (Swaleh et al., 2021). The EOSS is a tool that uses a five-stage scale to evaluate obesity-related comorbidities in an individual (Swaleh et al., 2021) (figure 1).

Figure 1: Edmonton Obesity Staging System and Body Mass Index Class



Obesity staging using recommended classification of BMI

Category	Body mass index
Underweight	< 18.5
Normal (healthy weight)	18.5–24.9
Overweight	25–29.9
Obesity class I	30–34.9
Obesity class II	35–39.9
Obesity class III	≥ 40

These obesity-related comorbidities can increase morbidity and mortality rates and raise health system costs for individuals living with obesity (Swaleh et al., 2021).

Health Promotion and Obesity

According to the WHO, health promotion "is the process of enabling people to increase control over, and to improve their health" (World Health Organization, 2023). A study by Malterud and Tonstad (2009) reviewing health promotion strategies to manage or prevent obesity were explored in this section to show the link between health promotion and obesity. This study looked at the challenges of preventing obesity using health promotion strategies and

found that preventing obesity is difficult due to an individual's vulnerability to weight gain and neurobiological determinants that can lead to weight gain not associated with the individual's lifestyle (Malterud & Tonstad, 2009). Some examples of neurobiological determinants that influence weight gain are, age, gender, and ethnicity (Malterud & Tonstad, 2009). The health promotion strategies that Malterud & Tonstad (2009), looked at included behavioural interventions, along with social and cultural contexts that can shape individual' behaviours, as well as access to physical activity and healthy foods.

The SDOH are important to consider in a health promotion context as they are the economic and social conditions that influence health status of individuals and communities (Bryant et al., 2015). Examples of SDOH are, income, education, social and community context, health and healthcare, and neighbourhood and built environment (Bryant et al., 2015). A study by Bryant et al. (2015), that looked at the impact of the SDOH on obesity found that health inequalities will continue to occur if healthcare professionals do not intervene. One way for healthcare professionals to address these inequalities is to incorporate SDOH knowledge to improve patient care and advocacy (Bryant et al., 2015).

Healthcare and a weight-centric approach

Healthcare professionals following a weight-centric approach to obesity management often stigmatize their patients and follow narratives such as "eat less and move more" instead of focusing on health behaviours and the cause of weight gain that is more typical of a health-centric approach (Campbell-Scherer et al., 2020). Another main difference between a healthcare professional following a health- or weight-centric approach is relative to the emphasis they place on their patient's weight regarding health, and how they treat their

patients based on their appearance (Tylka et al., 2014). Not acknowledging a patient's genetics as a factor related to a higher weight or assuming their higher weight is caused by non-compliance with health behaviour change principles would also follow under a weight-centric approach (Mauldin et al., 2022).

Healthcare and a health-centric approach

It is important to highlight the distinguishing characteristics when a healthcare provider takes a health-centric versus a weight-centric approach to obesity management. In a study by Fastenau et al. (2019), looking at patient-centered approaches to obesity management, the researchers identified the importance of empowering patients through health-related decision-making to improve the quality of patient care. Although this study did not use the term health-centric specifically, the patient-centered approach referred to can be considered to share many similarities. Indeed, Fastenau et al. defined it as "providing care that is respectful of and responsive to individual patient preferences, needs and values; and ensuring that patient values guide all clinical decisions" (Fastenau et al., 2019, P. 1). Some key dimensions of a patient-centered care approach that align with a health-centric approach include education and communication of care and services, emotional support, and support for long-term behaviour change (Fastenau et al., 2019). The patient-centered approach or health-centric approach may lead to more uptake and favourable outcomes in obesity management due to it allowing patients to work with healthcare professionals during the decision-making process (Fastenau et al., 2019).

Healthcare professionals following a health-centric approach recognize that there are weight biases and stigma often seen throughout healthcare that need to be addressed when

interacting with their patients (Tylka et al., 2014). Healthcare professionals following a health-centric approach are also more likely to use people-first language when discussing their patient's weight with them to reduce weight stigma (Kyle & Puhl, 2014).

Obesity is typically classified using BMI, which is not an accurate method to classify obesity (Wharton et al., 2020). BMI does not consider factors such as muscle mass, race, and sex, which can influence an individual's weight (Mauldin et al., 2022). An alternative to BMI is the Edmonton Obesity Staging System (EOSS) which comprises a 5-stage system that considers metabolic, physical, and psychological factors to help determine the health risks associated with excess adiposity (Wharton et al., 2020). This model highlights a need for changes in obesity management practices by identifying that health, well-being and co-morbidities should be considered in interventions and that for people with excess adiposity alone, there may be no need for intervention.

Identifying obesity as a chronic disease, as we would with other diseases such as diabetes, is another important next step. Having healthcare providers identify obesity as a chronic disease means considering it as a condition that requires long-term treatment and management plans in place to help reduce the risk of premature morbidity and mortality (Wharton et al., 2020). Unfortunately, the prevalence of weight bias and stigma among healthcare providers can reduce the quality of care for patients living with obesity (Wharton et al., 2020). Providing more training to healthcare individuals on obesity management, and the impacts of weight bias and stigma, may help reduce these negative connotations about the disease.

Along with identifying obesity as a chronic disease, advocating for the patient living with obesity is also important to ensure the patient receives the care they require (Wharton et al., 2020). Weight bias and stigma in the healthcare system can lead to the avoidance of healthcare services (Alberga et al., 2019). It has been found that healthcare professionals may hold strong implicit negative views towards patients living with obesity (Alberga et al., 2019). This was also supported in a previous study which explored the effects of stigmatization on individuals living with obesity by comparing two groups, one who has experienced stigmatization in a healthcare setting and one who has not (Hansson & Rasmussen, 2014). The group which experienced the stigmatization in a healthcare setting had a 1.5 kg/m^2 greater BMI and a BMI change of 1.46 kg/m^2 over the study period, higher than the group who did not experience stigmatization (Hansson & Rasmussen, 2014). This study supports the need for further education in healthcare professionals who care for patients living with obesity in order to help teach their patients how to maintain healthy behaviours such as a healthy diet and regular exercise, without focusing too heavily on weight loss.

Moving towards a health-centric approach to obesity management

According to a recent study by Mauldin et al. (2022), current healthcare mainly follows a weight-centric approach, which can lead to the experience of weight bias and stigma and subsequent avoidance of healthcare settings amongst the study's participants. A weight-centric approach has been shown to be ineffective for most patients long-term (Mauldin et al., 2022). Mauldin et al. (2022), claimed that one major reason that it is hard to shift from a weight-centric to a health-centric approach is due to a focus on body size as a primary metric for health. For example, in several academic articles, terms such as "ideal weight," "normal

weight," "healthy weight," and "morbidly obese" are used, which all have underlying assumptions associated with them (Mauldin et al., 2022, Pg. 1294). Most of these terms imply that there is a "right" weight that everyone should be, ignoring factors such as height, sex/gender, age, race and other SDOH that can impact an individual's weight status (Mauldin et al., 2022). These weight-centric descriptors can be harmful to patients as they frame people as 'different' and not the 'ideal' version of themselves (Mauldin et al., 2022).

A health-centric approach may be reflected in different ways in the literature. For example, a study by Tylka et al. (2014), looked at the difference between a weight-inclusive versus weight-normative approach to health and found similar results to the study by Mauldin et al., 2022. In the paper, Tylka et al. (2014, P. 6) defined weight inclusive as "the assumption that everybody is capable of achieving health and well-being independent of weight, given access to non-stigmatizing healthcare". Tylka et al. (2014, P. 2) defined the weight-normative approach as "the many principles and practices of healthcare and health improvement that prioritize weight as a main determinant of health." Tylka et al. (2014), found that the weight-normative approach to health, which emphasizes weight loss as its main priority, is not effective for most people, where they discovered high rates of weight cycling and weight regain. By contrast, the study found evidence that the weight-inclusive approach, typically used in the Health at Every Size model (HAES) was beneficial to improving physical, behavioural, and psychological health (Tylka et al., 2014). The HAES model can be defined as "a paradigm that supports size-acceptance, to end weight discrimination, and to lessen the cultural obsession with weight loss and thinness through promoting balanced eating, life-enhancing physical activity, and respect for the diversity of body shapes and sizes." (ASDAH, 2020). This approach

aligns with a health-centric approach because it works to reduce weight bias and stigma by instead promoting the idea that health can appear in several a variety of shapes and sizes. The approach differs from a health-centric approach in one important way, in that the HAES approach looks at size acceptance and challenges the notion of obesity as a health risk at all (ASDAH, 2020). The HAES approach has gained greater acceptance as a health-centric approach but is not without flaws, having a limited evidence base on its impact outside a narrow set of parameters (Penney and Kirk, 2015).

A study by Nutter et al. (2016), looking at weight bias through three different perspectives (weight-centric, health-centric, and HAES), supports the works of Giabbanelli et al. (2013), and Tylka et al. (2014) by claiming that although weight bias is harmful across these three perspectives, a weight-centric approach supports the 'thin-ideal' and causes social comparison (Nutter et al., 2016). This is because positioning weight to be within an individual's control can lead to negative health consequences such as weight bias, as previously noted (Nutter et al., 2016).

Lived experiences in Research

Using patient interviews to share lived experiences of individuals living with obesity is an important area of study. Studies that use qualitative approaches, such as participant interviews, have shown to provide a greater understanding of complex diseases such as obesity (Farrell et al., 2021). As Farrell et al. (2021) notes; "In spite of an increasing recognition of the integral role of patient experiences in health research, the voices of patients remain largely underrepresented in obesity research" (Farrell et al., 2021 P. 2). Research on the topic of obesity tends to lean more towards quantitative research with measurable outcomes, failing to

capture the complexity of the disease through lived experiences (Farrell et al., 2021). This research is important as it allows individuals living with obesity to share their expertise and knowledge of what it is like to live with obesity, something in which not all researchers can do, which can further help improve healthcare practices (Farrell et al., 2021).

Summary

In this section I looked at relevant literature related to the research topic. Definitions were provided for common terminology found throughout the thesis, and background to the research problem was given. An overview of contemporary obesity management in Canada was also proved. The next section presents the research design and methods of the study.

Research Design and Methods

This study sought to explore the lived experiences of adults living with obesity in Canada in accessing care for obesity management within a healthcare setting, to determine whether a health- or weight-centric approach to care was encountered and the strengths and limitations of each approach. This section will describe the relevant theoretical frameworks that guided the work and the methods selected to address my stated research questions.

Methodology

Qualitative research

Qualitative research refers to a type of research that explores real-world problems by using participants' experiences and perceptions through data collection methods such as interviews, focus groups, and observation (Tenny et al., 2022). Unlike quantitative research where numerical data are collected, qualitative data look to answer the 'how' and 'why' presented within research, making it the best suited research type for a study of lived experiences (Tenny et al., 2022). Qualitative research was applied in this thesis through conducting semi-structured interviews with participants to hear about their experiences seeking care for obesity management. Qualitative research is especially beneficial when wanting to uncover, describe, or explore a phenomenon where little is known about it (Cypress, 2015). Qualitative research also works together with a pragmatic worldview as both approaches strive to investigate reality (Helm, 2023). This approach allowed the lived experiences of participants to be shared as an approach to create social action and behaviour change (Cypress, 2015).

Pragmatic worldview

A pragmatic worldview guided this study. A pragmatic worldview focuses on "what works" as opposed to what may be considered "true" or "real" (Weaver, 2018). Early pragmatists declared that there cannot be one way to solve a problem and that consequences, not identified at the start, can help find several approaches to addressing any problems or concerns, such as respectful care for obesity management in a variety of different ways (Weaver, 2018; Brierly, 2017). The pragmatic worldview can help to understand the different factors that are involved in an individual's actions within a given situation (Helm, 2023). Therefore, this methodology was aligned with this study because it sought to identify whether participants had lived experience of weight-centric and/or health-centric messaging as they sought support for obesity management.

Thematic analysis

Thematic analysis is useful in identifying, analyzing, organizing, describing, and reporting themes found in a data set (Braun & Clarke, 2013). It is also said that thematic analysis can provide trustworthy and intuitive findings in research (Braun & Clarke, 2013).

Braun and Clarke's (2013) six-step model of thematic analysis were used during data analysis to help identify repeating themes and codes. Included in Braun and Clarke's (2013) model are the following steps: familiarization with the data, coding, searching for themes, reviewing themes, defining themes, and writing up, which will be expanded on later in the thesis.

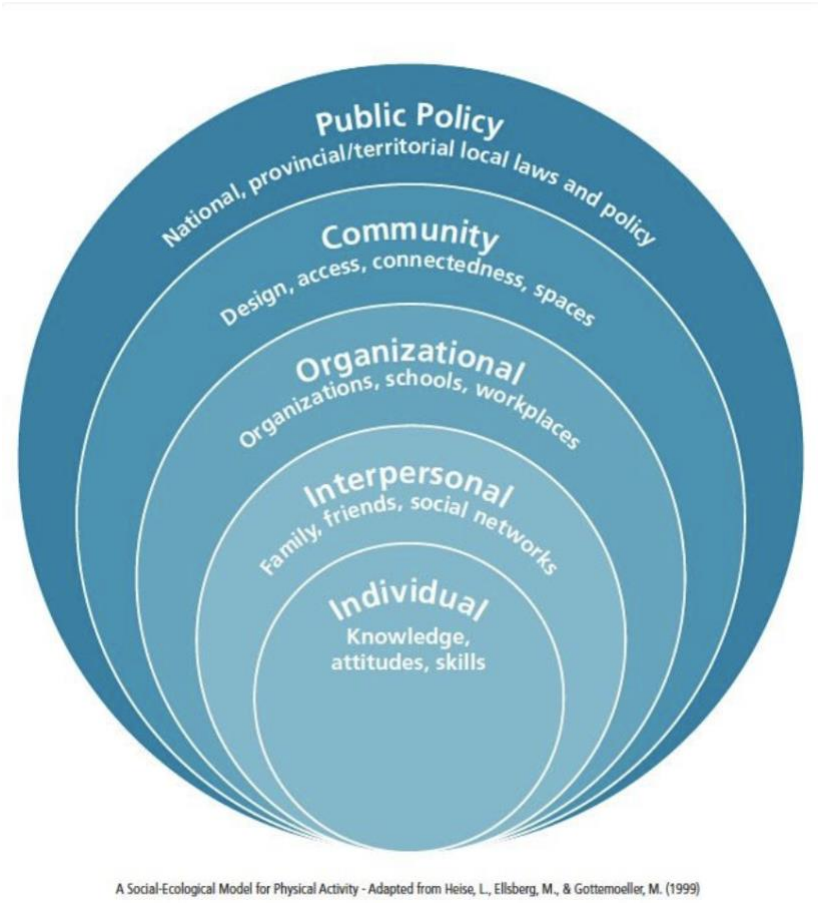
Social Ecological Model

The social-ecological model addresses the individual and environmental characteristics that can affect health outcomes on numerous levels (Golden & Earp, 2012). The social-ecological model is split up into five levels: intrapersonal, interpersonal, organizational, community, and public policy (Golden & Earp, 2012). These levels are used to understand the relationship between personal and environmental factors (Bronfenbrenner, 2005). The individual level looks at factors such as sex, age, and health (Bronfenbrenner, 2005). The interpersonal level looks at relationship factors between the individual and its peers such as family, friends, and coworkers (Bronfenbrenner, 2005). The organizational level looks at the relationship between the individual and organizations such as school or workplace (Bronfenbrenner, 2005). At the community level factors such as design, connectedness, and access are looked at (Bronfenbrenner, 2005). Lastly, at the policy level, local laws and policies can be explored (Bronfenbrenner, 2005). These five levels can influence and be interrelated within each other to address factors that affect health (Lee et al., 2017). According to Lee et al. (2017, P. 300), "each superordinate level influences the subordinate level." An example of how this may be used in the context of obesity management is a public policy may influence a Healthcare provider that influences an individual to follow certain healthcare advice that can benefit the individual's health (Lee et al., 2017). Using a multilevel approach with repeated interventions has been linked to a higher likelihood of achieving a positive outcome (Lee et al., 2017).

The social-ecological model is useful in understanding how environmental factors may affect an individual and their health (Scarneo et al., 2019). The separate levels allow for the

adaptation of interventions that address different health behaviours to align with each level of the model (Golden & Earp, 2012). The social-ecological model was therefore applied to categorize the key themes identified from the interview data into the subsections of the model to contextualize the spheres of influence that participants experienced. Figure 2 shows how the levels are conceptualized.

Figure 2. The Social-ecological model diagram



I applied the model to examine what or who the participant was interacting with when sharing their lived experiences. This allowed me to identify where or how health or weight-centric narratives were encountered by participants (see table 1).

Table I. The Social-ecological model and its relevance to understanding health-centric approaches to obesity management.

Social-Ecological Model Level	Interview Criteria and its Connection to Health or Weight-Centric Messaging in Obesity Management
Individual	Individuals' perception of their experience with a healthcare professional around obesity management.
Interpersonal	Individuals' relationships with people in their lives such as family and friends and their impact on seeking healthcare professionals for obesity management.
Organizational	Individuals' experience seeking healthcare professionals to help with obesity management.
Community	Individuals' experience with their community and community members when building relations and seeking support for obesity management.
Policy	Individuals' experience and awareness of policies in place to address obesity management and factors that may contribute to negative experiences such as weight bias and discrimination.

Golden & Earp (2012).

Once the key themes and their connected quotes were identified I mapped them to the level of the SEM that best aligned with each theme, acknowledging that the themes may be interchangeable across the five levels of the model. I read each quote to determine if the participant was talking about their own health or feelings to classify their experience as the individual level; if the participant shared experiences with peers such as family, friends, or coworkers I classified their experience as interpersonal; experiences with organizations such as workplace or healthcare setting I classified as organizational, as well as experiences with healthcare professionals as those interactions most likely took place in a healthcare setting; experiences where participants shared experiences about access and design of programs was considered at the community level, and lastly any experiences with laws or policies was connected to the policy level. The SEM is beneficial to this study to help the reader understand how environmental factors may influence obesity management interventions at different levels.

Application to the Current Study

This study used the pragmatic worldview approach, with generated themes from qualitative interviews subsequently framed on the SEM. This allowed me to explore the influence of health- and weight-centric messaging on individuals living with obesity when seeking care for obesity management. The analysis specifically looked at the experiences that participants shared that covered their relationships with peers, healthcare professionals, and community members. Through the lens of a pragmatic worldview approach, this study provides examples that participants shared around following a health-centric or a weight-centric approach to obesity management and the ways individuals living with obesity navigate obesity management interventions across different levels of the SEM.

Qualitative description

Qualitative description (QD) is a methodology used in qualitative research, particularly in health care related research, to discover the who, what, and where of experiences or events by informants who have insight on a poorly understood phenomenon (Kim et al., 2018). QD lends itself to a pragmatic worldview because this method tends to stay close to the data and experiences of participants (Sandelowski, 2000); (Neergaard et al., 2009). For the purpose of this study, QD was used to identify experiences that individuals living with obesity shared when interacting within a health care setting. Thematic analysis was also used in this study, as it is in alignment with QD design features and techniques when analyzing data (Kim et al., 2018). This methodology is particularly relevant in studies such as this one where information and data are collected from individuals experiencing the phenomenon being researched where time and resources may be limited (Bradshaw et al., 2017).

Methods

Participants

I conducted semi-structured qualitative interviews with participants who identified as living with obesity or who had previously lived with obesity. This sample size was chosen with the understanding that 10-15 total participants is enough to achieve saturation (i.e., no new themes are identified); (Dworkin, 2012). Research also suggests that anywhere from 5-50 participants is adequate in qualitative research (Dworkin, 2012). A sample size of 15 participants was therefore anticipated for this study, with a focus on adults (18 years old and older), living with obesity or who have previously lived with obesity and who had encountered a healthcare provider in the health system regarding obesity management.

Experiences where individuals sought support for a different health reason other than obesity, but the topic of obesity or excessive weight was brought up by the healthcare provider as a contributing factor, were also considered for this study. Examples of potential health system encounters included, family physician appointments, dietician appointments, psychological appointments (therapy), specialist appointments, following organizational diet plans (i.e., Weight Watchers), and appointments with certified health coaches.

Some participants were recruited from the Obesity Canada Public Engagement Committee. These participants were considered to have a deeper understanding of health-centric approaches, because of their role and experience with the Public Engagement Committee, and therefore more likely to be able to articulate the differences between a weight and health-centric approach. I purposively selected the participants to provide a range of

experiences with weight-centric and health-centric messaging. Table 2 provides the inclusion and exclusion criteria for the study.

Table 2: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Must be 18 years and older	Anyone under 18 years of age
Must be living with obesity or have previously lived with obesity	Someone who is not currently living with obesity and who has never lived with obesity
Must have sought out a healthcare provider in the health system regarding obesity management (examples of these healthcare providers can be found above) OR sought out care for a different health concern but the topic of obesity or excess weight is brought up by the healthcare provider as a contributing factor	Someone who has not sought out a healthcare provider for obesity management
Must have sought out treatment in Canada	Someone who has sought out treatment outside of Canada

This study was open to individuals who resided in Canada, and who had encountered a healthcare provider in the Canadian health system. Participants were mainly from the Halifax Regional Municipality area, which allowed for some in-person interviews to be conducted, if preferred by participants. Other interviews that were not able to be held in-person due to distance or comfort of the participant, were conducted online through a video call on the application Microsoft Teams. On average the interviews lasted around 40 minutes with a range from 21 to 58 minutes.

Recruitment

Individuals for this study were recruited through posters in healthcare settings, social media, or direct communication with the Obesity Canada Patient Engagement Committee (See

Appendix D). The posters included information on the type of participant I was looking for, what the study would involve for the participant and my contact information. The posters were also distributed to healthcare facilities that had agreed to display them, as well as shared virtually on social media through my personal social media accounts that allowed the poster to be reposted by others. Once participants showed interest in the study, they were contacted to assess eligibility and to provide further information of the study. Participants were also given the opportunity to either receive a twenty-dollar Indigo gift card or make a twenty-dollar donation to Obesity Canada once they completed the interview. If a participant chose to drop out before the interview, they were still eligible for the honorarium. Participants did not incur any expense unless they chose to complete the interview in-person, in which case they may have incurred transportation costs.

The Obesity Canada Public Engagement Committee works with individuals conducting obesity research on a regular basis to share personal experiences. I personally emailed the committee asking for participants and Obesity Canada was also asked to share the information on the study with their networks. I included members of the Obesity Canada Public Engagement Committee because they would be more likely to have a broader understanding of what weight- and health-centric approaches to obesity management are and would be able to distinguish the two approaches in experiences they have had interacting with healthcare providers. Although the participants from the committee had a better understanding of the two approaches, they were still able to share their own personal experiences both positive and negative, for the study.

Once participants reached out to express interest, I confirmed that they met the inclusion criteria. After participants showed interest in the study and the inclusion criteria were met, a consent form and study details (Appendix E) were provided via email, prior to the start of each interview. The participant was asked to provide consent by signing the consent form or verbally providing consent during their interview, to indicate they agreed to their interview being recorded, and for the use of direct quotes to potentially be featured in the result section of the thesis. All participants gave consent for the interview being recorded and for the use of direct quotes.

Data Collection and Management

Participants were asked a series of guided open-ended questions to allow for their personal experiences to be shared. The interview questions included information that allowed me to understand the type of healthcare setting(s) participants had encountered, why they chose each specific healthcare setting to talk about, and their personal experience, whether positive or negative, within the healthcare setting. The interview guide found in Appendix C provides more context to the type of questions asked to participants about their experiences. Interviews took approximately 30 minutes to an hour based on the amount of information participants were willing or able to share.

Throughout interviews I kept notes as an aide memoire, e.g., to capture participants' facial expressions, or emotional responses to questions that may elucidate more fully a participant's experience. Interview notes were saved on OneDrive.

Interviews were recorded using a digital recorder provided by my supervisor. Each interview was saved onto a memory card in the recorder before being transferred to a secure

drive (OneDrive) in a password-protected file and with a study ID. Interviews were transcribed and saved on OneDrive and the recordings were deleted. Any identifying data were removed from the transcripts to protect confidentiality.

Data Analysis

Once transcribed, the interview data were uploaded into Nvivo coding software. Nvivo 12 (QSR International, 2021) was used to classify key themes found throughout interview responses. Braun and Clarke's (2013) six-step model of thematic analysis was used to ensure these key themes were aligned with the study. The steps included in this analysis are as follows: (1) *familiarization with the data,* meaning all transcripts were reviewed in detail several times to ensure familiarity and that no data are missed before coding; (2) *coding,* where all phrases of data or units of meaning related to the research topic were labelled with a short description; (3) *searching for themes,* meaning similar or repeat experiences found within the data were separated into separate themes for coding; (4) *reviewing themes,* whereby all identified themes found throughout the data were confirmed to relate to the research topic; (5) *defining themes,* where all themes were described in detail using examples from the text; and lastly, (6) *writing up,* meaning an explanation as to what the data mean, how they contribute to the research topic and providing examples straight from the text to consider when looking at other studies. Once the themes were identified, they were further organized using the five levels of the SEM described in figure 1 above.

Throughout the coding process I looked for meaning in the data then created a code that best described what participants were saying. As I continued reading through transcripts, anytime I encountered an example that fit with a previous code I added it, and if I came across

a new code, I would label it as well. Some of the codes I identified throughout this process include positive experiences with healthcare professionals, negative experiences with healthcare professionals, diet cost, and family interactions. After reviewing all the transcripts for the first time I went back and read through them again to ensure I captured every code. After this process I started grouping the codes together to create four themes which are described in the results section. These broader themes were created with the help of my supervisor, by reviewing the data and codes together.

During the coding process I made an assessment of whether the experiences shared by participants reflected a health-centric or weight-centric approach. I did this by re-reading each coded quote and reviewing it with the definitions of both health- and weight-centric to see where it best fit. Through this process, I found that more negative experiences where the participant was left feeling defeated and frustrated, mapped to a weight-centric approach whereas more positive experiences where the participant felt hopeful and was encouraged, mapped to a health-centric approach.

Throughout the data analysis process it was also important to avoid any personal bias, I was able to do this by using direct quotes from participants and providing them the option to read their transcript, maintaining records of all important documents, re-reading all codes to ensure they are an accurate depiction of the participants responses, as well as not ignoring differences between myself and participants in regard to weight status.

Reciprocity and Ethics

This study was approved by Dalhousie University Research Ethics Board in January 2023. The researcher-participant relationship is key to conducting a successful study (Trainor &

Bouchard, 2010). Having participants share their lived experiences can benefit the study, but it is important that the study can benefit the participants long-term (Trainor & Bouchard, 2010). Committing to sharing the results of the study with participants, and other stakeholders such as in healthcare settings, can support healthcare improvement and inform additional training needs to improve the care experienced by individuals seeking obesity management care.

All individuals who voluntarily agreed to take part in the study received all necessary documents after the screening process was complete and before any interviews, including a consent form to sign, a description of their role in the study, and how results would be communicated to them after the study was complete, by myself (lead researcher) (See Appendix E). Participants were encouraged to ask questions via email or phone prior to the interview to ensure they were clear about what was expected of the study. This happened any time after the screening process was complete up until the start of the interview (within two weeks). This process was completed through email and participants were told they could email any questions or concerns they can think of before or up to the start of their scheduled interview. I also provided participants with the opportunity to ask any questions before starting the interview. Interviews were conducted in private, either in a private room in-person, or behind closed doors when interviewing participants virtually.

Participants also had the option to drop out of the study prior to the interview and analysis process, without explanation. This means that no data would have been collected prior to the participant wishing to withdraw. Prior to the data being analyzed, interview participants who wished to withdraw could choose to withdraw completely from the study or withdraw certain aspects of their interview up to two weeks after the interview was completed. After

their data were analyzed, it was not possible to remove them from the study and this was explained prior to signing the consent form. Participants could withdraw by emailing myself identifying that they would like to do so.

Confidentiality was maintained by removing the names of participants and replacing them with a code. Any other identifiable information such as place names were taken out or de-identified with a code or fake name. All data were kept in a password-protected OneDrive folder that only I had access to.

At the end of the study when no further communication was required with participants, email addresses were deleted, both from my email and any forms in the OneDrive file**.** As outlined in the ethics application, data will be destroyed five years after completion of the study.

I also offered member-checking to all participants which included sending the participant their interview data to ensure it was written correctly and that they were happy for the information that they provided to be used as data. If a participant wished to edit their transcript, I requested another meeting to discuss what changes they would like to make and why, however no participant wished to do so.

There was a risk that talking about experiences seeking support within health settings might be uncomfortable or distressing to participants. This risk was mitigated by explaining the purpose of the study and how data would be handled. It was possible that participants might get upset. In this case, I referred them to organizations that might be able to help them, e.g., Obesity Canada has an online community that supports people living with obesity. However, this was not something I encountered during the interview process.

Positionality in the Research

Positionality in qualitative research looks to assess the different characteristics of the researcher and the research subject that may influence the research process (Mason-Bish, 2018). As someone who is not considered to be living with obesity, I am different from the study population. However, although I personally do not live with obesity, I have several family members who do, which I believe helped me to connect with the study population and understand their struggles interacting with the Canadian healthcare system. Throughout data collection and analysis, I tried to mitigate any preconceived ideas or biases I might have held by actively listening to my participants experiences and not forcing my participants to answer any question they are not comfortable enough to answer.

Trustworthiness and Reflexivity of the Study

Trustworthiness aims to support the argument brought forward in the research study to show that the findings are worth paying attention to (Elo et al., 2014). The trustworthiness of this study was ensured by reviewing every step of the analysis process such as preparation, organization, data collection, and the reporting of results (Elo et al., 2014). All results were reported and included in the study to show its credibility, even if not all results benefitted the study's results. Reflexivity was gained through acknowledging how my life experiences such as my background, assumptions, and biases might impact the data collection and analysis of this study (Joseph et al., 2021).

I also tried to avoid personal bias by having interviews recorded and transcribed verbatim, throughout data collection and the thesis writing process, using people-first language and by verifying results with other study's results, reviewing data with participants and my

supervisor. I was able to verify the results found in my study with other data by looking at the results of published peer-reviewed articles on health- and weight-centric messaging or topics related to my study topic and comparing them to the results of my study to see if they align.

Dissemination Strategies

Participants were asked at the start of the study whether they would like to receive a summary at the end of the study. Once the study was complete, I emailed participants a summary of the results if they wished to receive one.

Summary

This section reviewed the design and methods used in the study, while also describing the study frameworks that guided the study through data collection and data management. A description of pragmatic worldview, thematic analysis, and the SEM was provided. Descriptive details on the procedure of data collection and data analysis throughout the study was also included. The next section reviews the study's findings.

Results

Introduction

This section describes the lived experiences of the participants as they interacted with the healthcare system to identify whether they had experienced and/or understood the value of the health-centric approach or a weight-centric approach to obesity management, which was the purpose of the study. Ten people participated in the study, which in qualitative research is determined to be enough to reach saturation (Dworkin, 2012). All were adults who were living with, or who had previously lived with obesity and who had interacted with the healthcare system in Canada. There were both male and female participants from across Canada, with two participants being a part of the Obesity Canada Public Engagement Committee. All participants identified that they had lived or were currently living with obesity and had sought out obesity care in Canada. All participants shared that they had experienced weight-centric messaging at some point while interacting with the healthcare system, with seven of the ten participants sharing that they had also experienced health-centric messaging when interacting with the healthcare system regarding obesity management.

Participants one, six, nine and ten were all adult woman (30 years of age +) and were not associated with Obesity Canada. Participants two, three, and four were all young adult woman (18-29 years of age) and were not associated with Obesity Canada. Participant five was an adult man (30 years of age +) and was associated with Obesity Canada. Participant seven was an adult woman and was associated with Obesity Canada, and lastly participant eight was an adult man and was not associated with Obesity Canada.

Four themes were identified through the analysis process. These were *the 'weight' of words, unsustainable care, care without context,* and *think 'healthy' thoughts.*

The 'weight' of words

The first theme identified was *the 'weight' of words*, which refers to the power that words could have on the participants, and how these words permeated interactions between their peers or healthcare professionals. The words that were described by participants as being directed at them through encounters generally and in the context of the health system, represented narratives that could cause harm, for example affecting their eating habits, relationships with others including healthcare professionals, and their mental health. In one example, a participant shared, which was a conversation they had with a healthcare professional, where the participant was inquired about getting a specific type of surgery. They described how their weight was brought up to shut down the option for the surgery: "I wanted to look into the option of getting a [specific surgery], so she asked me, like, my height and my weight, and immediately was like, well, you're obese, you're going to have to lose weight before you can get [specific surgery]" (Participant 2). Here, the word "obese", while routinely used within health care settings, had the power to define the participant's options for care and served as a barrier to accessing further support.

One participant shared that their family doctor never showed interest in supporting them when it came to weight loss, noting said that their doctors suggestion was to: "go eat a salad" (Participant 1). However, they explained how they are not able to just "go eat a salad" because they had Crohn's Disease, an inflammatory condition of the gut. They explained that: "with Crohn's disease, you actually can't… trust me, I'd love to have a nice salad but you know,

shepherd's pie is much easier to digest" (Participant 1). In this example, the lack of support that the participant perceived from their doctor is encapsulated by the reference to eating a food that was not in line with their health or dietary needs.

A different participant also shared a negative experience of their interaction with a healthcare professional, describing how: "she says you could be dead within X number of like 10 years or whatever, if you don't do something [referring to doing something about the participants weight]" (Participant 5). In this example, the weight of words is reflected in the mention of dying being an outcome that this participant could face. Such comments can introduce fear while also reflecting a weight-centric narrative that can be discouraging to patients, if not accompanied by any tangible support on how weight loss can be achieved.

Another participant expressed happiness at the thought of losing weight and becoming 'skinny':

> Like one part of the meds that I'm on, it can cause like, loss of appetite. So, [the doctor] was kind of like, wanted to make sure that I was still eating. So that I didn't, you know, so I think then there was also the part of me that was like, [the doctor] told me that and I was like, so you're telling me, I'm going to be skinny? [said while smiling] (Participant 2).

In this context, being skinny was viewed as something the participant wanted to aspire to, and that the way that the healthcare provider spoke to them led them to see this as a possible outcome from taking medication.

The quotes above illustrate the weight that participants placed on the words used by the people around them, and how these words or narratives were expressed, often as negative

interactions between their peers or healthcare professionals. Over half of the participants shared experiences of struggling with the fear of judgement which has led to some finding coping mechanisms that align with weight-centric messaging such as forced physical activity and avoiding eating to help them deal with negative views of themselves. Although not every participant experience within this theme was connected to a healthcare professional or healthcare setting, they still reflected the pervasiveness of negative comments around their weight status or behaviours, which can also happen when seeking care for obesity management.

Unsustainable care

The second theme of *unsustainable care* was identified and derived from participant accounts of obesity management interventions that participants felt were not sustainable in the context of their daily lives. This was explained by one participant:

> [Diet Plan Name] was really restrictive, and if I had, like, if I had put on like, maybe one pound or two pounds I would be meeting with the doctor, even beyond my case, well you know, why did you eat that orange? Or you can't have regular onions. Why did you have to have regular onions, why didn't you use green onions? So, it really started bothering me, they're very restrictive. And so even though I had lost some weight with them, I was not I mean, yeah, it was, I was unhappy with the program and worrying about it and that's why I eventually quit that and just slowly put the weight back on (Participant 8).

Another participant when asked if a diet plan that they have used in the past was sustainable, replied: “It was 0% sustainable. Like I think the intention of it is to like promote

healthy eating habits and stuff like that but I think it gets to a point where it glamorizes limiting what you eat so much that it's like it develops eating disorders" (Participant 2).

In this example, the participant recognized that the advice being given was not just unsustainable, but also potentially harmful.

Another participant shared how costly diet programs were and how the cost of these programs made them unsustainable for many, saying that they had to spend $2,000 a month for a diet plan: "I went to Herbal Magic, and that's where I started losing, but their supplements were $2,000 a month, and their supplements made me too hyper, and I just couldn't sustain that" (Participant 9). Another participant shared a similar experience with an expensive diet program: "… But that was again, that was $600 a month, just for the medicine and the needles, and the side effects were horrible. And I just don't like feeling horrible, you know? So that wasn't sustainable either. So, yeah, I did go, I got off track" (Participant 9).

Participants shared that weight loss programs often worked for the first several months but as soon as they stopped the weight would come back. This theme aligns with weight-centric messaging where the idea of "eat less" and "eat healthy foods" to lose weight is the main focus without considering a patient's genetics or circumstances. The weight-centric approach was seen to be unsustainable because it was not tailored to support sustained behaviour change.

Care without context

Participant experiences seeking treatment and care produced the theme *care without context.* This theme is similar to the previous one, where the advice that participants received was often viewed as unsustainable, due to cost or because it did not align with participant needs or experiences. Care without context reflects how participants shared their frustration

about the inadequacy of advice provided by healthcare professionals within the context of their lives. This was exemplified by the advice that patients were often give to “eat less and exercise more” without providing solutions that match a patient’s context, as one participant described:

> I think I was seeing her in the post-partum period, and she mentioned, I can't remember why but she mentioned like try losing some weight. And it definitely wasn't the first time but for whatever reason, like it just triggered me that day to be like okay, then tell me how to do that. And she was quite taken aback by the fact that I was like, you know, like, if you're going to dish out the advice, to go lose weight, tell me how I'm going to do that, because I've done every diet that there is, and I've tried everything. So, what's your suggestion here? And she didn't really know what to say, to be honest. And she did admit like, you know, after me kind of saying that that, you know, really, there aren't any great evidence based, you know, this is probably eight years ago, any evidence-based ways to lose weight and keep it off? So, I'm going to say, you know, what, anyway, so why are you, what's your suggestion without support? Like, how is anyone going to be successful (Participant 10).

Another participant shared a similar experience, where they explained that they didn’t expect one solution or a ‘magic pill’ to help them to lose weight but that they were expecting more options to be presented:

> I don't think anybody expects that there's a magic pill. But if we're being honest, there are medical options for weight management, and it sort of does feel a little bit off putting to say, you know, I've tried these things, and to not be presented any other options and speak to a nutritionist (Participant 6).

This participant also shared experiences of being judged, as soon as they were seen by a healthcare professional before even having the opportunity to explain why they were seeking care in the first place:

> I find a lot of people get overlooked for things, because of their weight. And they may be coming up with completely valid, you know, whether it's heart or breathing, or whatever, but actually has nothing to do with their weight. But it's being ignored, because this is the focus is like, yeah, the immediate bias is that while you're overweight, you're going to have other health issues, which is so not the case. Like, I would just hope that people have the opportunity to say how they feel about it. And if they don't want to talk about their weight than they shouldn't have to (Participant 6).

One participant described how their experiences within health care impacted their willingness to seek support:

> You know, like I, I would have probably gone to see a nutritionist or dietitian I can't remember which one… However, I have gone in the past, and the mindset was always the same, eat less, move more, you know, stay away from anything that is… part of the food guide, the rainbow. You know, if I mentioned that I seem to have better results losing weight if I restrict my carb intake, and I even have like genetic research studies, like because I'm into genetics and stuff as well. I checked my raw data; I can look at this at the snips and see that there's research saying that my specific genetic outcome is less tolerant to carbs and more likely to gain weight. And I can go to them with all of that, and they're just like, nope, doesn't fit my education. So, eat less, move more, have this,

this and this, because that's what the food guide says… it's a limitation to education (Participant 7).

Another participant also shared their thoughts on what seeking care when living with obesity is like:

> If you're obese, practically anything you go in for you can go in for a hangnail and they tell you if you lose weight, it will be better. It's the standard. Yeah, I think they look at you and go oh, you just need to lose weight, oh, you just need to lose weight, you know, oh, you've got breast cancer, you just need to lose weight (Participant 1).

Thus, care without context is reflected in the lack of options that participants were offered, because their weight was viewed as the only problem they presented with.

Think 'healthy' thoughts

The theme of *Think 'healthy' thoughts* was identified in relation to the way that participants shared more positive experiences when interacting with healthcare professionals. This theme was specific to participant experiences where their health was framed as the main priority. When asked if they preferred a more health-centric or weight-centric approach to care, one participant shared: "Health centric, 100%! As it's like, I would rather focus on me being healthy than me weighing less" (Participant 2).

Another participant when asked the same question, also said:

> Definitely health-centric, and that's primarily the approach of the ____ clinic. And they, you know, they don't want you to focus on the scale, it's not the be all and end all it's really a focus on your overall health. And so, I prefer that, as opposed to worrying about a number on the scale and in your weight (Participant 8).

This participant also shared that:

> This isn't a diet; this is how I'm going to eat and manage my weight for the rest of my life. So that's kind of a sense of a large ask, but by the same token, I've changed. The clinic, because it's health-centric changes your mindset and your attitude towards food. And you know, and they will say, well, you know, if you want to have that dish of ice cream, go ahead, and have that dish of ice cream or whatever. So, you don't feel that you're totally restrictive (Participant 8).

Participant 7 who was a part of the Obesity Canada Public Engagement committee and therefore more likely to have had greater exposure to the health-centric narrative, shared a positive experience seeking obesity management care where the healthcare professional acknowledged that there are several factors that contribute to an individual's weight. They described their care as:

> Fantastic, like, took me seriously understood that there was a lot of stuff hormonally going on and that. Like, essentially was like, it's not your fault I mean, there's things you can control, but like, there's no use in feeling guilty about it. There are so many other things that are out of our control, which I think we could all tell ourselves, but I think of something more coming from a practitioner or just somebody who's looking out for your health in any way, shape, or form (Participant 7).

Thus, for the participants who had experienced a health-centric approach, they were able to see their care as more holistic, which differed from the weight-centric approach that was expressed within the previous three themes.

Summary

This section shared the main findings of the study with quotes that illustrate the themes identified. The study found four themes*, the 'weight' of words, unsustainable care, care without context,* and *think 'healthy' thoughts.* The study found that individuals living with obesity often experienced negative interactions with health care providers (*the 'weight' of words*), that left them feeling ashamed and that there was no help available to them in relation to obesity management. If healthcare providers did share advice with them, this was not seen to be sustainable, either due to cost, or because it was not tailored to their individual needs or life circumstances (*unsustainable care*). This then impacted the care that they received because of their fear of being judged by healthcare professionals and because the options available to them were not always offered due to their weight status (*care without context)*.However, there were experiences with healthcare professionals that were described in the context of a health-centric approach. In these examples, participants felt that healthcare professionals that used a health-centric approach seemed to take them more seriously and to better consider their overall health (*think 'healthy' thoughts*).

Discussion

The purpose of this study was to explore how people living with obesity understand the value of health-centric rather than weight-centric messaging in support of behaviour change. Obesity is a complex chronic disease where excess adiposity impairs one's health and often requires long-term management (Wharton et al., 2020). A weight-centric approach encourages weight-loss with the intention of improving health through that weight loss. This was illustrated by three themes where participants felt like weight loss was the only option to improve health i.e., *the 'weight' of words, care without context,* and *unsustainable care*. In contrast, when participants encountered a health-centric approach that focused on patient goals and health behaviours and not the number on a scale, they felt more heard by the healthcare provider. This was illustrated through the *think 'healthy' thoughts* theme Focusing on patient experiences created a unique point-of-view, allowing for a more in depth understanding of what it is like to live with obesity. Allowing the participants to share their experiences seeking support in a healthcare setting therefore helped to elucidate the value of a health-centric approach for individuals living with obesity. It is also important to identify where these themes fit within different levels of the SEM to identify leverage points for intervention that might support a more health—centric approach within healthcare settings. Overall, the four themes could be mapped onto four of the five levels of the SEM, with some overlap of themes identified. The next section summarises these themes in the context of the literature and how they were related to the levels of the SEM.

The 'weight' of words

The *'weight' of words* theme reflected the negative experiences individuals faced when interacting with healthcare professionals, even though an individual's weight does not always reflect their health status (O'Hara & Gregg, 2010). Because this theme revealed how participants experienced their interactions with healthcare providers, it can be seen as aligning with both the intrapersonal and interpersonal level of the SEM. Participants shared how they were spoken about by their peers and healthcare professionals, and how this impacted them. Participants shared experiences of how their weight status made them feel, and how others perceived them. Within the context of obesity management, this was reflected back to them in comments that healthcare providers made about their weight or appearance, and not showing emotional support towards the individual when needed. The feeling of shame in relationships regarding obesity can cause several challenges with weight control and weight loss (Gruber & Haldeman, 2009).

Weight-related remarks by peers has been associated with negative body image, worsening mental health, and disordered eating behaviours (Eisenberg et al., 2011). A study by Eisenberg et al. (2011), found that hurtful weight-related comments from peers are commonly experienced during young adulthood and typically continues to persist over time. This type of teasing has been associated with higher rates of binge eating and purging (Eisenberg et al., 2011). A study by Wang et al. (2014), found that support when seeking behaviour change in weight loss amongst adults is often positive. Being judged by peers can negatively affect relationships, including relationships with healthcare professionals (Wang et al., 2014). Negative interactions with healthcare professionals such as the ones provided above in the

results section can cause harm such as low self-esteem and depression to the patient (Pearl, 2018). It is suggested that community-wide campaigns or interventions aimed at reducing weight-related teasing should be considered for prevention measures. These can allow individuals living with obesity to comfortably seek support from their family, friends, coworkers, and healthcare professionals without feeling judged (Eisenberg et al., 2011).

This theme connected to healthcare, and encapsuled the fear many patients have day-to-day. A study by McGuigan and Wilkinson (2015) looking at the connection between obesity and avoidance of healthcare found that fear of disapproval from healthcare professionals in relation to bodyweight was found to be a factor to healthcare avoidance. It was also found in this study that healthcare professionals showed a 'pro-thin', 'anti-fat' bias (McGuigan & Wilkinson, 2015).

This theme aligns well with the intrapersonal and interpersonal level of the SEM as it shares participant experiences trying and hide their body from their peers internally while also interacting with others. Experiences with healthcare professionals were shared in the result section that encapsule this level of the SEM. The examples provided are important in representing the experiences individuals living with obesity face every day that can be associated with their weight.

Unsustainable care

The *unsustainable care* theme relates to a weight-centric approach as it looks at weight-loss measures that are not sustainable due to cost or their restrictive nature. Having weight—loss as a main goal, or as a way of controlling access to care, also aligns with a weight-centric approach. This theme aligns most with the organizational level of the SEM, because it captures

participant experiences as they interact with different diet programs or organizations. This theme addressed experiences with weight loss programs that used unsustainable approaches like supplements or meal replacements, that were hard to use for any length of time. Participants shared that the weight-loss program they took part in often only offered a temporary fix as these programs typically only last for a few months and can be extremely costly. Although offering obesity management treatments aligns with the evidence (Wharton et al., 2020), having programs that only focus on weight loss can perpetuate the weight-centric approach in a way that is unhelpful and unsustainable. Weight-management programs need to offer sustainable options to work long-term (Worldwide Fund, 2020). Many studies have showed that restrictive diets are often not sustainable over long periods of time due to the strict rules around what individuals can and cannot eat as well as the potentially higher cost of healthy foods and diet plans (Fanzo & Davis, 2019). Dietary inequity across Canada is caused by a lack of access, availability, and affordability (Fanzo & Davis, 2019). Healthy and nutritious foods are increasingly more expensive than nutrient-poor foods, making them harder to access for those with a lower income (Fanzo & Davis, 2019).

The maintenance of long-term weight loss can be challenging and often leads to weight regain or weight cycling (Hall & Kahan, 2018). Obesity interventions that use prescriptive diets typically lead to rapid early weight loss followed by a weight plateau and/or a progressive weight regain (Hall & Kahan, 2018). Apart from unsustainable organized diet programs, the cost of obesity management and treatment costs billions of dollars every year (Tran et al., 2013). Individuals living with obesity often have to spend hundreds of dollars on obesity prevention programs placing a substantial economic burden (Tran et al., 2013). Canada lacks

sustainable obesity management programs with programs being expensive, lack of trained professionals, and lack of available programs, which follows a weight-centric discourse (Rehani, 2019).

The theme of unsustainable care fits best at the organizational level of the SEM as it shares participant experiences as they interact with different diet programs or organizations. The experiences shared in the results section under this theme relate to a weight-centric approach as the programs seemed to mainly focus on the participant losing weight and joining their program than on long-term health goals that a health-centric approach would follow. As previously noted, diet programs and organizations were considered a part of healthcare for the context of this study.

Care without Context

The *care without context* theme relates to a weight-centric approach where the weight-loss measures suggested to the participants by health care providers did not consider their needs or limitations. This theme reflected participant experiences requesting approaches for weight loss but not receiving anything more than "eat less, exercise more" a common trend in the weight-centric approach (McVay et al., 2019).

Care without context was one of two themes identified at the community level of the SEM. Care without context describes the care participants received from healthcare professionals and how it felt to not be heard fully when it came to obesity management approaches impacted them. This theme aligns with the study's purpose, sharing participants frustration following a weight-centric approach. Many participants explained that healthcare professionals would often tell the participant that they need to lose weight but would provide

no suggestion on how to do so. These participant experiences provide the idea that the healthcare professional sees the participants' weight as under their control which aligns with a weight-centric approach. A study through Duke University found that offering advice of "follow a diet" or "exercise more" does not help patients to lose weight (McVay et al., 2019). Instead, it is suggested that healthcare professionals should recommend a specific program, or specific routine for it to work and be sustainable (McVay et al., 2019). In this study it was found that participants who received specific advice on weight-loss, lost an average of approximately seven pounds more than their peers who received generic advice from healthcare professionals (McVay et al., 2019). The study also shared findings that healthcare professionals who showed empathy and sympathy for their patients, found more success in weight-loss in their patients (McVay et al., 2019). This study by McVay et al. (2019), shares the benefits of providing patient-centred care that focuses specifically on the patient and their needs. The lack of advice provided by the healthcare professional is most likely due to lack of training and available interventions (Auckbully et al., 2021). Healthcare professionals may fear offending patients when discussing weight concerns due to lack of training on the topic, which also creates frustration among patients who are seeking professional advice and treatment (Auckbully et al., 2021).

Healthcare professionals who show weight bias to patients have shown to negatively influence patient engagement in the healthcare system (Alberga et al., 2019). It has been found that as an individual's BMI rises, their use of healthcare services decrease (Alberga et al., 2019).

In Canada, there is a lack of healthcare professionals with adequate training in obesity management and treatment causing individuals living with obesity wondering what they should

do to lose the weight they are being told to lose (Wharton et al., 2020). An example of this is provided by the participant who asked for suggestions about how to achieve weight loss and the healthcare professional was caught off guard and had no suggestion on what to do. Canada is in need of more healthcare professionals to receive the proper level of training and education required to be experts in obesity and to provide more support to their patients (Wharton et al., 2020). This goes hand-in-hand with the recommendation from the Canadian CPG where it is said more training and education needs to be provided to healthcare professionals in order to reduce weight bias and stigma between healthcare professionals and their patients and to change their perspective from weight-centric messaging to health-centric messaging (Wharton et al., 2020).

Think 'healthy' thoughts

Lastly, the *think 'healthy' thoughts* theme reflected on positive interactions participants had interacting within healthcare. The examples provided at this level show the importance of adapting programs to fit the needs of the individual for them to work long-term and be successful as well as the importance of feeling heard and making connections with healthcare professionals. Both the *care without context* theme and *think 'healthy' thoughts* theme were found to fit best at the community level of the SEM as both themes sought to discuss design, access, and connectedness of interventions. These themes also show how the levels of the SEM can be interrelated as both themes share participant experiences interacting with healthcare professionals which can also fall under the interpersonal level of the SEM.

The think 'healthy' thoughts theme provided insight into the few positive experiences that individuals had with healthcare professionals, primarily those who used a health-centric

approach. The few positive examples provided looked at more sustainable obesity management interventions that considered the overall health of the individual and not just a number on a scale. This provided a better experience for the individual, as illustrated by their quotes.

Positive experiences with healthcare professionals are important to reduce avoidance of healthcare, as well as to build up trust in how they will be treated in the future and their trust in clinical decisions regarding their health (Mold & Forbes, 2013). Having trust between the patient and the healthcare provider can reduce patients' sense of powerlessness and reduce treatment avoidance (Mold & Forbes, 2013). The participants who shared experiences with healthcare professionals that followed a health-centric approach, shared more positive experiences, and continued their care with the healthcare professional as a consequence of this approach. Following a more health-centric approach to care can lead to better patient relationships and more trusted, sustainable care (Tylka et al., 2014). However, the lack of experiences shared by participants around health-centric approaches, despite prompting, suggests that this framing is not yet commonplace. Rather, it was found that participants had more negative experiences than positive ones, despite sharing their preference for health-centric messaging.

There was no specific theme identified at the public policy level of the SEM by participants. This may be because at this level of the SEM, policies that shape healthcare provider practice might not be visible to patients. However, perhaps reflecting a lack of policy, several participants shared that they were left to their own devices when seeking care for obesity management, meaning they have had to do the research of what specialists to go too, what programs are available and to fight for policy change, as many healthcare professionals

follow a weight-centric approach and tell their patients to exercise and diet without giving them suggestions on how. Not having easily accessible care, can turn away a lot of people from seeking help, as not everyone has the time or energy to do the research for themselves. Having healthcare professionals integrate the CPG into obesity management could be an appropriate action to encourage greater integration of a health-centric approach. This would be consistent with the public policy level, i.e., through ensuring adequate implementation of the CPG in practice.

Strengths and Limitations

The focus on patient narratives related to experiences living with obesity with a key focus on interactions within healthcare is a strength of this study. Participants varied in age, sex, level of family support, and access to care, allowing for a rich understanding of lived experiences. Using open-ended questions allowed for participants to share their experiences in their own words.

Some limitations of this study included that participants were predominantly women, who may have different experiences to men when it comes to obesity management and exposure to weight- or health-centric narratives. Interviews being conducted by myself with no personal experience living with obesity could also have led to discomfort by participants who may not have been willing to fully share their experiences. Participants may have not experienced the two approaches under study, making it challenging to articulate their thoughts about the two approaches. The participants may not reflect the broader population of people who seek care within the healthcare system. I tried to mitigate this limitation by sharing

information about the study widely, but it is possible that the participants who volunteered are not reflective of all experiences around obesity management.

Implications

The experiences of participants in this study suggest that a weight-centric approach was encountered more often than a health-centric approach to obesity management. As previously noted, a weight-centric approach is less desirable because of its focus on patients losing weight without considering patient goals or their health behaviours (O'Hara et al., 2015). When participants encountered a health-centric approach they found it to be more helpful and this led to more positive relationships between the healthcare professional and patient.

Health promotors and healthcare providers can use this study to understand the implications caused by using a weight-centric approach when interacting with individuals living with obesity. Understanding how patients feel when being treated using a weight-centric lens, while also understanding that several factors influence an individual's weight, such as the SDOH, and access and willingness to receive care, can help health promotors and healthcare providers to adapt their way of approaching individuals living with obesity. It was found in this study that patients prefer a health-centric approach to care over a weight-centric approach which also aligns with other studies on this topic. These implications can also be used in future health promotion work to ensure patients are well cared for in a manner that they want to be.

Obesity Canada PEC members may also have influenced the study as they were expected to have more understanding on what a weight- and health-centric approach was and what to look for in a healthcare setting. These individuals not only added their experience about seeking care for obesity management but the knowledge and understanding they

received on the topic of obesity through their education and training with the PEC. Their knowledge and experience on obesity and on weight- and health-centric approaches was evident in the data as the other participants did not have the same level of understanding or education.

Considerations for Future Research

Future research in this area could also include the experiences of healthcare professionals and how they understand the value of health-centric messaging. Interviewing healthcare professionals could help to identify gaps in education and training and provide insight into how healthcare professionals interact with patients. According to the Canadian CPG, most healthcare professionals do not receive adequate training on obesity, and alongside a lack of interventions, it can be challenging for them to provide respectful, evidence-based care to patients (Wharton et al., 2020). Having healthcare professionals reflect on the impact of the type of care they are providing to patients may help them understand the core components of a health-centric approach to obesity management.

Looking at the healthcare professionals' point-of-view alongside the perspectives of patients would be a useful next step, providing further context to the patient perspectives identified in the study. Interviews allowed the study participant to "…share their feelings, prejudices, opinions, desires, and attitudes towards different phenomena they experience in the workplace or other organisational contexts" (Dunwoodie et al., 2022).

Conclusion

This study explored how individuals living with obesity understood the value of health-centric rather than weight-centric messaging in obesity management. Ten participants shared

experiences with each of these types of messaging. Although experienced less often, participants shared that they preferred a health-centric approach and identified more positive experiences with this approach. Although the concept of health and weight-centric messaging in obesity management is not new, few studies have used patient perspectives to determine which approach is most often encountered or preferred when seeking care. Framed through a pragmatic worldview within the four levels of the SEM, the four themes identified were*, the 'weight' of words, unsustainable care, care without context,* and *think 'healthy' thoughts*. This research provided an opportunity to better understand the value of a health-centric approach to obesity management which participants viewed as more sustainable and less restrictive than a weight-centric approach, i.e., was preferred over an approach that emphasised weight loss. Participant narratives also suggested that obesity management interventions in Canada were lacking, inaccessible or unsustainable. Although participant experiences were not well reflected at the policy level of the SEM, there remains a need for policy options that reflect the evidence for obesity management that are described in the Canadian obesity CPG. Such options could provide the opportunity to reflect health-centric approaches in the care that is made available to people living with obesity in the future.

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Appendix A.

Terminology and definitions

Term	Definition
Weight-centric	"Defined as having the six following tenets: "(a) the belief that weight is under individual control, (b) the belief that weight gain is caused by an imbalance in caloric intake and energy usage, (c) the belief that health status can be predicted by weight, (d) the belief that excess body weight causes disease and early death, (e) the belief that methods for successful long-term weight loss involve the modification of eating and exercise patterns, and (f) the belief that losing weight will result in better health." (O'Hara & Gregg, 2010).
Health-centric / Weight-inclusive	Health-centric messaging in obesity management looks at diminishing the idea of "eat less, exercise more" and instead considers patient goals and current health behaviours (O'Hara et al., 2015)
Obesity	"A complex chronic disease in which abnormal or excess body fat (adiposity) impairs health, increases the risk of long-term medical complications, and reduces lifespan" (Obesity Canada, 2022).
Health at Every Size	"A paradigm that supports "size-acceptance, to end weight discrimination, and to lessen the cultural obsession with weight loss and thinness" and promotes "balanced eating, life-enhancing physical activity, and respect for the diversity of body shapes and sizes." (The Health at Every Size, 2020).
Weight stigma	"The social rejection and devaluation that accrues to those who do not comply with prevailing social norms of adequate body weight and shape." (Tomiyama et al., 2018).
Weight bias	"Negative weight-related attitudes, beliefs, assumptions and judgments toward individuals who are overweight and obese." (Washington, 2011).
Weight cycling	"Refers to individuals losing weight then gaining weight again that can repeat several times throughout an individuals' life" (Rhee, 2017).

Appendix B

Consent Form

Study Title:

Patient Perspectives on Weight vs. Health-Centric Messaging around Obesity Management: If not Weight, Then What?

Principal Investigator:

Francesca Rhodes, BSc. HPRO., MA HPRO (C)
Francesca.rhodes@dal.ca
(902) 293-2611
Dalhousie University School of Health and Human Performance

Supervisor:

Dr. Sara Kirk, PhD
Sara.kirk@dal.ca
(902) 494-8440
Dalhousie University School of Health and Human Performance

REB File:

2022-6434

Introduction

I invite you to take part in this research study that is looking at the experiences of people who live with obesity as they interact with healthcare providers. I am particularly interested in the messaging that you may have received about obesity management. This research is part of my master's degree in Health Promotion. Your participation in this study is voluntary throughout and you can withdraw from the study at any point up until your information is analyzed (usually two weeks after the interview). The study is described in detail below, explaining any potential risks or discomfort you may face by participating in this study. Any further questions about this study can be directed to Francesca Rhodes.

Purpose of this Study

The purpose of this study is to explore the experiences of people living with obesity as they interact with the healthcare system and healthcare providers. Providing individuals with the opportunity to explore the positive and/or negative messaging in obesity management will help us to learn about the value of a health forward approach in supporting people living with obesity.

Who can participate in the study?

You are eligible to participate in this study if you are an adult (18 years old and older), who identifies as living with obesity or having previously lived with obesity and you have encountered a healthcare provider in the health system regarding obesity treatment or management. Obesity is defined as "a complex chronic disease in which abnormal or excess body fat (adiposity) impairs health" (Obesity Canada, 2022). If you do not meet the above criteria, you will not be eligible to participate.

What you will be asked to do

You will be asked to participate in one recorded interview, either online or in-person, lasting about 60 minutes. The interview questions will be open-ended and guided (meaning they can't be answered with a simple yes or no), for me to learn more about your personal experiences and perceptions of how healthcare professionals talk to people about obesity in Canada.

Potential Risks and Discomforts

There are minimal risks associated with this study. You will be asked personal questions about your experience interacting with a healthcare setting which may cause discomfort. Any questions you are uncomfortable answering, please feel free not to answer or simply say "pass" during your interview. If at any point you feel distressed, please feel free to take a break from the interview or ask to withdraw. If you choose to withdraw, please let me know during the interview, or by email or phone afterwards and indicate whether I can use any data given before withdrawing.

Compensation

After the interview is completed, you will be given the choice of receiving a twenty-dollar gift card for Indigo or making a twenty-dollar donation to Obesity Canada as a thank you

for your time. If you decide not to move forward with the interview you will still be compensated for your time.

Confidentiality

Your name and identity will be kept confidential throughout the entire study process. When transcribing the interview, a code will be used in place of your name. The interview recordings and code that links your name will be kept in a locked file on my supervisor's computer and any physical copies will be kept in a locked filing cabinet that no one else besides my supervisor will have access to. All data will be deleted and shredded five years after the completion of the study. Any identifying information will be removed or altered.

Questions or Concerns

Any questions or concerns can be directed to myself, Francesca Rhodes, or my supervisor Dr. Sara Kirk. If you have any ethical concerns, you may contact Dalhousie Ethics by phone at (902) 494-3423 or by email at ethics@dal.ca

Appendix C.

Draft Interview Guide

1. Tell me about your experiences seeking support? Did you seek care for your weight? Or was your weight brought up as a cause for a different health concern?
2. What type of health-care setting/ health professional have you visited? What were your experiences? Was it easy to access this care?
3. What caused you to want to seek support for obesity management from a health professional or in a health-care setting? Have you had a support system throughout this process? (This question will only be asked to those who mentioned they purposely sought out support for their weight in question one)
4. What experiences in the healthcare system have you faced while seeking obesity management resources? Were they positive or negative?
5. What have these experiences with obesity management looked like and how did they impact your willingness to seek support?
6. What examples have you observed where healthcare providers, talk about weight? What examples have you observed where healthcare providers talk about health? We call these two approaches health-centric and weight-centric. Does this language resonate with you? Do you prefer one over the other? How do these approaches make you feel?
7. Is there anything else you would like to add before we stop this interview?

Appendix D.

Recruitment poster

Participants Needed for Research Study

DALHOUSIE UNIVERSITY
REB # 2022 6434

Have you been diagnosed as having obesity? Have you spoken to a health care provider about your weight status? I am looking for people to interview about their experiences

This research study is looking to see patients perspectives of health and weight-centric messaging in obesity management

Participants will take part in a one time interview, with guided questions. The interview should take about 30 minutes to an hour.

All participants will be given a $20 giftcard for their time

To participate, you must be:

- 18 years and older
- Reside in Canada
- Living with obesity or who has previously lived with obesity
- Has encountered a health care provider regarding obesity management

Francesca.Rhodes@dal.ca

Appendix E.

Consent Form Signature Page

Project Title: Patient Perspectives on Weight vs. Health-Centric Messaging around Obesity Management: If not Weight, Then What?
Lead Researcher: Francesca Rhodes, Francesca.rhodes@dal.ca

I have read and understand the process of this study. I have been allowed the opportunity to discuss and ask questions about the study and have received answers to my satisfaction. I hereby consent to take part in this study. I realize that my participation is voluntary and that I can withdraw from the study at any time up to when my data is analyzed (about 2 weeks after the interview takes place).

By signing this consent form, I acknowledge that I am giving permission for the following:

____ To have my interview recorded and transcribed

____ To have the researcher contact me with a summary of results

If so, please provide your email address

_____

____ To have portions of my interview quoted in the thesis, presentations, and any further writings, without identifying me

Name of Participant

Signature of Participant

Date

Appendix F.

Obesity Canada Public Engagement Committee Email for Recruitment

Good afternoon,

My name is Francesca Rhodes, and I am a MA Health Promotion Student at Dalhousie University in Halifax, Nova Scotia. I am looking for participants for a research study.

The study will explore participant experiences during encounters with healthcare providers about obesity management. I am looking for volunteers to take part in a one-time interview, with guided questions. The interview should take approximately 60 minutes to an hour and will be completed either online or in-person based on distance and availability. If you agree to participate, you will be given the choice of a $20 Indigo gift card or the option to donate $20 to Obesity Canada, to thank you for your time.

To participate you must:

- Be 18 years and older
- Reside in Canada
- Live with obesity or who have previously lived with obesity
- Have encountered a healthcare provider regarding obesity management (e.g., a doctor, dietitian, nurse, or physiotherapist) OR have sought out care for a different health concern but the topic of obesity or excessive weight is brought up by the healthcare provider as a contributing factor

If you are interested in participating, please contact me by email at Francesca.rhodes@dal.ca or phone number at (902) 293-2611.

I look forward to hearing from you!
Francesca

Appendix G.

Screening Documents

Are you 18 years and older?

Do you currently reside in Canada?

Are you living with obesity or who have previously lived with obesity?

Have you spoken to a healthcare provider about your weight status or has a healthcare provider talked to you about your weight even if it wasn't the issue that you went to them with?

Appendix H.

REB Letter of Approval

DALHOUSIE UNIVERSITY

Social Sciences & Humanities Research Ethics Board
Letter of Approval

January 31, 2023
Francesca Rhodes
Health\School of Health and Human Performance

Dear Francesca,

REB #: 2022-6434
Project Title: Patient Perspectives on Weight vs. Health-Centric Messaging around Obesity Management: If not Weight, Then What?

Effective Date: January 31, 2023
Expiry Date: January 31, 2024

The Social Sciences & Humanities Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans*. This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

Dr. Megan Bailey
Chair, Social Sciences and Humanities Research Ethics Board
Dalhousie University

Appendix I.

Participant Characteristics

Participants	Description	Associated with OC
Participant 1	Adult woman	No
Participant 2	Young adult woman	No
Participant 3	Young adult woman	No
Participant 4	Young adult woman	No
Participant 5	Adult man	Yes
Participant 6	Adult woman	No
Participant 7	Adult woman	Yes
Participant 8	Adult man	No
Participant 9	Adult woman	No
Participant 10	Adult woman	No