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Experience of the Obese Population With Weight Bias/Stigma

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MS, Marshall University, 2016

BS, Marshall University, 2011

Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

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Abstract

Obesity management has been identified as an important issue in health promotion, and some researchers have also reported that people who are obese often do not seek health care. Yet, current research is lacking on the complexities of weight stigma from the perspective of people who are obese. The purpose of this qualitive descriptive study was to understand the perceptions of weight bias/stigma of obese individuals. Guided by Goffman's Theory of Social Stigma and the Health Belief Model, purposive sampling was used to recruit 10 participants who had a body mass index greater than 30 and who lived in West Virginia, Southern Ohio, or Northeastern Kentucky. Semi structured qualitative interviews were conducted to obtain rich data about the experiences of study participants. Interviews were conducted until data saturation was achieved and overarching themes were identified from transcribed interviews using a six-phase thematic analysis. Five themes emerged including "I hate seeking healthcare", "always related to weight", "not listened to", "morbid obesity is a derogatory term", and "long term effects of weight bias". Findings from this study clarify why the obese population does not consistently seek healthcare. The Health Belief Model states that if perceived or actual barriers outweigh the perceived benefits of care, then an individual will not seek medical consultation. The participants reported that they did not seek healthcare because weight bias was a perceived or actual barrier to healthcare. The potential social benefit of this study is the insight given into the experiences and perceptions of people who are classified as obese. This insight may aid healthcare professionals to adjust their practices to address implicit and explicit bias and better meet the needs of people who are obese.

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Dedication

I would like to dedicate the dissertation first and foremost to God, without whose love and guidance there would be no reason to even have written this. I would like to thank my beautiful wife, Jennifer Brown, for the many hours she has given in our marriage for this accomplishment to be achieved. I would also like to dedicate this work to my children, Matison and Makenzie Brown; I hope that watching your dad finish this accomplishment will instill the drive to never give up on your dreams.

Acknowledgments

I would like to express my deepest appreciation to my committee chair, Dr. Amy Swango–Wilson. Dr. Swango-Wilson has been my mentor for what seems like forever, and I cannot imagine completing this without her. Dr. Swango–Wilson has an astonishing grasp of research that has made the dissertation process not only attainable but also engaging. Dr. Swango–Wilson has been the voice of reason during the many times that I convinced myself that "all but dissertation" was an acceptable goal. Dr. Swango–Wilson encouraged the vision of the research and had a shared passion with both the obese population and the Appalachian culture. I am very blessed to not only call her mentor but my friend as well.

Dr. Kathleen Brewer I met when taking classes at Walden University. I was instantly impressed with Dr. Brewer's sensitivity towards the underserved population I studied and her knowledge of qualitative research. I was able to meet with Dr. Brewer during my first residency; this is where I came to know Goffman. Though the time seems so long ago, the impact on my research and overall outlook on society forever changed during that 30-minute session. Therefore, I was ecstatic when Dr. Brewer agreed to be part of my committee. I am very blessed to have been able to learn from her, and I plan to take the valuable information forward into my career.

Thanks also to Dr. Anna Valdez whom I have only recently met after being appointed to be part of my committee. I have grown to truly admire your eye for detail. I am not going to lie; during my prospectus I did not appreciate this. However, going into my final presentation, I really admire how you are able to point out details that I have

missed even when staring at the study multiple times. I want you to know that I truly feel that I have a better product because of your concern with detail and understanding of the research.

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Chapter 1: Introduction to the Study

The purpose of this study was to gain an understanding of weight bias/stigma as perceived by individuals identified as obese in West Virginia, Southern Ohio, and Northeastern Kentucky. I also sought further understanding of their experiences with healthcare. Weight bias is a chronic stressor that can determine overall health (Emmer et al., 2020). People of the obese size of all ages and all backgrounds have reported being discriminated against (Tauber et al., 2018).

Current research is lacking on the complexities of weight stigma (Emmer et al., 2020). Specifically, more research needs to be done to disentangle the complex concepts of stigma and discrimination experiences of obese individuals (Emmer et al., 2020). The knowledge gap exists between understanding both individual and contextual factors associated with weight stigma (Emmer et al., 2020). In this study, I attempted to bridge the gap by delving into the perceptions of the obese population, therefore providing more insight on the specific subjective meanings associated with weight stigma from the individual perspective. The potential social benefit of this study is the insight given into the experiences and perceptions of this population. This insight may aid healthcare professionals to adjust their practices to meet the needs of this population group.

This chapter will include the rationale for choosing this topic and clear definitions of key terms used throughout the study. I will also provide background information on the problem being addressed and state the overall purpose of the study and the research questions (RQs) I sought to answer. The chapter also includes overviews of the theoretical and conceptual frameworks and nature of the study.

Background

Good health is socially valued. Obesity management has been identified as an issue in preventing good health (Alberga et al., 2018; Emmer et al., 2020; Puhl et al., 2015). Some reasearchers have also reported the lack of healthcare usage by obese individuals (Alberga et al., 2018). The larger the body mass index (BMI) of an individual, the fewer health services the individual seeks (Alberga et al., 2018; Aldrich & Hackley, 2010). The avoidance of healthcare services by the obese individual has possible detrimental effects, including obesity-related comorbidities and diseases (Phelan et al., 2015)

Weight bias and stigma are identified barriers to seeking healthcare services among obese individuals. Alberga et al. (2018) defined weight bias and stigma as "negative, prejudicial, or stereotypical beliefs and attitudes toward individuals based on their size" (p. 1). Alberga et al. found a strong implicit negative attitude toward obese individuals. The strong implicit attitude could contribute to multiple barriers to seeking healthcare (Alberga et al., 2018). The interaction with a healthcare worker who demonstrates weight bias/stigma can cause weight bias internalization (WBI; Pearl et al.,

2017). WBI is when the obese individual applies negative stereotypes to themselves and devalues themselves due to their weight (Pearl et al., 2019).

Researchers have conducted studies of experiencing weight stigma, weight stigma and poor health, and WBI and poor health (Pearl et al., 2017). Current research is lacking, however, on the complexities of weight stigma (Emmer et al., 2020). Specifically, more research needs to be done to disentangle the complex concepts of stigma and discrimination experiences (Emmer et al., 2020). In the present study, I examined the phenomenon of weight stigma/bias from the subjective point of view of the obese population to help better understand their perceptions. Understanding the obese population's personal feelings and experiences may enable healthcare workers to better interact with the obese population. More insight on this populations' perceptions and experiences of weight stigma/bias also furthers understanding of the barriers that have been researched in previous studies (Alberga et al., 2018; Elran–Barak & Bar–Anan, 2018; Miller et al., 2013).

Problem Statement

Many individuals in the United States view a well–proportioned figure to be ideal (Kavic, 2001; Pearl et al., 2017; Tauber et al., 2018). Being overweight or obese in a society that reveres a particular body type often leads to mockery (Blair et al., 2011; Emmer et al., 2020). There are many cartoons, movies, plays, and books in which the overweight person is laughed at without sympathy or understanding to counterbalance the prejudice (Kavic, 2001; Pearl et al., 2017; Tauber et al., 2018). Many people understand that ridicule of another for being obese or for being different for any other reason is

insensitive and unjustified (Kavic, 2001; Pearl et al., 2017; Tauber et al., 2018). However, much of the research and popular culture focus on obesity centers on the debilitating health quality of the obese person and not the over-critical tendencies of the society (Crandall, 1994; Foster et al., 2003; Gujal et al., 2011).

Sabin et al. (2012) examine if there were implicit and explicit attitudes about weight among a large group of medical doctors. The authors researched 2,284 physicians utilizing the Weight Implicit Association Test. The study results showed that, on average, the physicians showed strong implicit bias toward the obese individual. Also, the study showed that amongst those who have an implicit bias, there are more explicit anti-fat attitudes.

Seymour et al. (2018) completed a qualitative exploratory study to determine whether the actual care given to patients was affected by weight bias exhibited by health care professionals. The study included a sample of 220 healthcare professionals. The professionals completed the Attitudes Towards Obese Persons scale to assess scenarios to evaluate the quality of care. The methods were categorized into a high weight bias and a low weight bias group. Thematic analysis was used to group certain themes related to the quality of care. Most of the participants demonstrated high weight bias. The analysis revealed that the profession with high weight bias offered health advice regarding weight loss and less teaching on disease process or overall health. Also, both groups started the obese population on medication much sooner than the nonobese population. The researchers identified a need for further studies to help educate health professionals on

the importance of empathy and compassion when treating all patients regardless of weight.

Gonzales et al. (2018) discussed patient-provider relationships among American Indians and Alaska Natives (N = 87) by examining patient activation, perceived weight bias, and working alliance. The researchers found that the patient can experience a positive relationship between provider and patient with underlying weight bias on the part of the provider. Patients may be masking provider weight bias, and the positive–provider relationship may not be benefiting the obese population like the nonobese population. Secondly, the patient may be internalizing self-weight-biased attitudes, resulting in the perception that the weight bias they are experiencing is justified. Therefore, the patient feels responsible for the negative assumptions and the medical neglect they receive (Gonzales et al., 2018). Further research on provider weight bias in the healthcare setting may expose barriers to addressing inequities in healthcare (Gonzales et al., 2018).

Keyworth et al. (2012) examined nursing students' perceptions of obesity and behavior change. Participants reported an inability to meet the needs of the obese patient related to the training the students received. The study included 20 nursing students who were interviewed. The audiotaped interview was transcribed and analyzed for themes. Participants stated that there were many challenges to healthcare practice, one of them being managing obesity. The study adds to previous research documenting that qualified nurses hold negative judgments toward the obese population (Brown, 2006). The students' lack of professional development in being able to discuss weight management with obese individuals is a gap in the development of the student. Inability to

communicate with patients due to stigma/bias towards the obese population may limit the treatment regime and the relationship between the obese and healthcare professionals, resulting in the obese failing to seek healthcare.

Puhl et al. (2014) discussed assessed weight bias among professionals who specialize in treating eating disorders and to what extent the professionals bias affects the treatment of the obese individual. The study included 329 professionals who work in the field of treating eating disorders. The participants were anonymous and completed online self–report questionnaires. The results showed that negative attitudes existed in those who treat eating disorders. Although the participants felt confident in providing treatment to the obese population, the majority demonstrated weight bias negative attitudes toward the obese population. Professionals who had a higher level of weight bias were more likely to blame weight on behavior and have negative attitudes toward the patient. Like other professionals, professionals who treat eating disorders are not immune to weight bias. The findings demonstrate a need for further research regarding health professionals' weight bias and perceptions of an obese individual.

Negative attitudes about obesity are prominent and pervasive, especially in North American society. People who are obese are often stereotyped as lazy, lacking self–discipline, noncompliant, and unsuccessful (Puhl et al., 2014). Furthermore, studies have linked obesity to weight bias (Blair et al., 2011; Crandall, 1994, Elran–Barak & Bar-Anan, 2018). Researchers have found evidence of weight bias among healthcare workers (Gujral et al., 2011; Halvorson et al., 2019; Miller et al., 2013; Puhl et al., 2014). Obese people are often associated with noncompliance of healthcare treatment (Pearl et al.,

2017; Schafer & Ferraro, 2011). However, there is a gap in the research regarding the effects that weight bias has, if any, on the perceptions of people who are obese regarding healthcare. To address this gap in the literature, I researched the impact that weight bias in healthcare has, if any, on the obese population of rural Appalachia, a region with a high rate of obesity (Abshire et al., 2017; Rice et al., 2018). By exploring the phenomenon of weight bias from the obese person's personal experience, I sought a first-person perspective regarding the phenomenon of weight bias/stigma.

Purpose of the Study

The purpose of this study was to understand the phenomenon of weight bias from the perspective of obese individuals in West Virginia, Southern Ohio, and Northeastern Kentucky. I also wanted to explore these individuals' experiences of healthcare. The focus was on adults who met the BMI requirements and have been previously stigmatized against. The study was a qualitative study of the perceptions and personal experiences of the obese population regarding weight bias. I explored participants' perceptions of prejudice, focusing on how the bias made them feel and shaped the healthcare they received and what the lasting effects of the bias were. The qualitative research involved a naturalist paradigm. One of the naturalist paradigm assumptions is that the knower and the known are interactive and inseparable (Lincoln & Guba, 1985). Therefore, understanding the knower will allow further understanding of the known (Lincoln & Guba, 1985). The purpose of the research was to understand the perceptions of the obese population regarding weight bias/stigma. Gaining further understanding from the point of

view of the obese population about weight bias/stigma will allow further understanding of any discrepancies felt by the obese individuals.

Research Questions

RQ1 (qualitative): What are the perceptions of people who are obese who have experienced weight stigma/bias from a healthcare setting in West Virginia, Southern Ohio, and Northeastern Kentucky?

RQ2 (qualitative): What, if any, are the lasting effects as perceived by people who are obese related to the weight stigma/bias from a healthcare setting in West Virginia, Southern Ohio, and Northeastern Kentucky?

Theoretical Framework

Societal conceptions of ideal weight underlie much of the stigma obese individuals experience. Goffman (1963) stated that society features a categorical system based on the complement of a set of attributes felt to be normative and natural for the members of the society. Multiple studies have used this definition of categorical society. Puhl et al. (2008) stated that discrimination is a prejudice that refers to an adverse treatment of people based on the people not fitting into a specific group. Goffman further explained that society has expectations or demands related to normative or natural features. So, when a stranger is present before society, and the stranger possesses a differing attribute, the stranger will be seen as a less desirable individual (Goffman, 1963). The less desirable individual is seen as discredited and tainted in the minds of the society based on the attribute (Goffman, 1963). Goffman defined the effect of this discrediting attribute as a stigma.

Overweight individuals are frequent targets for stigmatization, prejudice, and bias in North American society (Puhl et al., 2008). Negative stereotypes often underlie the weight-based stigma and discrimination overweight individuals experience (Puhl et al., 2014, p. 66). In the current study, I used stigma as a reference to examine the implicit feelings of the obese population in West Virginia, Southern Ohio, or Northeastern Kentucky. The term *stigma* has been used with synonyms such as *discrimination*, *bias*, and *stereotypes*. Previous researchers have examined barriers to healthcare for the obese population. In one study, obese individuals were found to face barriers to health promotion that were often overlooked by society, such as embarrassment, a disproportionate focus on weight loss, antifat bias, and weight discrimination by health professionals (Chambliss et al., 2004). However, it is important to note Goffman's (1963) assertion that stigma may be self-induced. Therefore, in the current study stigma also represented any perceptions that would keep an obese individual from seeking healthcare treatment.

Conceptual Framework

I used contextual lens of the health belief model (HBM) to study the perceptions of weight bias among the obese population. The HBM states that people will achieve optimal behavior change if they focus on perceived barriers, benefits, self–efficacy, and threat (Jones et al., 2016). Research shows that obese individuals understand that they are at risk for developing insulin resistance and Type 2 diabetes, hypertension, dyslipidemia, cardiovascular disease, stroke, sleep apnea, gallbladder disease, hyperuricemia, and osteoarthritis (Khaodhiar et al., 1999). The obese population also understands that

seeking healthcare will help to limit the effects of comorbidities caused by obesity (Khaodhiar et al., 1999). The question then is why so few of the obese population seek treatment. According to studies of the HBM, the two most optimal predictors of adopting a behavior are perceived benefits and perceived barriers (Lin et al., 2019). The obese individual is constantly in a cost-benefit analysis of perceived benefits versus perceived barriers (Champion & Skinner, 2008). In this study, I investigated the subjective perceptions of the obese population regarding weight bias as a perceived barrier.

Nature of the Study

The nature of this study was a qualitative descriptive study. The use of a qualitative design was essential for this research for several reasons. The first and most important reason was that qualitative method emphasizes the participant's meaning. Creswell (2014) stated that qualitative designs focus on learning the meaning that the participants hold about the problem or issue, not the researcher’s meaning. Another reason for using a qualitative design is the importance of developing a complex picture of the problem or issue under study or a holistic account.

To recruit participants, I used purposive sampling. recruited participants using fliers, emails, letters, and word of mouth in the selected geography (West Virginia, Southern Ohio, or Northeastern Kentucky). Snowball sampling was used to find others who fit the requirements outlined in the descriptive study. Participants met the qualifications for being obese. The obese population is characterized by a BMI greater than 30. (Centers for Disease Control and Prevention, 2018). The results are based on the

BMI calculation BMI = kg/m^2 (Centers for Disease Control and Prevention, 2018). I interviewed the selected individuals until saturation was established.

Definitions

The two most common types are explicit and implicit. Both explicit and implicit bias will vary depending on how the bias is triggered (Halvorson et al., 2019). An important note to remember is that both implicit bias and explicit bias can be measured quantitatively (Halvorson et al., 2019). Also noteworthy is that medical professionals can demonstrate both explicit and implicit bias (Halvorson et al., 2019).

Before detailing the types of bias, it is important to note some essential points about bias that researchers have shared. Many kinds of prejudice, stereotypes, and discrimination exist regarding a person's weight (Tomiyama et al., 2015). Weight bias is nuanced; however, the most dominant trait amongst people demonstrating prejudice is the belief that the person is lazy and therefore has excess weight (Wakefield & Feo, 2017). This stigma could then be manifested into self–induced weight bias or what is commonly called *weight bias internalization* (*WBI*).

Explicit bias: A conscious negative attitude against a specific social group (Tomiyama et al., 2015). Explicit bias would take the stance of an antifat attitudes (Tomiyama et al., 2015). Explicit bias would lead individuals to see obese people as lazier than thin people and tell them about it (Tomiyama et al., 2015). According to Tomiyama et al. (2015), the number of cases of explicit bias is on the rise in the public as people start to become more vocal about thoughts related to obesity.

Implicit bias: Negative attitudes that can be activated without conscious knowledge (Tomiyama et al., 2015). A good example is if a nurse, nursing assistant, or physician gave better treatment to a thin patient without the healthcare professional knowing they have any biased attitude toward the obese individual. Implicit bias can be linked to a lower rate of preventive care and an increase in return emergency room visits (Elran - Barak & Bar - Anan, 2018). Ironically, the people who experience implicit bias also have an increase in obesity (Elran - Barak & Bar - Anan, 2018).

Obesity: Too much body weight for height (Brown, 2006; Budd et al., 2011; Chambliss et al., 2004; Hruby & Hu, 2015). Anthropometrically, obesity is a subcategory of the BMI. BMI is a person's weight in kilograms divided by the representation of height in meters squared (Centers for Disease Control and Prevention, 2018). A high number related to BMI can indicate high body fatness (Centers for Disease Control and Prevention, 2018). According to the Centers for Disease Control and Prevention (2018), obesity is subdivided into three categories:

1. Class 1: BMI of 30 to < 35.
2. Class 2: BMI of 35 to < 40.
3. Class 3: BMI of 40 or higher.

Class 3 is considered morbidly obese and the highest risk for comorbidities (Centers for Disease Control and Prevention, 2018). If a person has accumulated a large muscle mass like athletes, they are still considered morbidly obese because they do not meet the weight versus height parameters (Centers for Disease Control and Prevention, 2018).

Assumptions

The research was qualitative. Certain assumptions are made based on a qualitative research paradigm. Qualitative assumptions are based on subjective reality. Researchers assume that the research is context-bound, but some specific patterns and themes can translate into an understanding of a given phenomenon (Creswell et al., 2007).

In conducting the study, I assumed that obesity was still be a healthcare problem. This is justified by a comprehensive literature review of current peer-reviewed journal articles related to the subject of obesity (see Chapter 2). Second, I assumed that obesity was still thought of as a potential area of stigma/bias. This assumption is again justified by a comprehensive literature review of current peer-reviewed journal articles related to bias toward the obese population. Third, I assumed that participants would answer the interview questions truthfully and honestly. This assumption was justified because of the need to provide anonymity and confidentiality to the study participants. All participants were volunteers and had the freedom to drop out of the study at any time without any sort of punitive consequences.

Scope and Delimitation

The delimitations of the study centered on its focus on the obese population in West Virginia, Southern Ohio, and Northeastern Kentucky. This is a small sampling of obese individuals in an area known as the Appalachian region. I could have looked at the relationship between healthcare professionals and the obese population in Tennessee, Virginia, North Carolina, Pennsylvania, or any other territory within the area known as the Appalachian region. Another delimitation of the study is that I was open to any

person who met the criteria for being obese by the BMI standard scale and had a history of experiencing bias due to weight. Future researchers could narrow study participation to specific numbers such as greater than 40 on the BMI standard scale.

Limitations

One of the biggest limitations of the study is that the qualitative data only reflected a snapshot of the participants at the time of the interview. Also, the data cannot be generalized outside of the group. However, the data are a helpful starting point to developing an understanding of the concept. Another limitation of the study could be fear of retaliation from the health care community. Participants might fear that they can not get medical treatment, especially in such a small region, if they were honest about the bias that they had received. The lack of honesty caused by fear of retaliation could limit the study.

Significance

The significance of the study is that it contributes further understanding of the obese population's perceptions of healthcare management. Knowledge of this population's perceptions of healthcare management will allow an insight into barriers they face, if any, in today's healthcare system. One such barrier that could potentially surface is bias. Bias is negative connotations about a group or members of a group (Blair et al., 2011). Bias can be either explicit or implicit. Explicit bias requires that a person be aware that they are showing bias toward another individual (Blair et al., 2011). Implicit bias is unintentional and often done without being consciously aware of the bias (Blair et al., 2011).

Researchers have extensively examined explicit bias among providers, nurses, medical students, nursing students, psychologists, and fitness professionals (Puhl et al., 2014). Recent research has shown that the healthcare population holds implicit and explicit negative opinions related to the obese population (Phelan et al., 2015). Implicit biases can substantially cause patients to feel disrespected, inadequate, and unwelcomed (Phelan et al., 2015). Implicit attitudes can lower patient ratings of care and therefore lead to a 19% higher risk of patient nonadherence and mistrust (Phelan et al., 2015). The significance of the study is that it considers whether implicit bias is a causative barrier.

Developing an understanding of how the obese population perceives healthcare or why they abstain from healthcare could allow insight if there is a bigger problem. Researching the level of any implicit bias that occurs among the healthcare population could help uncover a barrier that even the health care team member does not realize is present. The data collected from this study could clarify whether there is a gap in the care that the healthcare professional is providing and the one that they strive to deliver. Study results may help provide insight into the participant experience and bridge a gap in provider understanding. Furthermore, the study may effect positive social change by expanding providers' understanding of how patients perceive weight management, which may enable them to change their approaches to weight management education. The positive social change would allow the obese population to be heard and honestly tell their story. By understanding their stories, healthcare practitioners could make modifications in their weight management education and overall provision of care to help improve conditions for the obese population and decrease weight bias. This may limit the

number of perceived barriers to seeking healthcare and eventually allow obese people to seek care, reduce comorbidities, and possibly live longer lives. Further research could be done to develop an obesity screening tool that provides set standards and helps to decrease bias, therefore regulating the way that care is delivered to the obese population.

Summary

This research study was qualitative. I used a qualitative approach to explore the perceptions of healthcare of the obese population in West Virginia, Southern Ohio, and Northeastern Kentucky. The results of the study may promote further research regarding the obese population, specifically towards healthcare. The results may also provide insight on whether there is an implicit bias toward the obese population. The study may promote education to help decrease the amount of discrimination, specifically bias that is not recognized by healthcare professionals. This may enhance understanding for both the professionals and the obese population to limit specific comorbidities related to weight and promote healthy lifestyles.

Chapter 2: Literature Review

Introduction

There is substantial research on bias in caring for persons experiencing different types of diseases, conditions, and disorders. Researchers have conducted extensive research on bias in caring for individuals with developmental delays or specific diseases or patterns of drug use and abuse, for instance (Aryal, 2017) This is due primarily to research showing how detrimental bias is to overall health and well-being (Aryal, 2017). However, the amount of research that has been done on bias in caring toward the obese is considerably reduced. As Phelan et al. (2015, p. 321), more research is needed on how stigma affects care for individuals with obesity.

The goal of this literature review is to summarize the history of weight bias, the role of implicit versus explicit weight bias, the impact of obesity in the Appalachian area, and the problems associated with weight bias. I also want to provide background as to the importance of research on weight bias in Southern Ohio, West Virginia, and Northeastern Kentucky. In doing so, the literature review supports the importance of understanding the gaps in research related to weight bias. Before reviewing the literature, I provide overviews of the literature search strategy, theoretical foundation, and conceptual framework.

Literature Search Strategy

To search for literature for the study, I used the population, intervention, comparison, and outcomes (PICO) method, which served as a guide for the keywords used in the search databases. Keywords included, but were not limited to, *weight bias*,

implicit, *Appalachia*, *healthcare*, *doctors*, *nurses*, *dieticians*, and *hospitals*. ERIC, PubMed, Medline, EBSCOhost, and SAGE were searched using the Summon program. I also searched for information on Google Scholar. Sources included peer-reviewed journal articles, books, theses, and dissertations. Twenty sources, dating from 2003 to 2021 were identified as relevant material. The majority were published within the last 5 years.

I used older sources to provide the reader with history related to the topic of weight bias. Other sources were also inclusion for their position on the study topic and referenced in the reference section. However, the most relevant sources for this study were included to provide the groundwork for the literature review. It is important to note that the amount of research related to weight bias, primarily implicit weight bias in the Appalachian area, is very limited. This lack of research demonstrates that there is indeed a gap in the literature.

Theoretical Foundation

Research on stigma can be traced back to the 1960s when sociologists started developing theories on stigma and deviance (Taylor, 2006). Beckner (1963) developed the labeling theory of deviance, which states that society creates certain behaviors by labeling certain people as "outsiders." Scheff (1966) explored how society marks individuals to determine what type of treatment they will receive, specifically in mental illness. Scott (1969) challenged that the personality and characteristics associated with being blind were not inherent but part of a role given to them by society for them to coexist with those with normal vision. Goffman (1963) used the term *stigma* and stated that those who experience stigma are disqualified from normal social functioning. Those

considered unpleasant from a societal standpoint will not be allowed to function within the context of what is deemed to be normal (Goffman, 1963). This theorizing was happening during a time when the established regimen was to lock them in asylums as a vehicle for social control (Taylor, 2006). Authors such as Goffman, Scheff, and Scott were challenging society and profoundly influenced professionals, especially in the areas of mental illness (Taylor, 2006).

The central proposition of Goffman's (1963) theory is that society utilizes a categorical system based on the complement of a set of attributes felt to be normative and natural for the members of the society. Therefore, if someone does not fit within the categorically set list of attributes, that person is deemed "unworthy" to be placed into societal norms (Goffman, 1963). My rationale for using Goffman's theory is that weight bias is a form of stigma. When Goffman first developed his stigma theory, people with mental illness were being placed in asylums not for the protection of the patient but to remove the patient from a society that was not capable of handling the illness (Taylor, 2006). As the undesirables fail to meet the norms and start to be seen more frequently, the stigma will evolve into a process known as scapegoating (Shoham, 1970). Asylums were a form of scapegoating according to the definition of the evolution of stigma (Shoham, 1970). The obese population is dying from comorbidities related to not seeking healthcare (Blair et al., 2011). The question remains the growing death rate related to obesity, or has the stigma of obesity evolved into the process of scapegoating?

There are some limitations to Goffman's theory. The theory ignores social class and how social class, both historically and culturally, affects societal normalcy (Kuso,

2004). Also, the theory assumes a set value system shared by all in the distribution of stigma (Kuso, 2004). However, multiple researchers have used Goffman's theory in the context of social stigma. Goffman's theory has been used for studies on HIV (Aryal, 2017), nursing judgment in ethical situations (Dunger et al., 2017), and drug addiction (Henderson & Dressler, 2019). Atmaca (2020) stated that a student's perception of themself after being branded a troublemaker and stigmatized by both teachers and peers related to their behavior and appearance changed to thinking of themself as a "thug." Goffman's theory is still widely used today and has theoretical relevance.

Conceptual Framework

The conceptual model chosen for the research plan was the HBM. Four perceptions serve as the primary constructs of the HBM: perceived seriousness, perceived susceptibility, perceived benefits, and perceived barriers (McCormick - Brown, 1999).

> The HBM posits that people will take action to prevent illness if they regard themselves as susceptible to a condition (perceived susceptibility) if they believe it would have a potentially serious consequence (perceived severity) if they believe that a particular course of action available to them would reduce the susceptibility or severity or lead to other positive outcomes (perceived benefits) and if they perceive few negative attributes related to the health action (perceived barriers). (Jones et al., 2016, p. 568).

Social psychologists developed the HBM in the 1950s by to explain the failure of people to prevent and detect disease (Champion & Skinner, 2008). "Cognitive theorists emphasize the role of subjective hypotheses and expectations held by individuals,

believing that behavior is a function of the subjective value of an outcome and the subjective probability, or expectation, that a particular action will achieve that outcome" (Champion & Skinner, 2008, p. 46). According to Champion and Skinner (2008), the HBM has the following constructs:

- perceived susceptibility, which refers to the likelihood of getting a condition
- perceived severity, which refers to feelings about the seriousness of contracting an illness related to the physical, social, and psychological health
- perceived benefits, which refers to the persons' belief that good will come from actions taken by the individual
- perceived barriers, which refers to the potential negative aspects of a particular activity or impediments (physical, social, and emotional) to take a specific action
- cues to action, which refers to strategies to activate change
- self–efficacy, which refers to confidence in one's ability or the ability to act

The conceptual diagram for the HBM can be found in Appendix A. The obese person will decide to either seek health care treatment or not seek health care treatment based on all the factors of the HBM. "A nonconscious, cost-benefit analysis occurs wherein individuals weigh the action's expected benefits with perceived barriers" (Champion & Skinner, 2008, p. 47). The framework will allow further investigation into the subjective context of what the obese population considers barriers.

Literature Review Related to Key Variables and/or Concepts

History of Weight Bias

Much research has been done on weight stigma or weight bias. Throughout history, weight bias has resulted in suffering for vulnerable populations and prevented healing and the progression of diseases (Puhl & Heuer, 2009). Across the globe, overweight people are viewed as lazy, incompetent, and at fault for being overweight (Pearl et al., 2017; Puhl & Heuer, 2009). Due to these negative beliefs, the overweight population faces public derogation, devaluation, and discrimination (Pearl et al., 2017). Discrimination has been shown to be a barrier to health care and healthy behaviors in other vulnerable populations. Therefore, the overweight population is stuck in a vicious cycle in which society views obesity as a result of a lack of self-control and shames obese people about not seeking healthcare advice (Puhl & Heuer, 2009).

Weight bias/stigma is not a new term. In 2001 in the first comprehensive review of weight bias, researchers summarized decades of research showing weight bias in domains including education, employment, and health care (Puhl & Heuer, 2009). This research revealed years of unfair treatment to the obese population (Puhl & Heuer, 2009). For many years the obese have been the target of various adverse psychosocial and physical health outcomes (Puhl et al., 2014).

In the past decade, the prevalence of weight discrimination has increased and is now comparable to that of racial discrimination (Puhl et al., 2008). Obese individuals are six times more likely to report height and weight discrimination than normal-weight individuals (Puhl et al., 2008). The increase in stigma could be related to the socially

accepted culture of bias toward the obese (Puhl & Heuer, 2009). Multiple professionals have voiced attitudes of discrimination, including employers, coworkers, teachers, psychologists, physicians, and nurses (Puhl & Heuer, 2009). The term *weight stigma* rarely is conversed in the context of the public health domain, however (Puhl & Heuer, 2009). Weight stigma, some believe, is a way to motivate an obese individual to lose weight (Puhl & Heuer, 2009).

Society is not entirely to blame. The construct of dominant culture is partly to blame for how society views obese individuals (Puhl & Heuer, 2009). Weiner et al. (2009) first addressed the consistency between the relationships of personal responsibility and stigmatizing conditions. Conditions that were viewed as low on the responsibility scale were often met with emotional responses such as pity and understanding. However, needs that were considered as high on the responsibility scale, such as obesity or drug abuse, were met with the emotional response of disdain and anger. Society does not regard obese individuals as suffering from a disease but regards them as architects of their ill health (Puhl & Heuer, 2009). According to society, obese individuals are responsible for their obesity due to laziness and overeating (Puhl & Heuer, 2009). Society's view has provided the foundation for a degree of weight stigma that is seen as beneficial and necessary (Puhl & Heuer, 2009).

Weight Bias in Healthcare

Weight bias, which has already been established in society, also is present in healthcare. Puhl and Brownell (2006) published research that obese adults found weight bias and discrimination in 69% of physician interactions, 46% of nursing interactions,

and 37% dietary interactions. Health Care Professionals (HCPs) demonstrating bias toward the obese individual will have less respect for the patient and a perception of lower patient adherence (Halvorson, Curley, Wright, & Skelton, 2019). According to Seymour et al. (2009), HCPs who demonstrated weight stigma were faster to dispense medications and less likely to focus on education. The HCPs who demonstrated weight bias were also very rigid regarding diet and exercise recommendations and showed less empathy and compassion.

Brown and Bud (2013) state that 69% of 398 British nurses believe that obesity was directly related to personal choices pertaining to exercise and diet. Professionals who believe that people with obesity are responsible for their obesity are more likely to believe that the obese person is purposefully hindering treatment (Phelan, et al., 2015). Thus, HCPs who view obesity as a preventable condition also believe that any failure to treat the condition is related to poor motivation and compliance (Wakefield & Feo, 2017). Another critical point is that even HCPs who work specifically with the obese population and wish to be unbiased can still struggle with weight stigma due to societal demands (Wakefield & Feo, 2017).

Problems With Weight Bias

Weight bias/stigma has been viewed as a motivation for people to help them lose weight. This is false for a couple of reasons. First, if weight stigma has been effective as a motivator to lose weight, then the number of obese individuals should be decreasing (Puhl & Heuer, 2009). The number of obese individuals is on the rise (Puhl & Heuer,

2009). Secondly, several studies have consistently shown the harmful effects of weight bias on individuals (Puhl & Heuer, 2009).

Perceived weight bias is associated with adverse health effects (Shank et al., 2019). Cortisol, lipid, and glucose levels become unregulated, and the person has poorer health outcomes (Shank et al., 2019). Also, weight stigma/bias can lead the obese individual to WBI. WBI is associated with both anxiety disorders and depressive disorders. WBI can lead the obese to develop maladaptive eating behaviors, body shame, perceived stress, substance abuse, decreased quality of life, avoidance of physical activity, and avoidance of healthcare (Alberga et al., 2018). WBI also causes multiple physical aspects to the obese population. WBI includes elevated chronic inflammation, cortisol and oxidative stress, metabolic dysfunction, and worsened glucose regulation (Blair et al., 2011; Ogden et al., 2006; Phelan et al., 2015, Puhl et al., 2014).

Obesity in Appalachia

Obesity is a significant health concern. Approximately 70% of people fall into the overweight or obese category worldwide (Abshire et al., 2017). A population that is at the pinnacle of this obesity crisis is the Appalachian culture. "Appalachia is a 531,000 km region in the USA encompassing 13 states following the Appalachian Mountains from northern Mississippi to southern New York" (Abshire et al., 2017). The populations of these Appalachian communities have reported some of the highest-ranking body weights (Rice et al., 2018).

There have been several studies done to determine the reason for the disparities in Appalachia. Some of the factors that have been established as determinants are limited

availability of nutritious food and limited access to recreational facilities (Abshire et al., 2017). Other factors include the psychological undermining of the need for preventative behaviors such as diet or exercise (Rice et al., 2018). Appalachians may believe that "I am going to die anyway" or "cancer is caused by everything" (Rice et al., 2018). Still, other researchers define these disparities as a cultural issue with overestimating their own personal vitality (Rice et al., 2018). However, multiple studies states that the highest rates of obesity are present among the 25 million residents that reside in the Appalachian region (Ogden et al., 2006; Pancoska et al., 2009; Rice et al., 2018).

Breaking down the obesity in Appalachia even further, research has shown that there is also a discrepancy between rural and urban Appalachia. Obesity in rural residents ranged from 36 – 40 percent, and for urban residents, the range was 30 – 33 percent (Abshire et al., 2017). Some of the worst of these counties are in Appalachian, Kentucky, which ranks as among the worst 10 percent in the nation (Abshire et al., 2017). Rural residents are less independent of diet, exercise and have more socioeconomic factors than urban residents (Abshire et al., 2017).

Culture and heritage are two essential components of the Appalachian people. Appalachian people may view obesity differently from non-Appalachian residents. Abshire et al. (2017) state that among college students going to school in Appalachia, the students with the highest rate of obesity are the ones who grew up in Appalachia and not the ones who transferred in from a non-Appalachian community. "Students who were lifelong residents of rural Appalachian Kentucky were at greater risk for having excess body weight than those living in urban, central Kentucky" (Abshire et al., 2017, p. 1).

Research has shown that obesity is not simply a diet and exercise problem but also very much related to genetics, environment, metabolic, social, and economic factors (Budd, Mariotti, Graff, & Falkenstein, 2011; Phelan, et al., 2015). Research has also shown that weight bias exists among the United States population and the worldwide population (Puhl et al., 2008; Wakefield & Feo, 2017). There are different types of weight bias, including but not limited to implicit and explicit (Puhl & Heuer, 2009). Research has shown that the consequences of weight bias are detrimental (Blair et al., 2011; Brown, 2006; Crandall, 1994; Elran–Barak & Bar–Anan, 2018; Miller et al., 2013). However, there is not much research regarding weight bias amongst the population who show the highest form of obesity.

There is a definite gap in the research regarding implicit weight bias in healthcare among the Appalachian population. There are many articles when reviewing the literature on weight bias in healthcare, which returned 67, 483 results. Implicit weight bias in healthcare returned 2515 results. Weight bias in Appalachia delivered 264 results. Weight bias in healthcare in Appalachia returned 100 results. Finally, implicit weight bias in healthcare in Appalachia returned just five results, and two of the five were diagrams.

There is a need for research among the population in Appalachia (Ogden et al., 2006; Pancoska et al., 2009). Rural Appalachia is at a higher risk than even urban Appalachia (Pancoska et al., 2009). Bias related to obese individuals will directly affect the overall health outcomes and willingness to seek medical attention (Brown, 2006; Chambliss et al., 1994; Crandall, 1994; Garcia & Amankwah, 2016). Research shows implicit bias may be present in individuals without being cognitively aware of the bias

(Elran-Barak & Bar-Anan, 2018; Pearl et al., 2019). Weight bias directed at an individual directly correlates with the individual having negative feelings about themselves and devaluing themselves (Puhl et al., 2014). Finally, the obese population are more at risk for health comorbidities and need to have a trusting relationship with the healthcare population (Blair et al., 2011; Brown, 2006; Crandall, 1994; Foster et al., 2003; Garcia & Amankwah, 2016; Gujaral et al., 2011; Halvorson et al., 2019).

There are definite conclusions one could draw from the research provided. One could assume that there is, in fact, implicit weight bias in healthcare in Appalachia. One could also assume that the perceptions of healthcare by the obese Appalachians are negative, which is the reason for the lack of healthcare services. However, given the complexity of the culture and the lack of research regarding both bias and perceptions in the Appalachian culture, there is no conclusive evidence related to either. Therefore, this research study aims to discover the perceptions of the obese population in Appalachia regarding weight stigma.

Perceptions of the Obese

Previous research has been completed regarding perceptions of the obese population. Adult individuals who are obese are subject to various experiences that satisfy the criteria of stigmatization (Lewis et al., 2011). Stigmatizing attitudes of the healthcare population is perceived by the patients (Malterud & Ulriksen, 2011). Stigma is transferred by subtle processes where blame is delivered to the level of responsibility of the obese person (Malterud & Ulriksen, 2011). The obese are held accountable for their

body weight and their attributed lack of commitment by investment to change (Malterud & Ulriksen, 2011).

Weight stigma has been linked to adverse health behaviors that impair health (Puhl et al., 2020). Obesity stigma is shown to manifest in many different social discourses (Lewis et al., 2011). These discourses are diverse and can extend from control of a situation to an attitude of social responsibility and decreased social worth (Lewis et al., 2011). The different types of stigmas can be received and interpreted differently, specifically by the individuals being stigmatized against (Lewis et al., 2011). Therefore, subjective experiences of the stigmatized are essential for understanding stigma (Lewis et al., 2011).

Summary

Research has demonstrated that society has a history of weight bias (Brown, 2006; Puhl & Heuer, 2009; Puhl & Heuer, 2010; Phelan et al., 2015). Research has also demonstrated that weight bias has been seen in the healthcare field (Brown, 2006; Chambliss et al., 2004; Dunger et al., 2017; Garcia & Amankwah, 2016). There is evidence that weight bias does not even need to be purposeful and can be done without the person knowing (Blair et al., 2011; Seymour & Schumacher, 2018). Research has demonstrated that one of the most extensive areas for both obesity and comorbidity is in the Appalachian region (Abshire et al., 2017; Pancoska et al., 2009; Rice et al., 2018). However, the gap in the research is the correlation between if health care providers demonstrate implicit bias toward the obese population and the perception of the obese population towards healthcare. Specifically in the Appalachian region due to the

increased numbers of obesity and comorbidities (Abshire et al., 2017; Pancoska et al., 2009). "Research priorities are identified, including the need for future studies to identify mechanisms through which weight stigma may undermine or facilitate weight-related treatment outcomes" (Puhl et al., 2020, p. 274). The knowledge of the research study will provide data to increase understanding of the perceptions of the obese population to allow further research on weight – stigmatizing and the effects that weight stigma has on obese individuals.

Chapter 3: Research Method

Introduction

The purpose of this chapter is to introduce the research methodology for this qualitative study regarding the perceptions of the obese population in West Virginia, Southern Ohio, and Northeastern Kentucky. I conducting the study, I wanted to further understand how participants perceive healthcare management. The applicability of theory will also be discussed in-depth in this chapter. The research design and rationale; methodology, including participant selection logic, instrumentation, recruitment and data collection procedures, and data analysis plan; and ethical procedures are also components of this chapter.

Research Design and Rationale

RQ1 (qualitative): What are the perceptions of people who are obese who have experienced weight stigma/bias from a healthcare setting in West Virginia, Southern Ohio, and Northeastern Kentucky?

RQ2 (qualitative): What, if any, are the lasting effects defined by people who are obese related to the weight stigma/bias from a healthcare setting in West Virginia, Southern Ohio, and Northeastern Kentucky?

The nature of this study was a qualitative descriptive study. I conducted a qualitative study to allow the participants the opportunity to tell their experiences. Currently, little is known about weight stigma, specifically from the obese person's subjective meaning (Emmer et al., 2020). A qualitative research approach allowed the participants to give examples and feelings related to weight stigma. This input yielded

more understanding of the personal relationship associated with the objective term *weight bias/stigma*.

The qualitative research design chosen for the research project was a qualitative descriptive study. Qualitative descriptive follows the empirical method of investigation aiming to describe the informant's perception of an experience (Neergaard et al., 2009). Qualitative descriptive studies are the least theoretically structured of the qualitative approaches (Lambert & Lambert, 2012). Studies with this type of design tend to draw from naturalistic inquiry, which allows researchers to study in a natural state within the contexts of the research arena (Lambert & Lambert, 2012). Researchers who conduct qualitative descriptive studies do not use pre-selected study variables, does not manipulate the variables, and does not commit to anyone's theoretical view of a target phenomenon (Lambert & Lambert, 2012). The use of a qualitative descriptive design allows the participants to give a detailed description in their language (Neergaard et al., 2009).

The design will follow the work completed by Sandelowski (Sandelowski, 2000). According to Sandelowski (2000), the research philosophy should be pragmatic, the sample should be purposeful, the data collection should utilize minimally – to – moderately structured open-ended interviews, the analysis should use a flexible coding system that corresponds to the data collected, and the outcomes should be a straight description of the data organized in a way that "fits" the data. The use of the design completed by Sandelowski (2000) is only a template; the issues are not exhaustive or exclusive in either way because the true nature of a qualitative descriptive study is to be

flexible (Neergaard et al., 2009). By using a qualitative descriptive design, I was able to listen to participants' descriptions of weight bias as they experienced in West Virginia, Southern Ohio, and Northeastern Kentucky. Participants' responses were helpful to me in identifying themes related to barriers experienced by the obese population in these areas.

Role of the Researcher

My role as the researcher was to discover by listening the feelings of the participants. I set up an area for each interview and observation to mimic the natural environment of the volunteer as much as possible. I was also responsible for protecting the safety of the information provided and data received. I examined any reflexivity before performing the research. "Reflexivity is the process that challenges the researcher to explicitly examine how his or her research agenda and assumptions, subject location, personal beliefs, and emotions enter into the research" (Hsiung, 2008, p. 211). The researcher will uphold the validity and confidentiality as stated previously in Chapter 1.

Methodology

Participant Selection Logic

The qualitative section of the research was done using purposive sampling. "Regarding the use of sampling in a qualitative descriptive design, virtually any purposeful sampling technique may be used" (Lambert & Lambert, 2012). I recruited participants from the selected geography using word of mouth, social media, and flyers as some examples. The flyer (see Appendix B) was placed in third-party organizations, including, but not limited to, churches, restaurants, gyms, and stores. I included my email address for potential participants to contact me. I used snowball sampling to find others

who fit the requirements outlined in the study. The inclusion criteria for the study were that participants lived in the defined society and met the standards defined as obese. Obese individuals are defined as having a BMI greater than 30 (Centers for Disease Control and Prevention, 2018). The results are based on the BMI calculation BMI = kg/m^2. (Centers for Disease Control and Prevention, 2018).

Sampling Strategy

For the study location, I chose a general area based on four qualifications:

- The individuals need to be recruited from an area with a high number of obese individuals per health department reporting.
- The area needs to be in the Appalachian region.
- The individuals need to have experienced weight bias/stigma in a healthcare setting.
- The individuals must be willing to talk about their experiences.

The general area chosen based on the qualifications was Northeastern Kentucky, Southern Ohio, and West Virginia. West Virginia falls only second to Puerto Rico for the highest rate of obese adults in the United States (Pancoska et al., 2009). Also, West Virginia is the only state to fall entirely in the Appalachian region (Pancoska et al., 2009). Therefore, West Virginia mets the two qualifications for sampling area.

The second step for choosing a sample was to determine a sampling strategy. The purpose of sampling is to obtain cases rich in information to saturate the data. (Lambert & Lambert, 2012). I used two different techniques for establishing a sample. The first technique I used was to obtain a purposive sample. Grove et al. (2015) stated that

purposive sampling allows the researcher to choose who will participate in the study. I first narrowed down the general area to a city or town located in the general area. Upon establishing a specified sampling area, I then used a predesigned flyer, word of mouth, and social media to help advertise the need for participants. I was particular in the type of person needed for the study. The following qualifications had to be met:

- 18 years of age or older
- BMI over 30
- lived in Northeastern Kentucky, Southern Ohio, and West Virginia longer than 10 years
- has experienced weight bias/stigma regarding healthcare
- willing to discuss weight bias/stigma regarding healthcare
- agrees to meet with me for an initial interview on the given date and subsequent follow-ups

I also used network recruiting. Even though the recruiting technique is rigorous, information is gathered from specific sources that could elude the researcher (Grove et al., 2015). Network recruiting, also known as snowball, helps use word of mouth from the participants. I asked the participants to offer my email address to other potential participants who met the research qualifications.

I continued to recruit participants until saturation was met. Saturation is when the researcher cannot gather new information based on additional sampling (Grove et al., 2015). Verification is when the researcher can draw conclusions based on the information gathered (Creswell et al., 2007). I anticipated that 10 participants would be

sufficient with the understanding that more might be necessary to reach the verification level.

Instrumentation

After sampling, the next step was to identify the type of qualitative instrumentation to be used. Sandelowski (2000) stated that the use of minimally to moderately open-ended questions for interview and observation is effective. Therefore, I used both interview and observation during the qualitative study. Before the interview part of the research, I gathered all the participants, described what is expected, and had the participants sign an informed consent. In order to gain participant involvement, there is particular importance placed on divulging why the interview is taking place, the reason behind the interview, and most importantly, that the data may be published (Creswell et al., 2007). As Rubin and Rubin (1995) stated, institutional review boards (IRBs) recommend that all participants sign an informed consent. Therefore, the participants are not deceived about the nature of the study (Rubin & Rubin, 1995).

I conducted the interview first. Qualitative interviews are designed to gather data to help either build a specific theory or to help explain a particular phenomenon (Rubin & Rubin, 1995). Confidence is also essential in the interview process because participants are more open with answers. Diligence in listening allowed aspects of the culture to be discussed by the participants in the study.

According to Lambert and Lambert (2012), interviews for qualitative descriptive studies can be individual or group, structured or open-ended. I designed the interview to begin with general questions and then become more specific as the interview continued.

The IRB looked at both the legal and ethical aspects of the research before I began the study. Also, the IRB reviewed the study for apparent bias. Some example questions are as follows:

1. Tell me about your healthcare experience.
2. Describe, if any, limitations you have experienced regarding healthcare.
3. Describe if any a time when you felt weight bias/stigma was present during a healthcare visit.
4. Tell me if any lasting affects you feel are related to the weight bias/stigma you have experienced.

Appendix C contains a full list of the interview questions used in the study.

Procedures for Recruitment, Participation, and Data Collectiono

For the interview portion of the study, the researcher will utilize Zoom interviews due to the pandemic and the social distancing protocols. The researcher will utilize the recording device on the Zoom program to record each session. The researcher will meet with the participants individually for an hour. The researcher will utilize an interview guide with five open-ended questions related to the topic of cultural factors related to obesity. The researcher will utilize a general question approach then become more specific as the questions progress.

Once the sample has been taken, the researcher will conduct the interviews. Before the interview begins, the researcher will remind the interviewee of what was stated in the informed consent. The researcher will then reiterate the amount of time specified in the informed consent. Then the researcher will ask the interviewee if they

have any more questions. Once the interviewee is comfortable with the situation, the interview will begin.

The researcher will stick to the questions. A good interviewer is a good listener rather than an accomplished speaker (Creswell et al., 2007). The interview will flow according to the interviewee. The open-ended questions will allow the participant to speak freely about healthcare and any feelings associated with healthcare, both positive and negative. Upon completion of the interview, the researcher will thank the participant for allowing the interview to happen.

The researcher will ask the participant if they know anyone else who would have an opinion or knowledge of healthcare. The reason for this question is that the researcher is utilizing a sampling strategy known as network sampling. The researcher is attempting to make more connections related to the area if the themes are not clear and more samples are needed.

The researcher will interview participants until data saturation is attained. Data saturation is defined as the degree to which new data repeats what is expressed in the old data (Saunders et al., 2018). Data saturation can also be looked at as “informal redundancy” (Sandelowski, 2000, p. 875). As defined by this study, data saturation was based on the researcher's sense of what is being said during the interviews. However, during the data analysis, if there is not enough data to determine themes, the interview process will continue.

Data Analysis Plan

Data analysis was completed by utilizing the six-phase guide framework for thematic analysis (see Appendix D; Braun & Clarke, 2006). The first step in the qualitative analysis is to become familiar with the data (Braun & Clarke, 2006). Becoming familiar with the data was done by the researcher taking the interviews and typing them word for word into transcripts. The researcher will then read and re-read the transcripts to allow the researcher to become familiar with the entire body of data.

Upon completing the transcripts and familiarity with the research, the next step is to generate initial codes (Braun & Clarke, 2006). Data analysis of a qualitative descriptive study, unlike other qualitative approaches, does not utilize a prefabricated set of rules generated from a philosophical stance (Lambert & Lambert, 2012). Therefore, their initial codes for the qualitative descriptive study were not clearly defined as needing to be deductive or inductive. However, to enhance confirmability, the researcher will utilize inductive coding. Inductive coding is when the codes will be generated from raw data and not pre-set codes from the researcher (Braun & Clarke, 2006). The researcher will take each transcript and utilize highlighters of different colors based on discovered codes while reading the transcripts.

A good example would be blue for a specific code and pink for another. The researcher will then utilize Microsoft Excel to group the transcription data with the given codes. This will help organize the codes with the data and help to better transition to the next step.

The third step in data analysis will search for themes (Braun & Clarke, 2006). Themes, by definition, are patterns in the data that are deemed essential and say something about an issue relevant in the research (Braun & Clarke, 2006). There is no one rule on what makes a theme (Braun & Clarke, 2006). The researcher in step 2 has all of the information from the transcripts grouped into codes in an Excel spreadsheet. Therefore, the researcher will utilize the codes presented in step two of the data analysis plan and look for the significance of how the codes fit together. The researcher will then organize the codes into broad themes to provide information related to the RQs. At the end of the third step, the researcher will have themes, codes, and transcription data organized for easy review and modification in an extensive spreadsheet.

The fourth step in data analysis is to review the themes (Braun & Clarke, 2006). During this phase, the researcher will dissect the themes created in step three and review them. The researcher will keep in mind that the themes need to make sense and that the data supports the themes. This step will also allow the researcher to determine if themes overlap or if there are themes within a theme. Reviewing the themes was more accessible due to the researcher having the information in one spreadsheet. The spreadsheet will allow easy access to the complete information and enhance the ability to see discrepancies in the data categorization.

The fifth step in the data analysis is to define the themes (Braun & Clarke, 2006). Defining the themes is to identify what each theme is about (Braun & Clarke, 2006). During this step, the researcher will take each theme and decide what the theme is, stating if subthemes relate to the central theme and how each theme relates to one another. After

the themes have been defined, the researcher can move to the next step, writing up the information. This is when the researcher will pen chapters 4 and 5 of the dissertation study.

Issues of Trustworthiness

Qualitative research emphasizes exploring individuals' experiences, describing the phenomenon, and developing theories (Vishnevsky & Beanlands, 2004). Four different criteria were utilized to develop trustworthiness in qualitative research (Lincoln & Guba, 1985). The four different categories are credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985).

Credibility is the participants' view and representation of the participants by the researcher (Polit & Beck, 2012). Credibility was maintained by discussing the themes with the participants after the researcher has completed the interviews and transcribed the transcripts. The participants will inform the researcher if the themes are consistent with the information they were trying to portray. This will provide credibility to the study by allowing participants to state their views and reevaluate their statements once the transcription has been transcribed.

Dependability is the consistency of the data over parallel conditions (Polit & Beck, 2012). The dependability of the study was ensured using external audits. External audits are done by having a separate researcher not involved in examining the process and product (Lincoln & Guba, 1985). This was done by the research committee, who are credible researchers, and will determine both the accuracy and validity of the research study.

Confirmability is the researcher's ability to demonstrate that the participants' responses were not based on researcher bias (Polit & Beck, 2012). The confirmability of the research was maintained by utilizing reflexivity. Reflexivity states that "a researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (Malterud, 2001, pp. 483 - 484). To ensure confirmability, the researcher will briefly report in the manuscript how one's preconceptions may have happened during the research process (Lincoln & Guba, 1985).

Transferability refers to findings that can be utilized across multiple studies (Polit & Beck, 2012). The researcher will provide a thick description based on the participants' exact words. Thick description is a way of achieving external validity by describing in sufficient detail how the conclusion drawn is transferable (Lincoln & Guba, 1985). The researcher will ensure that if the participant is pausing based on shock or disbelief, the pause was noted and included in the detail of the experience.

Ethical Procedures

Ethical behaviors bind researchers to ensure that the results of the study are sound. Ethics pertains to not harming. The protection of human research is the top priority (Kim, 2012). Investigators must ensure that steps are aligned with the fundamental principles outlined in the *Belmont Report*; these include respect for the individuals, beneficence, and justice. These basic principles listed in the *Belmont Report* are the criteria utilized by the IRB to evaluate research on human participants.

Ethical considerations for a qualitative study should include informed consent to conduct the research, confidentiality, and risk-benefit ratio (Kim, 2012). The informed consent should be written to outline a brief explanation of the research study, including background information relevant to the study. The risk and benefits of the study also need to be explained to the participants. The purpose of explaining the background, risks, and benefits to the participants is so the participants can make an informed decision to participate or not. Also outlined in the informed consent was procedures, time periods associated with procedures, and questions they might be asked during the study. The researcher will also describe how the data utilized during the study was stored, including how long after the study the information was kept.

Ethical considerations were conducted in the following capacity related to the study. All participants of the study were on a volunteer basis. Before the obese individual participates in the study, they were educated thoroughly and sign an informed consent. Participants will also be informed that multiple people were utilized for the coding of the study. All offensive, discriminatory, or unacceptable language was avoided in the research study. Both privacy and anonymity were maintained throughout and after the research study. Before the study, the researcher will gain approval from the IRB at Walden University.

Summary

The goal of this chapter was to outline the methods used to answer the RQs. The procedure, participants, collection, and design were expounded upon to help give specifics to the research to be performed. A qualitative approach utilizing a qualitative

descriptive method was explained. Utilizing the qualitative descriptive method will allow the obese population to have their description to help answer the RQs. In Chapter 4, I present the results of the study.

Chapter 4: Results

Introduction

The purpose of the study was to understand the perceptions of weight bias from the perspective of obese individuals in West Virginia, Southern Ohio, and Northeastern Kentucky. I also wanted to explore these individuals' experiences of healthcare.. I recruited participants who had been defined as an obese individual (> 30 BMI). who lived in West Virginia, Southern Ohio, and Northeastern Kentucky, and who had previously experienced weight stigma or bias. I interviewed individuals until saturation was fulfilled.

I then carefully reviewed and coded the data for emergent themes related to the RQs, which were as follows:

RQ1 (qualitative): What are the perceptions of people who are obese who have experienced weight stigma/bias from a healthcare setting in West Virginia, Southern Ohio, and Northeastern Kentucky?

RQ2 (qualitative): What, if any, are the lasting effects defined by people who are obese related to the weight stigma/bias from a healthcare setting in West Virginia, Southern Ohio, and Northeastern Kentucky?

In this chapter, I will explore these themes and other study findings regarding the perceptions of participants regarding healthcare in West Virginia, Southern Ohio, and Northeastern Kentucky. I also discuss the findings regarding the perceived effects of weight stigma/bias in healthcare settings. The chapter also includes discussion of the setting, participant demographics, data collection, data analysis, and evidence of trustworthiness.

Setting

The setting was influenced by the COVID–19 pandemic. I relied heavily on precautions set forth in state and national guidelines. One of the key influences on the setting was the potential risk in conducting face-to-face interviews during the pandemic. To address this risk, I conducted participant interviews using Zoom technology. The setting was more challenging to control than a face-to-face one due to background noises on the participants' side of the Zoom call. However, I feel, especially during the pandemic, that Zoom was the best option for gathering data during this challenging period.

Demographics

I interviewed 10 participants. The participants for the study were from varying parts of West Virginia, Southern Ohio, and Northeastern Kentucky. Table 1 shows a demographic breakdown of where each participant was located. The participants and I developed an alpha code as a label for participants in the study. The alpha code has no correlation with names or initials of the participants. The participants are defined by their assigned alpha code in the Tables 1 and 2, the latter of which provides a summary of the gender and geographic locations of participants.

Table 1

Participant Breakdown

Participant	> 30 BMI	Geography	Gender
LN	Yes	West Virginia	Male
DG	Yes	West Virginia	Female
II	Yes	West Virginia	Female
JR	Yes	Southern Ohio	Female
ND	Yes	Northeastern Kentucky	Female
PE	Yes	West Virginia	Female
KG	Yes	Northeastern Kentucky	Male
RR	Yes	Southern Ohio	Female
NS	Yes	West Virginia	Male
AE	Yes	West Virginia	Female

Note. BMI = body mass index.

Table 2

Geographic and Gender Breakdown

Percentage above 30 BMI	Percentage from each state	Gender percentage
100%	West Virginia 60% Southern Ohio 20% Northeastern Kentucky 20%	Female 70% Male 30%

Note. BMI = body mass index.

Data Collection

The total number of participants for the interview was 10. As the number of interviews approached 10, I found that data points were being repeated, therefore indicating that data saturation. I decided not to pursue additional participants for this reason. The interview portion of the study was done entirely utilizing Zoom due to the

pandemic and social distancing protocols. I used an interview guide with five open-ended questions, as demonstrated in Chapter 3's Methodology section. If cued, I probed with an additional open-ended question to gain more insight from the participants. I used the recording device embedded into the Zoom software to record the interviews for download. The built-in Zoom recording device was seamless in design and use, which is why I chose this device over a manual recorder. Each interview had 1 hour allotted for the participants to answer the questions. Most interviews ranged from 25 to 35 minutes in length, with the second to last question being if they would like to add anything else. Other than the use of Zoom in the data collection, no other unusual circumstances were encountered.

Data Analysis

I completed data analysis by using the six-phase guide framework for thematic analysis (see Appendix D; Braun & Clarke, 2006). The first step in the qualitative analysis was to become familiar with the data (Braun & Clarke, 2006). I recorded the interviews and listened to each interview twice before typing them word for word. I then read and reread the transcripts to gain familiarity.

Upon completing the transcripts and familiarity with the research, the next step was to generate initial codes (Braun & Clarke, 2006). Data analysis of a qualitative descriptive study, unlike other qualitative approaches, does not involve a prefabricated set of rules generated from a philosophical stance (Lambert & Lambert, 2012). I used the information given by the participants to formulate initial codes. I did this by taking each typed transcript and using different highlighters located in the Microsoft Word toolbar to

color code information that would relate to the primitive codes. I then made lists on Microsoft Excel and cut and pasted the color-coded information that fit under the coded header. The lists helped to organize the data and better prepared me for the write-up of the information.

The third step in data analysis was to search for themes (Braun & Clarke, 2006). Themes, by definition, are patterns in the data that are deemed essential and say something about an issue relevant in the research (Braun & Clarke, 2006). There is no one rule on what makes a theme (Braun & Clarke, 2006). There were many primitive codes that I had formulated on the Excel sheet. These codes ranged from "I hate going to the doctor" to "I hate insurance." I used the codes to find themes among the information given. The themes were a broader approach that exemplified the collective codes to help tell the story of the participants. At the end of the third step, I had all themes, codes, and transcription data organized for easy review and modification in an extensive spreadsheet.

The fourth step in data analysis was to review the themes (Braun & Clarke, 2006). During this phase, I dissected the themes. The themes were analyzed to ensure that the themes made sense. The themes were also analyzed to determine if there were overlapping themes or themes within a theme. I had all themes and codes organized into the spreadsheet, which helped with ease of analysis.

The fifth step in the data analysis was to define the themes (Braun & Clarke, 2006). During this step of the process, I decided what the themes expressed. I had themes

and subthemes that related to two main questions. I spent much time looking over the themes trying to differentiate what story the participants was telling.

Evidence of Trustworthiness

Qualitative research emphasizes exploring individuals' experiences, describing phenomena, and developing theories (Vishnevsky & Beanlands, 2004). Four different criteria are utilized to develop trustworthiness in qualitative research (Lincoln & Guba, 1985). The four different categories are credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985).

Credibility is the participants' view and representation of the participants by the researcher (Polit & Beck, 2012). I maintained credibility by discussing the themes with the participants after I had completed the interviews and transcribed the themes. The participants were asked if the themes matched what they were communicating after coding. This was done by discussing over the phone if the themes matched what the participants stated. The participants agreed that the themes were, in fact, correct in what they wanted to communicate.

Dependability is the consistency of the data over parallel conditions (Polit & Beck, 2012). I ensured the dependability of the study by using external audits. External audits are done by having a separate researcher not involved in examining the process and product (Lincoln & Guba, 1985). I was in contact with my chair multiple times during the study to ensure that the research process and the data were accurate and valid.

Confirmability is the researcher's ability to demonstrate that the participants' responses were not based on researcher bias (Polit & Beck, 2012). I maintained the

confirmability of the research by utilizing reflexivity. The definition of reflexivity is “a researcher’s background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions” (Malterud, 2001, pp. 483-484). I only used information given by the participant. Participants were interviewed using the same interview script. If participants mentioned something during the interview that needed clarification, I would ask for clarification. The clarification of the answers enhanced the credibility to the study by allowing the participants to clarify their meanings in their own words. In the Limitations section in Chapter 5, I discuss potential issues with preconceptions and the steps I took to ensure transparency, consistency, and communicability.

Transferability refers to findings that can be utilized across multiple studies (Polit & Beck, 2012). I provided a thick description based on the participants' exact words. Thick description is a way of achieving external validity by describing in sufficient detail how the conclusion drawn is transferable (Lincoln & Guba, 1985). I collected the information precisely the way the participants stated, including the breaks and the uhms (which signal that the participant was thinking). I did not modify any stories or change any dialog to make the information flow easier. The participant's exact information allows the participant's personality to show and therefore allows the conclusions or themes to be transferable to other studies.

Results

The results section of the research project was broken down into themes and subthemes. The information was delivered in the purest form of how the information was received. According to Rubin and Rubin (1995), quotations should be utilized in the purest form to keep the reader from making inferences. Quotations should also come from a source who knows the answer to the questions (Rubin & Rubin, 1995). So, the information was delivered directly from the participants of the interviews through quotations.

Theme 1: I Hate Seeking Healthcare

One of the main themes that the study participants wanted to bring out was the fact that they hated seeking healthcare. Nine out of 10 participants spoke of their disdain for seeking healthcare. Examples of some of the responses are: " I hate going to the doctor. I hate, you know. Uhm any type. I mean no matter what it is I hate. I really do hate that," Stated JR. JR also stated, "I'm not the kind that will neglect something to the extent of you know, I guess overly extensively. Waiting to go to the doctor, but I will definitely try to put it off as long as I can for sure."

II stated, "I'm a nurse and you feel like you as a nurse, you feel like you should be able to go to the doctor no problem, but sometimes I feel a little stressed out. I don't want to go." II also stated, "I don't want to be that I don't want to be there. Of course, I want to treat myself, but I just think it's embarrassing sometimes." ND stated, "I hate going to the doctor, I hate it." ND also stated, "I hate the whole process. I mean, I hate going there and getting weighed." PE stated, "I dread going to the doctor. I really do, I always have."

AE stated, “I don't go to the doctor unless I have to because I get sick and tired of him not listening to me." RR stated that "Uhm gosh, I hate it. I've always hated going to the doctor," RR continued, "For years and years I only went to the doctor if I absolutely had to because I always felt looked down on by doctors." NS states, "I really don't go to the doctor, it is annoying for me to go there be told I need to lose weight."

Theme 2: Always Related to Weight

Another central theme that emerged from the data was that everything mentioned to the participants from healthcare was either directly or indirectly related to weight. This theme was broken down into two subthemes. The first subtheme was that weight is the cause of your problems. The second theme was that losing weight will fix your problems. Nine out of 10 participants mentioned weight as either the cause of their problems or that weight was mentioned as the solution to fixing their problems.

Weight as the Cause of Participant’s Problems

The first subtheme discussed from the data is that weight is the cause of the participants' problems. LN stated, "they call your name, and the very first thing they do is they say get on the scales you get on the scales. You know you are overweight; you know you have been overweight. I have been overweight all of my life. The second thing after getting you on the scales, which is kind of how I believe this is kind of psychological to a degree because the very next thing they do after you step off the scale to take your blood pressure, which you know is going to be elevated once you see your weight. It is typically it is like, well, if you lose weight, your blood pressure will come down. Your diabetes will go away, and it seems as though that using the term losing weight is the universal

catchall to every medical issue that I have, which I understand that more than likely it is. But I do not need to be reminded of that every three months." II stated, "I went to focus on my anxiety because I was having a lot of panic attacks. But what it ended up being focused on was that I needed to lose weight." JR stated about a shoulder injury playing sports at 17 years old, "I was probably, I would say every bit of maybe 17 probably if I had to guess. I can't fully remember, but I was younger, and uhm, I was sitting there with my mom and the doctor had walked straight in and literally like he looked at me. He's like, well, I had been reviewing your MRI. Well, clearly he was like, I'm not sure really what we're going to do to fix the problem, he said, except clearly and he like looked at my mom and then he looked back at me, and he was like clearly we have a weight issue that needs to be controlled first" PE stated, "I had a doctor told me one time that I wouldn't live past 40 because that my weight would half my age."

Weight as the Cure to Participant's Problems

The second subtheme discussed from the data is that weight is the cure to all your problems. LN stated, "I know that what I'm going to hear is if you lose weight then these problems will vanish." ND stated, "If you work out then you won't be as sick as you are or, well. The problem is I can't workout. Yes. Because I don't feel good. I mean, she'll tell me ways to try to lose weight and everything, but I kind of feel like everything goes back to my weight." RR stated, " Several years ago like I said, I don't like to go to the doctor but I got so sick I didn't have any energy and I was working and it was hard to stay awake at work and I felt like I absolutely had to see a doctor. When I went to see the doctor of course it was because if I'd lose weight, I'd have more energy, it was just

terrible that I was carrying all this weight around. I took his word for it until I ended up in the hospital with diabetes, which he never tested me for because the only thing wrong with me is that I needed to lose weight. You think someone would say oh your fat maybe you have diabetes, but he didn't look at it that way, he just thought your fat you need to lose weight and everything will be OK."

Theme 3: Not Listened To

The next theme that emerged from the data was that the obese population does not feel listened to. ND states, "Sometimes I'm not taken serious as I should be. My doctor starts giving what he thinks is friendly advice, but it's not. It's not perceived as good advice. He is just quite rude about it. He is very degrading about my care and especially by mentioning my weight all the time." ND continues, "I went to another doctor, and as soon as I walked down the hallway, I was weighed; I was there because I was suffering from COVID, I couldn't breathe. The doctor came in and told me that if I worked out more, then I wouldn't be as sick, and the reason I don't feel good was because I was overweight; I mean, I was really sick, but all she could get to was to tell me to lose weight." AE states, " Oh yeah, definitely. I have thyroid trouble. I've had it for 13 years and. I had seven children, and I was never over 160 pounds, and I'm 5'9". I was never a heavyset person, and I got thyroid problems, and all of a sudden, I kept gaining and gaining no matter what I eat. Don't matter what I exercise, what I do. Therefore because of the weight, my health is going down. And every time I go to the doctor, I'm explaining this to them. They're like, well, you need to not eat. You need to eat better. OK, I am. But you need to exercise. I am, and you need to do this and this, but they're not getting to the

root of the problem, which is a thyroid to help me out to lose the weight. So therefore, they're just taking my money and putting me on drugs because now I'm on blood pressure and water pills. And then because you're overweight, you get depressed, and I'm depressed, I guess. So, all they're doing is filling me full of drugs and giving me a death sentence to die from a heart attack or overweight. So yeah, they're concentrating on the weight, but they're not concentrating on the problem." AE continues, "Yeah, I don't like going to the doctor anymore because I'm tired of being. I'm tired of pills being put down my throat and not actually listening to me and trying to fix the problem. I mean, if you don't know enough about what's wrong with me, just say you don't. Don't sit there and keep putting me on pills, after pills, after pills, after pills. It's I just feel like they're legal drug pushers." II states that "Uncomfortable and embarrassed, you know, uhm, you don't want to focus on the things. I know that I need to lose weight, but that's not why I went to the doctor. So, it definitely made me feel uncomfortable. And again, because I worked with these people at the hospital. And it made me feel like I wonder what all these people are thinking of when they see me at the hospital when I'm working with them." PE states, "I feel like I am not listened too, I know my body, I feel like I'm not listened too. I don't know if it's just me, or the doctor, or what but it happens over and over again." NS states, "I went to the doctor and I had gained 10lbs, and even though all my labs were a healthy adult, the doctor was sure to note and tell me that I needed to really start watching what I was eating and lose weight even though my labs were good." NS continues, "It just seems like no matter what is going on, they focus on my weight, and it is almost like blinders; anytime I have an issue, it has to be weight."

Theme 4: Morbid Obesity Is a Derogatory Term

Most of the participants mentioned the term *morbid obesity*. According to LN, "Lets define the term morbidly obese. When you think of morbidly obese, the first thing I think of is that I am a carnival attraction somewhere that people, you know that I am some kind of freak or some kind of a monster" LN continues, "First of all by the term morbid obesity, it sounds like a dirty name." ND states that "When you hear the word morbid obesity, it's very upsetting, it's depressing, I mean it's not something you want to be told and you know you don't wanna hear, it's not something you want to be told, and it's not something you wanna be either." ND continues, "It's not like you choose that, It's not like I want an extra 50 plus pounds on my body, it's a complete struggle and name calling doesn't help" PE states, "The word morbid obesity is Morbid, I don't like that word at all." NS states that "To me that word seems very degrading to somebody you know, almost like you know you're calling them a very harsh term by using the term morbid and obesity together. Even though it is a disorder, to me it is something that is almost ridiculing them in nature by calling them morbidly obese."

Theme 5: Long-Term Effects of Weight Bias

Long-term effects are effects physically, mentally, and emotionally that the obese population feels that could potentially keep them from seeking health care in the future. The long term effects have come from previous experiences with health care providers. The following is the data collected in the theme of long-term effects. LN states, "I played my part, I have tried every diet that has been advertised. My primary motivation for my change was my daughter. I have lost 130lbs. It was me and my personal motivation that

did that. To say that the healthcare system did anything for me or helped me by angering me or making me more determined. I can't do that. Actually, hearing about it every visit just made me sick of going. Healthcare did nothing for me." LN continued, "I am kind of a catch 22 I have to seek health care; if I don't, I can't get my prescription for insulin; please understand it is not my desire to seek healthcare; it is just I have to. I think the healthcare industry just makes the patient feels angry; there is tension there, and to be honest, I don't want to go, and in some cases, people just don't go, and then something happens, and they end up really sick or dying. They get really sick because they never see a doctor because they have been turned off to it because all the time, they are told they need to lose weight." ND states that "I mean that makes you hesitate to even go to the doctor when you need to, and it just gives you a big hesitancy and adds stress for situations that aren't even perceived or related to your weight." ND continues, "You know no one wants to be morbidly obese, nobody sits down and says you know I want to have a BMI of 35. The doctors they don't look at me as human, they look at me as overweight or worse uh, morbidly obese; there is a lack of sensitivity to it." NS states, "It keeps you from not wanting to go to the doctor because I don't want to hear them say, oh you need to lose weight even though you might be going to for an injury or sickness."

Treatment of Discrepant Cases

The discrepant case is KG. KG stated, "for the most part, he did not mind going to the doctor." KG stated, "As I got older, I am now 50 and realized I had diabetes, you need to seek health attention because you don't remain healthy your entire life" KG continues, "I have been diabetic for 17 years, and that is when I really started going to the doctor"

KG explains, "I work in the acute healthcare setting, and I have known my doctor since he was in medical school." KG states, "I also see a cardiologist once a year, and I have a new GI doctor, but I don't care for them much." This is a discrepant case because the interviewee had an inside opportunity to pick which physician they wanted to see, but there was some trepidation when a new physician was introduced. KG states, "He is new, and I have not talked to him or even seen him for longer than 5 minutes."

Summary

The perceptions of the people who are obese who have experienced weight stigma/bias from a health care setting in West Virginia, Southern Ohio, and Northeastern Kentucky has given subjective meaning and stories to help frame the first-person point of view from a group that is from their own words not only from an underserved Appalachian population but a group that is from their report underserved in the underserved population. According to the stories mentioned, there is a disconnect between what is needed from the obese population and what the healthcare community feels is important. The obese population interviewed do not trust health care providers, feel like health care providers are constantly judging them, and would not seek help from health care providers except for medication needs. The obese population have given multiple reasons that their perceptions of health care have been skewed in the long term. Health care providers telling them to lose weight for a surgery only to not do surgery and tell them to lose more weight, weighing them in front of the office staff and open areas, and giving advice solely based on size and not necessarily health at the time of

appointment are examples of some of the long-term effects mentioned by the obese population.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

There were multiple themes that emerged from the study. Almost all of the obese population interviewed stated that they felt that their healthcare experiences revolved around weight. Almost all of the obese population interviewed reported having been told multiple times that their comorbidities can be controlled by weight. Almost all of the obese population interviewed have been told multiple times that their weight has contributed to health discrepancies. Half of the obese population interviewed focused on the term *morbid obesity* and indicated feeling that the term is a derogatory term. All of the participants interviewed expressed feeling that they are not listened to. Almost all of the obese population interviewed, despite stating they know it is important to seek healthcare, reported that they do not seek healthcare regularly. Less than half of the participants interviewed said that if they did not need their medication, they would not seek a health care provider. Half of the obese population interviewed stated that they had lost weight on their own.

Interpretation of the Findings

The stories of the obese population from West Virginia, Northeastern Kentucky, and Southern Ohio who participated in this study extend the knowledge on disconnections in U.S. healthcare. Weight stigma has been linked to adverse health behaviors that impair health (Puhl et al., 2020). The stories that were shared by the participants in this study mirror these adverse health behaviors. However, another point that stands out in the research is the amount of personal strain the participants placed on

themselves when discussing their communication with their healthcare provider. All of the participants said that, at one time or another, they would blame themselves for the acts that they were explaining.

I viewed the identified themes under the contextual lens of the HBM. The HBM states that people will achieve optimal behavior change if they focus on perceived barriers, benefits, self–efficacy, and threat (Jones et al., 2016). All of the participants interviewed indicated that they believed they were not listened to in a healthcare setting. All but one participant gave detailed accounts of times when they were not listened to by healthcare professionals. When patients are not listened to, there is a failure to communicate. Communication failures between healthcare and patients contribute to adverse events (Killian & Coletti, 2017). Communication failures are a barrier to seeking healthcare.

Almost all of the participants said they were told multiple times to lose weight even if weight was not affecting their visit. Almost all of the participants were told that weight was also the cure and the cause of all their problems. Weight bias/stigma has been viewed as a motivation for people to help them lose weight. This is false for a couple of reasons. First, if weight stigma has been effective as a motivator to lose weight, then the number of obese individuals should be decreasing (Puhl et al., 2020). The number of obese individuals is on the rise (Puhl et al., 2020). Secondly, several studies have consistently shown the harmful effects of weight bias on individuals (Puhl et al., 2020).

Almost all of participants stated that they do not want to seek healthcare. Around half stated that they seek healthcare because they need their medication. Perceived weight

bias is associated with adverse health effects (Shank et al., 2019). Cortisol, lipid, and glucose levels become unregulated, and the person has poorer health outcomes (Shank et al., 2019). Also, weight stigma/bias can lead the obese individual to WBI. WBI is associated with both anxiety disorders and depressive disorders. WBI can lead obese individuals to develop maladaptive eating behaviors, body shame, perceived stress, substance abuse, decreased quality of life, avoidance of physical activity, and avoidance of healthcare (Alberga et al., 2018).

Half of the participants interviewed stated they have lost weight on their own because they knew it was necessary. None of these participants stated they had any help from the healthcare community. Almost all of the participants interviewed stated they hate seeking healthcare. Bias related to obese individuals will directly affect the overall health outcomes and willingness to seek medical attention (Brown, 2006; Chambliss et al., 1994; Crandall, 1994; Garcia & Amankwah, 2016). Research shows that implicit bias may be present in individuals without their being cognitively aware of the bias (Elran-Barak & Bar-Anan, 2018; Pearl et al., 2019). Weight bias directed at an individual directly correlates with the individual having negative feelings about themselves and devaluing themselves (Puhl et al., 2014). Finally, the obese population is more at risk for health comorbidities and needs to have a trusting relationship with healthcare providers (Blair et al., 2011; Brown, 2006; Crandall, 1994; Foster et al., 2003; Garcia & Amankwah, 2016; Gujaral et al., 2011; Halvorson et al., 2019).

Limitations

A limitation to the study is the possible self bias of the researcher. . Reflexivity states that “a researcher’s background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions” (Malterud, 2001, pp. 483-484). I am part of the obese population with a BMI greater than 30. I have family and friends who are also part of the obese community and have experienced bias. Finally, I have been subject to weight bias in the past. These experiences could result in bias. To increase confirmability, I developed transparency, consistency, coherence, and communicability. "Transparency means that the reader of the qualitative research study is able to see the basic processes of the data collection" (Rubin & Rubin, 1995, pp. 85-86). In Chapter 4’s Data Analysis section, I outlined the process in detail for collecting, transcribing, and coding the received information.

Consistency and coherence are the next step in ensuring the credibility of the research. Consistency ensures that themes in one interview were consistent with themes in the other interviews (Rubin & Rubin, 1995). I ensured that all the themes had matching consistencies, as outlined in the Data Analysis section, by reading and transcribing the interviews and then utilizing a color-coding system and a spreadsheet to classify information according to themes. Coherence of themes is the process of explaining why contradictions to themes happened (Rubin & Rubin, 1995). I discussed the discrepant case in the Results section of Chapter 4 with explanations on why the discrepant case was a possibility. I also demonstrated consistency across cases. I interviewed participants

from different states that fall in the same geographical area. Saturation was attained during the interview sessions. Saturation is defined as the point at which new information is not gained (Rubin & Rubin, 1995). Consistency was achieved by interviewing participants from different areas giving similar answers. Consistency across the cases is defined by core concepts and themes that are consistently demonstrated across different cases and settings (Rubin & Rubin, 1995).

Finally, I demonstrated communicability. The term *communicability* refers to accurately conveying participants' information while allowing fellow researchers to understand and accept one's descriptions (Rubin & Rubin, 1995). "In order to increase how well the research communicates is to make sure that those being interviewed talk about their firsthand experiences, rather than acting as informants on the experiences of others" (Rubin & Rubin, 1995, p. 91). I accomplished this by using personal stories and situations that were dear to the participants, I used exact words and terms to preserve the authenticity of the conversations. The authenticity of the interviews reflects the firsthand experiences and therefore demonstrates communicability.

Another limitation to the study is the vernacular of the participants. Understanding culture is a key to the study, and the Appalachian culture is similar to other cultures in that the culture has individualized wording. I believe that answers given were very Appalachian; for instance, in Appalachia, the term *healthcare* is denoted as the doctor. So, when someone from Appalachia says "I went to the doctor," they could mean they went to the emergency room, urgent care clinic, or physician appointment. My goal was for the participants to describe in their own words how they felt. Using participant

terminology added to the authenticity and individualization of participants and did not take away from the overall perceptions as the study was to understand the culture seeking healthcare.

Recommendations

There are a couple of recommendations to further research following the study. One key aspect of the study was that participants could give real-life examples to demonstrate firsthand their feelings regarding how they had been treated or why they did not want to go back to their healthcare provider. There is an opportunity for researchers to replicate this study in different areas worldwide. The replication of the research would allow different groups to be participants in future research studies. Groups could include urban, midwester, or deep southern to allow understanding if the feelings of the people of West Virginia, Southern Ohio, and Northeastern Kentucky are isolated.

Another recommendation for other researchers is to formulate a theory based on the information given. A theory would explain the obese population's perceptions and could be utilized in different scenarios. The theory could support a model that researchers could use to develop a scale similar to those utilized with drugs/alcohol to limit or eradicate bias. This scale could be implemented throughout the healthcare system to equalize the treatment of obese individuals. Another recommendation could be to perform additional research looking at provider bias towards patients with high BMIs. The study could be completed under the lens of either implicit or explicit bias. The study would allow an idea of what level of bias is present from the healthcare providers' experiences.

Implications

This research has several implications for social change; however, the main focus of the study remained consistent. The main focus of the study was to allow a small sample of the obese population to tell their experiences to inform healthcare providers about their experiences. I conducted to allow the obese population to give personal experience and insight on different aspects of seeking healthcare. Allowing the obese population of West Virginia, Southern Ohio, and Northeastern Kentucky to tell their perspective gives insight into a culture within a culture. Taking the time to listen to what happened and why it is important helps equalize the health care experience. Listening to the firsthand experiences allows the reader to understand the reasons that the obese population are not seeking healthcare. The HBM model states that if the perceived or actual barriers outweigh the perceived benefits, then an individual will not seek medical consultation (Champion & Skinner, 2008). None of the individuals interviewed stated they want to go to the doctor. Some went based on medication needs, but none wanted to go. This study has contributed insight to help inform healthcare providers about the lived experiences of the obese population. By learning about the experiences, the health care providers can be better equipped to alter and mold their practices to help decrease or prevent potential biases.

Conclusion

Much information has been gained from the study. A population that sees themselves not listened too, or creators of their demise. The obese population states that they understand there is a potential of death, but state they would choose death over

taking advice from someone whom tells them consistently to simply lose weight. Professionals tell the obese population that weight is the problem causing all issues in their lives, and weight is the cure to make everything better in their lives. The obese population has trusted a system that has vowed to do no harm. The obese population seeks understanding from healthcare, seeks acceptance from healthcare, and seeks compassion from healthcare; however, the do no harm mentality has left them void and dejected. Americans live in a society that rebukes bias with alcohol, drugs, mental health, race, and sex. However, for a population that is desperately seeking help, according to RR, "For years and years I only went to the doctor if I absolutely had to because I always felt looked down on by doctors." As a society, we have to bridge the gap and not accept weight bias as the last acceptable form of bias.

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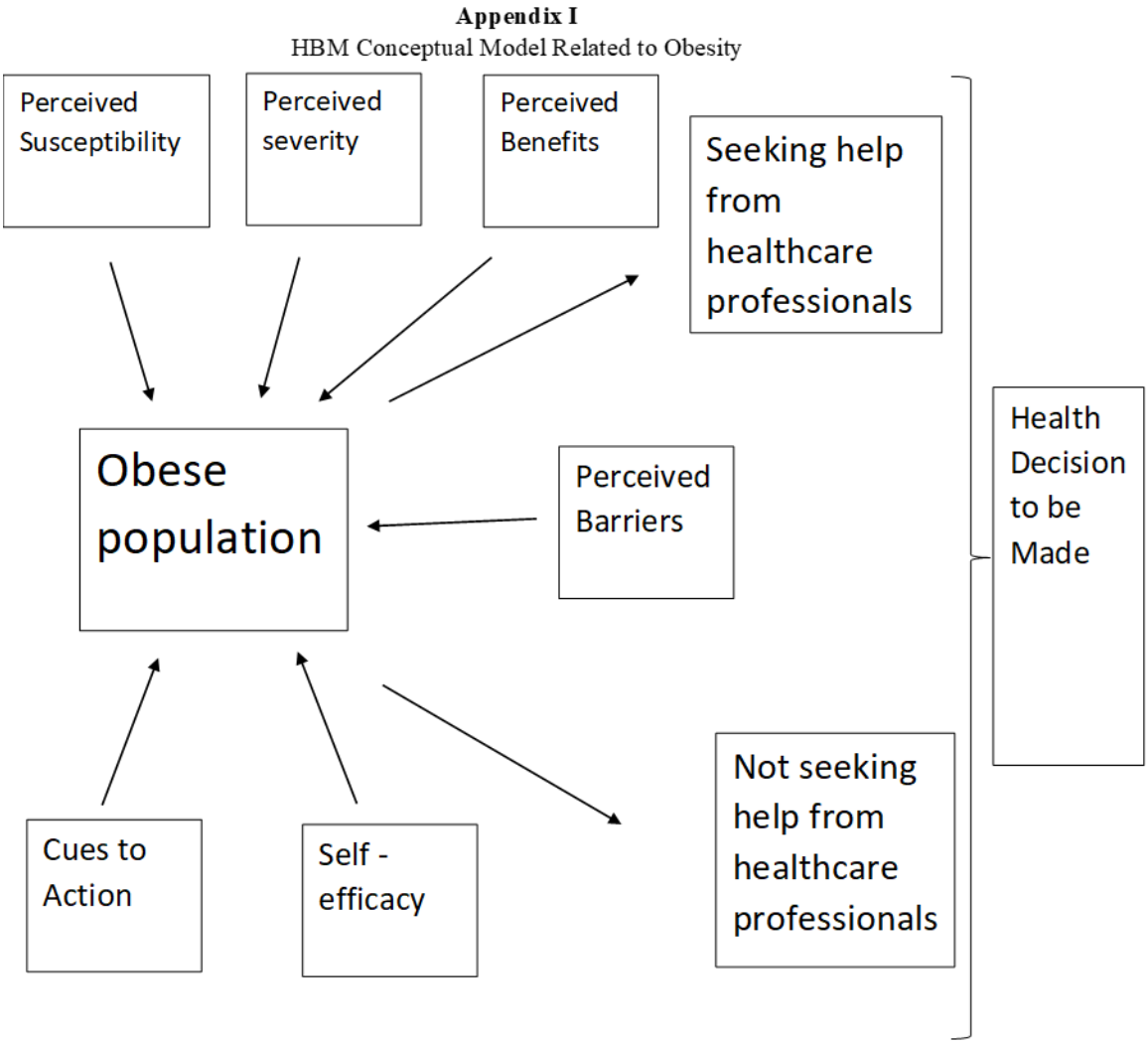
Appendix A: Health Belief Model (HBM) Applied to This Study



Appendix B: Flyer

Do you feel like you have not been treated fairly based on your size by the healthcare community?

Are you willing to share your personal experiences regarding your healthcare experience?

If you:

Are over 18 years of age AND

Have a body mass index greater than 30 (obese) AND

Have a story of not being treated fairly by the healthcare community AND

Live in West Virginia, Southern Ohio, or Northeastern Kentucky

Then you are invited to participate in an exciting study about the perceptions of the obese population regarding weight stigma/bias in the healthcare system!

I am a doctoral student at Walden University, and I am conducting this study as part of my dissertation and would appreciate your participation.

You will be asked to send an email stating you want to be in the study. Upon receiving the email, the researcher will send an invitation letter and consent form. If chosen you will participate in a zoom interview that will last about an hour.

Interview participants will be receiving a $10 Amazon gift card. Not all study participants will be invited to interview.

If you want to be in the study send an email stating “I want to be in the study” to:

[email address redacted]

Appendix C: Interview Questions

1. Describe your healthcare experience?
2. Describe specific examples related to the answer you gave about your healthcare experience?
3. Describe if any, limitations you have experienced regarding healthcare?
4. Describe if any a time when you felt weight bias/stigma was present during a healthcare visit
5. Tell me if any lasting affects you feel are related to the weight bias/stigma you have
    a. experienced?
6. Is there anything you would like to add?

Appendix D: Phases of Thematic Analysis

Phase	Description of the process
Familiarizing yourself with your data	Transcribing data, reading and rereading the data, noting down initial ideas
Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
Reviewing themes	Checking in themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic map of the analysis
Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story of the analysis tells; generating clear definitions and names for each theme
Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis