Physical Therapists' Ways of Talking About Overweight and Obesity: Clinical Implications

Jenny Setchell, Bernadette M. Watson, Micheal Gard and Liz Jones

PHYS THER. Published online December 4, 2015
doi: 10.2522/ptj.20150286

Running head: Physical Therapists Talk About Overweight and Obesity

Research Report

Physical Therapists' Ways of Talking About Overweight and Obesity: Clinical Implications

Jenny Setchell, Bernadette M. Watson, Micheal Gard, Liz Jones

J. Setchell, BSc(Pty), GradCert(ClinPty), School of Psychology, Faculty of Health and Behavioural Sciences, The University of Queensland, St Lucia, Brisbane, Queensland 4103, Australia. Address all correspondence to Ms Setchell at: jennysetchell@gmail.com.

B.M. Watson, PhD, School of Psychology, Faculty of Health and Behavioural Sciences, The University of Queensland.

M. Gard, PhD, School of Human Movement and Nutrition Sciences, Faculty of Health and Behavioural Sciences, the University of Queensland.

L. Jones, PhD, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia.

[Setchell J, Watson BM, Gard M, Jones L. Physical therapists' ways of talking about overweight and obesity: clinical implications. *Phys Ther*. 2016;96:xxx–xxx.]

Published Ahead of Print: xxxx

Accepted: November 22, 2015

Submitted: May 10, 2015

Abstract

Background: How people think and talk about weight is important because it can influence their behavior towards people who are overweight. One study has shown that physical therapists have negative attitudes towards people who are overweight. However, how this translates into clinical practice is not well understood. Investigating physical therapists' ways of thinking and speaking about overweight and obesity in the context of their work can provide insight into this under-researched area.

Objectives: To investigate physical therapists' ways of talking about overweight individuals, and discuss clinical implications.

Design: The study employed an interpretive qualitative design.

Methods: The research team used discourse analysis, a type of inductive qualitative methodology, to guide data collection and analysis. The data came from six focus groups of 4-6 physical therapists in Queensland, Australia who discussed weight in a physical therapy environment. Participants (n=27) represented a variety of physical therapy sub-disciplines.

Results: Data analysis identified four main weight discourses (ways of thinking/speaking about weight). Participants described patients who are overweight as 1) little affected by stigma, and 2) difficult to treat. Further, participants portrayed weight as 3) having simple causes, and 4) important in physical therapy. Alternate weight discourses were less frequent in these data.

Conclusions: Results indicated some physical therapists' understandings of weight might lead to negative interactions with patients who are overweight. Findings suggest physical therapists require more nuanced understandings of: how patients who are overweight might feel in a physical therapy setting; the complexity of causes

of weight; and possible benefits and disadvantages of introducing weight management discussions with patients. Therefore, education should encourage complex understandings of working with patients of all sizes including knowledge of weight stigma.

Introduction

Physical therapists have demonstrated negative attitudes towards people with high body weights (weight stigma),[1] and patients have perceived elements of physical therapy interactions as weight stigmatizing[2]. Despite this, there has been little investigation of how and why this occurs, nor how to reduce this weight stigma. One way to investigate further physical therapy interactions that involve weight is to look at *discourses* about weight. A discourse is a distinct way of thinking or talking about a topic.[3] People's weight discourses are important because they can influence their behaviour towards people who are seen as overweight.[4] While physical therapy weight discourses (i.e., ways of thinking or talking about weight) have not yet been investigated, some common weight discourses in other health contexts may be relevant to physical therapy. One weight discourse in healthcare emphasizes individually controllable lifestyle causes such as diet and exercise. This commonly held perspective is pervasive despite evidence to the contrary.[5] For example, many studies, including large Cochrane and government reviews, report that changing lifestyle factors such as exercise[6,7] and diet[7] have minimal, or no effect on weight. Further, researchers have considered the importance of other contributors to the trajectory of weight, including for example: medications, epigenetics, rising maternal age, micro-organisms, medications, assortative mating, sleep debt and endocrine disorders.[8] Focussing on diet and exercise as the primary ways to reduce weight may have negative implications, such as setting a patient up for weight loss failure and reproducing stigma. Other authors have discussed that believing that people are individually responsible for their excess weight can be a cause of,[9] and also an excuse for,[10] negative attitudes towards people who are overweight.

Academic and clinical biomedical discourses also commonly involve talking about overweight and obesity as contributing to, or causing, many health problems, including those that present to physical therapy. While, undoubtedly, excess body weight can contribute to some conditions, health related literature often exaggerates predictions of increased morbidity and mortality, and some unexpected findings suggest we need to consider this 'common knowledge' carefully[11]. For example, a systematic review including 2.88 million participants found people in the 'overweight' BMI category have a *lower* mortality rate than those in the 'normal' category, and people in the 'moderately obese' category have *the same* mortality rate as those in the 'normal' category.[12] Another extensive systematic review of 65 high quality epidemiological studies showed *no causal relationship* between weight and back pain, and only a *possible weak association.*[13] Similarly, a meta-analysis of the effect of weight loss on osteoarthritic knee pain demonstrated minimal effect of weight loss on pain scores.[14]

If some of healthcare professionals' main discourses are that weight is individually controllable and an extensive health problem, they are likely to employ certain clinical practices. For example, healthcare professionals may try to change individual patient behaviors rather than consider systemic issues,[15] and may give undue attention and resources to addressing bodyweight[16].

Putting too much emphasis on weight as a health problem, and as individually controllable, may, in part, be due to weight stigma.[17] Weight stigma can be defined as negative attitudes towards people who are perceived to be overweight. These attitudes can result in people stereotyping those who are overweight as, for example, lazy,

inactive, or unhealthy. Like other western cultures, this is true of general Australian attitudes[18]. This study particularly investigates institutional stigma[19] (stigma that is produced and perpetuated within an organised body of people – in this case physical therapy). While the focus of the study is not to determine where this stigma comes from, certainly weight stigma can come from the attitudes of the health professionals, or the perceptions of patients or a combination of both[19]. If people perceive themselves to be the target of weight stigma there are often adverse physical and psychological outcomes.[20] Patients who feel stigmatized for their weight by their physicians exercise less[21], avoid health care appointments[22] and have more disordered eating[23]. For these reasons it is important that weight stigma is reduced. It is evident from two systematic reviews[24,25] that weight stigma interventions have had minimal success to date, and tend to focus on one contributing cause of weight stigma at a time. The minimal success suggests that the causes of weight stigma may be more complex than one element. In addition, other authors have suggested that to be successful such interventions in healthcare settings would need to consider the diversity and uniqueness of healthcare cultures.[26,27] This indicates that an in-depth investigation of the relevant healthcare culture (in this case physical therapy) would be important to reduce weight stigma.

As mentioned, researchers have not yet directly considered physical therapists' weight discourses. Findings from a survey of physical therapists' attitudes towards people who are overweight indicate physical therapists, in keeping with biomedical discourses, are likely to have simplistic understandings of weight, and may give undue clinical attention to weight.[1] Further, a study on patient perspectives showed patients expect physical therapists to judge them based on their body size.[2] Whether

physical therapists are helping or harming patients with interactions involving weight has received little research attention. This is important from an ethical standpoint, given that physical therapy codes of conduct include 'do no harm'.[28] Attention to patients' weight by physical therapists is likely intended to improve outcomes by, for example, reducing the load on joints, discussing management of type II diabetes mellitus, or improving chronic pain. However, as noted, weight is a sensitive topic, and those who experience weight stigma have poorer health outcomes than those who do not[29]. Therefore, interventions intended to improve patient health may result in harm if patients perceive them as stigmatizing. In order to consider whether physical therapy interactions involving weight are likely to have positive or negative clinical outcomes we posed the following research question: How do physical therapists speak about overweight and obesity in the context of their work?

Methods

Theoretical approach

Discourse analysis, the methodology employed in this study, provides a way of understanding how distinct patterns of thinking or talking about a topic (discourses) can be used by speakers to construct certain social or psychological practices[30,31]. Discourse analysis is a type of interpretive qualitative methodology,[30] that was a branch of the linguistic turn in social science where an analysis of language is seen as central to the way that people think and behave[31]. Discourse analysis has a constructionist epistemology[32] that posits the language we use constitutes, rather than simply reflects, our reality[33]. As such, discourse analysis does not attempt to find out what 'really happened', nor reconstruct people's experiences. Instead, it looks at how these ways of talking make certain practices more likely.[34] More specifically, in this

context, data were collected from focus groups and analyzed[3,35] to identify how participating physical therapists' language creates or re-enforce**s** certain ways of understanding body weight in their role as health professionals. Stigma can be produced in interactions through reproduction of certain discourses.[36] By analyzing the way physical therapists talk about larger patients, this project builds on previous research that has shown weight stigma amongst physical therapists[1], and that some patients perceive weight stigma in a physical therapy context[2], developing a picture of how physical therapists "construct" particular kinds of patients. While, of course, this project will not be able to demonstrate how physical therapists act, it will provide insight into weight stigma in physical therapy and has potential to inform ways to reduce it. Discourse analysis has been utilized elsewhere in health research[(e.g.,37-39)], however, this method has rarely been used in physical therapy[(e.g.,40)]. Thus, in keeping with calls for different methodological approaches in physical therapy research[41,42], discourse analysis offers a relatively novel approach to understanding physiotherapy.

Pilot

A pilot study was conducted with a group of six physical therapists who were experienced clinicians from a variety of sub-disciplines. Following **a** review of the audio recording of the group discussion, minor changes were made to the focus group guide (Appendix 1) and demographic questions.

Participants

In line with most developed countries, physical therapy in Australia is an integral part of the health system.[43] Australian physical therapists commonly work in both private and public settings and have considerable autonomy in assessing, diagnosing and

treating relevant conditions.[43] All participants were qualified physical therapists currently residing in Australia who were available to attend a focus group in, or close to, the city of Brisbane. Participants were recruited via email and word of mouth invitations using professional networks, as well as by contacting interested participants from a previous study. Purposive sampling was used to ensure a diverse range of physical therapists (Table 1), including recruitment from a broad range of sub-disciplines, types of health service, work locations, and levels of experience.

Procedure

Physical therapists participated in focus groups in October and November 2014 in physical therapy workplaces. Focus groups grounded in discourse analysis, are not designed to reach consensus, but rather to explore a range of ways of talking about a topic and facilitate understanding of 'typical vocabulary and thinking patterns' of the sample.[44] Physical therapy environments were chosen for the group discussions to evoke participant memory of clinical experiences.[45] The locations were: an urban musculoskeletal private practice (two groups), a hospital rehabilitation facility, an acute hospital setting, a rural musculoskeletal practice, and a physical therapy 'laboratory' in a university. The research team contacted potential participants by an introductory email outlining the topic and study design. The first author followed up interested participants by phone or email contact to determine convenient focus group locations and times. Recruitment ended when data reached saturation (i.e. when no new topics emerged).[46] Saturation was determined during recruitment because the data collection and recruitment processes occurred concurrently, and analysis was conducted iteratively during this time.

There were between four and six participants in each of the six semi-structured focus group session, and each ran for approximately one hour. Participants read an information sheet that included detailed explanation of the study and its potential risks, signed a consent form, and provided demographic information (Table 1) before commencing the study. The first author, who is trained in conducting focus groups, facilitated all groups and kept a reflexive diary during data collection. For more detail on the procedure during the focus groups see the focus group guide (Appendix A) and the *Materials* section below. All group discussions were audio recorded and transcribed verbatim. Participants' confidentiality was protected by assigning pseudonyms in transcriptions and data were handled within institutional data management guidelines. After the study, participants read debriefing information about what to do if they experienced distress as a result of participating in the study. The institutional ethics body granted ethical approval for the study. The research team took numerous steps to avoid influencing the results with the facilitator's views, including: use of open, broad introductory statements in participant communication such as 'weight in a physical therapy context'; minimising the facilitator's input into the focus groups; and reviewing recordings to exclude from analysis answers to any inadvertently leading questions. To encourage reflexivity the facilitator used a study diary and had critical discussions with the investigatory team and external experts. Further discussion of the possible influence of the facilitator on the results is presented in the discussion. *A priori* procedures for rigour and quality in qualitative research were instituted and followed as outlined in COREQ[46].

Insert Table 1 about here.

Materials

The research team developed the question guide (Appendix A) from findings of previous studies of physical therapists and weight interactions[1,2], as well as other existing literature on overweight and obesity. Specifically, questions encouraged participants to discuss weight in the context of their work as physical therapists. Topics included: weight discussions with patients, perceived role of physical therapists in weight management, what it is like to treat patients who are overweight, causes of overweight or obesity, and how patients who are overweight might feel in a physical therapy environment. There was also opportunity for open discussion at the end of the session.

Data Analysis

Transcripts generated from focus groups were analyzed using discourse analysis.[31] Specifically, the investigators analysed how physical therapists' language choices (discourses) create, re-enforce or legitimize certain ways of understanding weight. Analysis involved an iterative process of data examination and organisation in response to the research question. Following each focus group the facilitator (J.S.) noted down initial thoughts and reactions. J.S. then listened to the audio recordings and made open coding notes of discourses from these data. The same investigator (J.S.) then read verbatim transcripts to further refine these discourses. Another investigator (B.W.) then read the transcripts, and discourses were discussed until agreement was reached between the investigators. These first stages all took place iteratively during the data collection process. When data collection was complete, J.S. re-read the entire transcribed dataset several times crosschecking discourses across these data. J.S. manually coded these discourses into data management software under

headings identified during analysis. These headings represented different discourses relating to the research questions and included both dominant and less common discourses. To enhance trustworthiness[30] of the results, the other investigators (B.W., M.G. and L.J.) reviewed the transcripts and the analysis. While J.S. is a physical therapist, these other investigators, from the disciplines of psychology (B.W., L.J), and human movement and nutrition sciences (M.G.), provided an external perspective. All investigators are experienced in qualitative research including discourse analysis. Discrepancies and new ideas were discussed until agreement was reached and integrated into the results. B.W., M.G. and L.J. confirmed the final analysis was a credible, reasonable interpretation and grounded in the data. Further efforts to ensure rigor and trustworthiness included providing a summary of findings to participants for feedback, peer review of the data analysis process, reporting of contradictory discourses, and review of results by two experts external to the research team.

Results

The data analysis identified four main discourses. These discourses are discussed below, supported by quotations from the transcripts (with pseudonyms used). Table 2 presents a summary of the analysis, and includes a brief explanation of each discourse. The study design did not lend itself to statistical analysis of whether any of the participants' demographic, professional or physical characteristics influenced their responses. However, discourses found in these data were relatively consistent across participants.

Insert Table 2 about here.

1: Patients who are overweight are little affected by stigma

Participants often spoke about weight as a neutral attribute (i.e., not stigmatized) without the moral, social, and psychological implications of a stigmatized condition. This can be contrasted with findings from interviews with patients who more consistently portrayed their body weight as a stigmatized attribute in a physical therapy context[2]. Participants' framing of weight as a psychologically neutral topic was particularly evident in responses to a question regarding patient experiences of attending physical therapy. The following example demonstrates how participants in one group had never considered people who are overweight might feel uncomfortable entering a physical therapy environment:

INT: "How do you think an overweight person might feel coming into a physiotherapy environment?"

((long pause))

INT: "If anything?"

((long pause))

ROGER: "I suppose that I, um, I don't know. I can't relate to it ……"

NICOLLA: "I don't know."

((GENERAL LAUGHTER))

ROGER: "Good summary."

NICOLLA: "I haven't thought about how they would feel coming to see me. Ever."

JACQUI: "I don't know that it would be a thing to single out to say obese people would feel different than non-obese people…."

Other participants demonstrated an understanding that patients who are overweight might feel *some* discomfort in a physical therapy setting. These discourses portrayed weight as not psychologically neutral. For example, Renae identified the anxiety and fear of judgements patients have described in another study[3] coming into a physical therapy environment. Renae said: *"[patients who are overweight] might be a bit anxious about what we're going to make them do. Possibly that thought that they may be judged a bit about their size"*. Similarly, Lin identified potential discomfort in the open environments typical in many physical therapy settings. Lin considered that this discomfort could be significant enough to discourage patients from attending treatment.

"if it's an open environment like this [a gym-like setting in a musculoskeletal clinic], and they have to exercise, say Pilates and things, where they have to be moving around and everyone's walking in and out and can see them, they may feel self-conscious about that perhaps. So you know, whether people don't come because of that…"

The following two examples outline participant recollections of circumstances where they did not express sensitivity about weight when interacting with overweight patients. This included assuming their patients did not already know they were overweight. Both participants recalled negative reactions from these patients as a result:

ANTHONY: *"I became less and less subtle on the hint that she was excessively overweight. We're talking close on 180 kilos… in the end I basically said… 'you're*

fat, and you need to do something about it or you're not going to get rid of this problem'. She stormed out, refused to pay her bill…."

JACOB: "*I only remember one who basically didn't like what I said and didn't want anything to do with me after that, which was fine but she was obviously in denial that she was overweight. And she was quite grossly overweight too so..."*

Overall, participating physical therapists' accounts appeared to lack the nuance and depth of patient descriptions Setchell et al[2] found in interviews with patients of physical therapists. While no formal comparative study has been conducted, Setchell et al's[2] thematic analysis of their interviews showed that patients consistently discussed discomfort and perceptions of judgment about their weight as a result of physical therapists' communication styles, physical characteristics of clinics, and in physical therapy advertising and promotional material.

2: Patients who are overweight are difficult to treat

Almost all participants spoke about working with people who are larger bodied as difficult. For example, participants used negative words including: *'dangerous'*, *'risky'*, *'hard'*, *'challenging'*, and *'difficult'*. Three areas of perceived difficulty were most often discussed: palpation, manual handling, and sourcing of equipment. Julie said: *"I've found it really difficult... having my hands on people that are larger has definitely been challenging for me. I find it a lot harder to feel, and I do a lot of manual therapy too so I do move limbs a lot you know, and it's a lot harder"*. While Julie was a relatively inexperienced physical therapist, participants, regardless of their experience level frequently discussed manual handling and palpation as challenging

with these patients. The groups also portrayed sourcing appropriate equipment as difficult. For example, Sahara, who worked in an acute hospital setting said: *"it's just more strain on resources and more time consuming, particularly if they're lower functioning, because you have to use all these other sort of equipment, like hoists"*

By contrast, a minority of participants described working with larger people as nothing out of the ordinary and something that could be managed with little difficulty within physical therapists' usual skillset. Hillary was one of the few participants who discussed treating overweight patients in this way. *"I just view it as another co-morbidity really. It's just another piece that potentially adds some complexity to it but it's not a major barrier. You just get on and do like you would with anyone."* These contrasting ways of talking about patients who are overweight invite consideration of the reasons for this variation**,** including whether portrayal of patients who are overweight as 'difficult' is due to actual technical difficulty or due to weight stigma (or a combination of both). This is explored in the final section of this paper.

3: Weight has simple causes (diet and exercise)

While participants frequently portrayed weight as primarily a consequence of lifestyle factors (i.e., diet and exercise), they also discussed other determinants of weight such as medications, hormones, and genetics. However, they gave these other factors comparatively little attention. The following conversation is a good example of the amount of attention given to lifestyle factors. In this discussion, Evelyn briefly mentioned that weight is complex but then focused on diet and exercise and, as was typical of most groups, others started to join in along this same line.

"EVELYN: I think for just an average outpatient physio (a) you haven't really got the time for it and (b) it starts to get complex but keep it basic. If they are hugely obese, a little bit more movement, a little bit less food, they'll lose weight.

JACOB: That is exactly what I usually start with. Halve your portions and just continue exactly what you're doing - - -

EVELYN: And go for a walk, yeah.

JACOB: - - - but halve your portions and if you can halve your portions for two weeks, if you don't notice a difference, I'll be surprised."

Another group followed a similar pattern. Roger had given a fairly nuanced discussion about the *"very, very multifactorial"* causes of weight including *"a genetic component"*, and "*emotional"* aspects. He summed this up by saying: *"why a given person is overweight is completely individualistic really."* When the facilitator then asked *"Does anyone else have anything to say about that?"* others in the group, and Roger too, focussed in on lifestyle factors, even though these were only one of the factors originally discussed by Roger.

"JACQUI: I think Roger said it when he said lifestyle.

UNIDENTIFIED FEMALE: Mm. (agreeing)

JACQUI: That sort of encompasses a lot of - all the different aspects of that single person and why people - yeah, why obesity is part of their life.

INT: What do other people think about that?

SIOBHAN: Yeah, I'd agree.

ROGER: Yeah."

Only one group gave more attention to contributors other than diet and exercise. Kaleb began by discussing a lifestyle factor (diet) as a big influence on weight. He then moved on to mention *"the medical side of it"* including medications, yet he ended his perspective back on lifestyle by saying: *"the way I see it, it comes back to basics of diet and exercise"*. However, the other participants steered the conversation back to discuss non-lifestyle contributors. Liam mentioned *"personality"* and *"physiology"*, Macy discussed *"social and emotional factors"*, and Renae discussed mental health. This group recognized and gave attention to the complexities of obesity.

4: Weight is important in physical therapy

Participants portrayed weight as an important factor in physical therapy in three ways: as a contributor to patients' pain or illness, as something that requires addressing, and as something physical therapists *should* address. For example, Jethro described weight as a significant contributor to back pain when he told the group what he commonly says to some patients: *"you do need to lose a few kilos, otherwise if you're as heavy as you are your back's gonna stay bad, and I can only help you so much and there's got to come a point where there's got to be less loading on your spine"*. Later in the same group another participant, Jacob, was even more explicit: *"I'm actually pretty blunt in saying that if you don't [lose weight], you're not going to get the operation. You're going be in pain for the rest of your life and you'll develop a hell of a lot of other problems so…"*. Groups used this focus on the importance of weight as a contributing factor to pain/illness to indicate that excess weight is something that requires addressing. This was particularly evident in participants' choice of certain words in the quotes above. For example, Jethro used the word *"need"*, and both

Jethro and Jason used the threat of negative consequences if their patients don't lose weight: *"your back's gonna stay bad"*, and "*You're going to be in pain for the rest of your life…"*.

Most participants spoke about weight as something that *should* be addressed. For example, Jacqui said: *"I think somebody [i.e. physical therapists] has to take the responsibility of having that discussion with the patient."* In the same focus group Siobhan concurred with this, saying: *"where it is an important factor to what's going on with them, say an arthritic knee, we definitely have a role. Um we need to mention it…"*.

Focus group discussions also contained some counterpoint discourses to the portrayal of weight as important, although these were relatively uncommon. For example, some participants said that weight discussions were not always appropriate. Leon said:

"We have to be careful as to not project that, I feel, onto patients while they're here doing rehabilitation… it's not the primary reason they're here. The primary reason is their rehabilitation, so if we start projecting weight loss guidelines, information, education, then that can provide then a negative environment for the patient."

Neive outlined another circumstance where she learned that emphasizing weight loss was not appropriate, and changed her practice as a result:

"I had a lady who was quite significantly overweight and she was in - I can't remember exactly what but it was a surgical problem … I was actually quite surprised when the dietician was … saying: 'well, actually while you're in this stage of recovery, you don't actually want to lose weight. It's about your nutrition not necessarily… about weight loss as such'".

Evelyn portrayed weight discussions as not important for a different reason. She talked about how bringing up weight might be stating the obvious: *"most people are pretty realistic about what they actually look like"*. In another group, Jacqui described how some patients have explained this explicitly: *"you have patients that come in and say, 'My doctor told me this and this person's telling me this, and this person is, and I'm tired of hearing it'"*. Jacqui concluded that in these circumstances she would not discuss weight with the patient.

To summarize this fourth discourse, it was more common for participating physical therapists to foreground weight as their responsibility to discuss. What was less commonly talked about was that this might not always be appropriate. The tension between these two perspectives sometimes played out in discussions between different physical therapists in the groups and sometimes the same physical therapist contradicted their own previous statements. Thus highlighting some of the tensions and uncertainties about the role of the physical therapist in the area of weight management.

Discussion

This study used a discourse analysis approach to understanding elements of weight related interactions in physical therapy practice. Results indicate that certain ways of talking about weight are common in physical therapy. These discourses make some ways of working as physical therapists more likely and, therefore, have implications for patient outcomes. Clinical implications are discussed below. First, however, the scope of application of the results is considered.

There are a number of considerations when interpreting and applying the findings discussed in this paper. As mentioned in the Method section, the first author took a number of steps to withhold her views from the focus groups. However, she is an experienced physical therapist, female, and thin, which may have had effects on the results. Having a group facilitator who is a physical therapist 'insider'[47], and is also thin, may mean participants would have been somewhat open about their experiences with patients, including possible negative attitudes towards those who are overweight. On the other hand, some participants may have had knowledge of the facilitator's previous work on physical therapists and weight that may mean negative attitudes towards excess weight were not openly discussed. Efforts were made to reduce these effects by establishing an open environment where all views were respected. While this study was conducted in one area of Australia, and may not be entirely generalizable to different socio-cultural environments, it is likely to have applications to physical therapy globally, considering international similarities within the profession[43]. Furthermore, as in many other countries, negative attitudes towards weight are common in Australia[48], and Australian public discourses commonly refer to a rising prevelence of obesity, which is often labelled an 'epidemic'[11]. Attempts

were made to discuss topics broadly and to recruit a variety of physical therapists to increase breadth of relevance.

Clinical implications of findings are discussed below with each discourse considered separately:

Patients who are overweight are little affected by stigma

Many people who are seen as overweight are likely to have experienced persistent and ongoing stigma with considerable psychological outcomes[49]. A lack of consideration of the effects of weight stigma may mean physical therapists neglect psychological, moral, or social implications of interactions involving weight. As a result, physical therapists may not prioritize communication skills that are important in such psychologically sensitive situations. This has implications for the patient-therapist interaction and could lead to negative health outcomes for the patient.[50] Other research discusses a lack of a patient-centred approach in physical therapy[51]. The lack of awareness of stigma, however, can be understood as an additional element of this lack of patient centred approach, and contributes a novel aspect to an understanding of weight stigma in physical therapy. While weight stigma had been found to be an element in physical therapy in a study of patient perspectives,[2] it was unknown whether physical therapists were aware of this. Lack of awareness of weight stigma might appear surprising given that weight stigma is widespread,[52] and has been identified as a particular issue in health[53]. However, this may in part be due to it being a relatively newly recognised stigma that has not always been present in most cultures.[52] Education about minimizing weight stigma may present a way forward to improve patient outcomes and perceptions of physical therapy.

Patients who are overweight are difficult to treat

Most participating physical therapists portrayed patients who are overweight as difficult to treat. This is also a novel finding and has significance because seeing something as difficult may make it more challenging than it otherwise might be[54]. It may change physical therapists' attitudes towards the task or make them reluctant to undertake the task. This discourse of difficulty could result from a lack of appropriate manual skills and training, or there may be an attitudinal cause or a combination of both. If due to a lack of skills, the results of this study indicate this could be addressed by education to improve technical skills to manage larger bodies including palpation, manual handling, and purchase of equipment. However, if the underlying reason for this portrayal of treatment of larger patients as difficult is attitudinal (and this is consistent with the blame and moral judgment discussed elsewhere[11]) it could be the result of stigma. This can be seen in that the same language is unlikely to be applied as consistently to a pregnant woman, for example, who may also be 'difficult to treat' but is unlikely to be talked about in the same way. These attitudes could be addressed in education about weight stigma. It is of note that some participating physical therapists did not portray treating overweight patients as difficult. Their perspectives may help to highlight a way forward for physical therapists to develop more positive understandings of working with people who are larger bodied.

Weight has simple causes (diet and exercise)

Finding simplistic understandings of the determinants of weight, that emphasize mainly diet and exercise, is not new. This has also been demonstrated in a quantitative study of physical therapists' attitudes.[1] Focus on diet and exercise has a number of implications. First, other causes of weight[8] may not be investigated, which may have negative health implications. Second, patients may be set up for failure, because using diet and exercise to change weight has demonstrated minimal efficacy to date[7]. Third,

one of the elements of weight stigma is blaming people for their weight by automatically assigning weight causes to those that are individually controllable[55]. As a result, patients may perceive that they are the target of weight stigma if these causes are given emphasis. Overall, clinical implications of this discourse may include poorer health outcomes due to potential misdiagnosis, patient sense of failure, perceived weight stigma, and reduced rapport. Changing assumptions that diet and exercise are the main causes of weight can help to avoid these negative outcomes.

Weight is important in physical therapy

The results suggest that physical therapists talk about weight as important to address and they feel like they should be 'doing their bit' to 'combat obesity'. Clinically this may mean there may be an overemphasis on weight that could come at the expense of patient rapport, or may draw attention from other important presenting issues. As outlined in more detail in the introduction, while excessive weight undoubtedly contributes to some physical therapy conditions, evidence does not support its contribution in many instances[11-14]. As a result, physical therapists need to be careful about how they prioritize weight management as part of their strategies to address presenting problems. This could include a greater awareness of when physical therapists (individually or as a profession) perpetuate discourses that seek to 'normalize' patients' bodies[56], as distinguished from engaging with patients who wish to consider weight management as part of collaboratively established goals.

To summarize, the four weight discourses found in this study are likely to encourage some problematic clinical practices. These include: not being prepared to negotiate the psychological aspects of possible weight stigma, not feeling competent and confident working with patients who are overweight, primary emphasis on diet and

exercise to change weight, and over consideration of weight. The clinical repercussions of these ways of thinking about weight may negatively affect interactions with patients and as a result compromise health outcomes for patients. However, results were not without ambivalence and alternate discourses could provide other ways of thinking about weight with more positive clinical outcomes.

Other authors have investigated the socio-political factors that underpin the development of dominant ways of talking about weight that are reflected in these physical therapy discourses. In depth discussion of these is beyond the scope of this paper, which prioritizes practical implications. However, as these underlying factors may limit the ability to change practice, some are outlined here briefly. Gard and Wright[11], and Lupton[10] examine the moral imperative underlying dominant medical ways of thinking and talking about weight, similar to those found in this study. These authors show how overweight and obesity can be understood as 'failure' in a contemporary socio-political environment that upholds the importance of individual rather than institutional responsibility. The first discourse in this study, in which physical therapists talk about weight as 'neutral', can be seen as part of a larger medical discourse that positions the health professional as the 'objective observer'[17], free from moral judgment or other subjectivity. Physical therapists also generally adhere to a biomedical, mechanistic view of the body that suits simplistic understandings rather than subjective experiences of living in a body.[56] Findings of this study indicate that to suit the needs of patients who are overweight, a biomedical view is insufficient, and an understanding of the psycho-socio-political implications of bodies is required. Trede[57] suggests a way forward is to acknowledge and reflect on our subjectivity as physical therapists. Trede[57] also discusses the lack of a truly

collaborative approach in physical therapy that may explain why weight stigma and judgment about the causes of weight go unchecked. Thus, for enduring changes to our way of thinking about weight it may also be important to adjust our worldview and *modus operandi* as physical therapists.

The results of this study give an indication of a way forward to improve outcomes for patients in physical therapy interactions involving weight. Physical therapists could benefit from a more comprehensive understanding of how patients who are overweight might feel in a physical therapy setting, to inform their interactions with patients. Further, results suggest greater emphasis should be placed on the multifactorial nature of the determinants of weight beyond diet and exercise so other health factors are not overlooked, and patients do not feel judged. Considering it is likely most physical therapists will work with patients who are overweight or obese, it is important to find ways to reframe discourses portraying larger patients as 'difficult' that were particularly pervasive in discussions about palpation, manual handling, and sourcing equipment. Finally, it is important to consider when to prioritize inclusion of weight management in treatment of presenting problems or holistic practice to ensure weight stigma does not reduce positive outcomes for patients. To address these issues education should encompass complex understandings of weight and its associated stigma.

Acknowledgments

All authors provided concept/idea/research design and writing. Ms Setchell provided data collection, participants, facilities/equipment, and institutional liaisons. Ms Setchell, Dr Watson, and Dr Jones provided data analysis. Dr Watson, Dr Gard, and Dr Jones provided consultation (including review of manuscript before submission).

The authors thank the participants for contributing their valuable time and energy to this research. They also thank Professor Gwen Jull and Patrick Swete-Kelly for their valuable thoughts on the final draft of the manuscript and Performance Rehab, Greenslopes Hospital, The University of Queensland, and Coolum Physiotherapy for providing focus group locations.

This project is part of the requirements for a PhD program undertaken by the Ms Setchell that is supported by a fellowship from the Fellowship Fund Inc of Graduate Women Queensland.

DOI: 10.2522/ptj.20150286

References

1. Setchell J, Watson B, Jones L, Gard M, Briffa K. Physiotherapists demonstrate weight stigma: A cross-sectional survey of Australian physiotherapists. Journal of Physiotherapy. 2014; 60(3):157-162.
2. Setchell J, Watson B, Jones L, Gard M. Weight stigma in physiotherapy practice: Insights from patient perceptions of interactions with physiotherapists. Manual Therapy. 2015; In Press.
3. Braun V, Clarke V. Successful qualitative research. London, UK: Sage; 2013.
4. O'Brien KS, Latner JD, Ebneter D, Hunter JA. Obesity discrimination: The role of physical appearance, personal ideology, and anti-fat prejudice. Int J Obes. 2013; 37(3):455-460.
5. Bombak AE. The contribution of applied social sciences to obesity stigma-related public health approaches. Journal of Obesity. 2014:1-9.
6. Shaw K, Gennat H, O'Rourke P, Del Mar C. Exercise for overweight or obesity. Cochrane Database of Systematic Reviews. 2006; CD003817.
7. Australian Government. Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia: A systematic review. 2013
8. McAllister EJ, Dhurandhar NV, Keith SW, Aronne LJ, Barger J, Baskin M, et al. Ten putative contributors to the obesity epidemic. Crit Rev Food Sci Nutr. 2009; 49(10):868-913.
9. DeJong W. The stigma of obesity: The consequences of naive assumptions concerning the causes of physical deviance. Journal of Health and Social Behavior. 1980; 21(1):75-87.
10. Lupton D. Fat. New York, NY: Routledge; 2012.
11. Gard M, Wright J. The obesity epidemic: Science, morality and ideology. London, UK: Routledge; 2005.
12. Flegal KM, Kit BK, Orpana H, Graubard BI. Association of all-cause mortality with overweight and obesity using standard body mass index categories: A systematic review and meta-analysis. JAMA. 2013; 309(1):71-82.
13. Leboeuf-Yde C. Body weight and low back pain. Spine. 2000; 25(2):226-237.
14. Christensen R, Bartels EM, Astrup A, Bliddal H. Effect of weight reduction in obese patients diagnosed with knee osteoarthritis: A systematic review and meta-analysis. Ann Rheum Dis. 2007; 66(4):433-9.
15. Airhihenbuwa CO, Ford CL, Iwelunmor JI. Why culture matters in health interventions: Lessons from hiv/aids stigma and ncds. Health Educ Behav. 2014; 41(1):78-84.
16. Campos P, Saguy A, Ernsberger P, Oliver E, Gaesser G. The epidemiology of overweight and obesity: Public health crisis or moral panic? Int J Epidemiol. 2006; 35(1):55-60.
17. Murray S. Pathologizing 'fatness': Medical authority and popular culture. Sociology of Sport Journal. 2008; 25:7-21.
18. Puhl RM, Latner JD, O'Brien K, Luedicke J, Danielsdottir S, Forhan M. A multinational examination of weight bias: predictors of anti-fat attitudes across four countries. Int J Obes. 2015; 36:1166-1173.
19. Bos A, Pryor J, Reeder G, Stutterheim S. Stigma: Advances in theory and research. Basic and Applied Social Psychology. 2013;35(1):1-9.

20. Puhl RM, Heuer CA. Obesity stigma: Important considerations for public health. American Journal of Public Health. 2010; 100(6):1019-1028.
21. Vartanian LR, Novak SA. Internalized societal attitudes moderate the impact of weight stigma on avoidance of exercise. Obesity. 2011; 19(4):757-762.
22. Drury C, Louis M. Exploring the association between body weight, stigma of obesity, and health care avoidance. Journal of the American Academy of Nurse Practitioners. 2002; 14(12):554-561.
23. Ashmore JA, Friedman KE, Reichmann SK, Musante GJ. Weight-based stigmatization, psychological distress, & binge eating behavior among obese treatment-seeking adults. Eat Behav. 2008; 9(2):203-9.
24. Daníelsdóttir S, O'Brien K, Ciao A. Anti-fat prejudice reduction: A review of published studies. Obesity facts [Review]. 2010; 3(1):47-58.
25. Lee M, Ata RN, Brannick MT. Malleability of weight-biased attitudes and beliefs: A meta-analysis of weight bias reduction interventions. Body Image. 2014;11(3):251-9.
26. MacKean G, GermAnn K. Reducing weight bias and stigma in british columbia's health care system: Findings from a critical review of the literature and environment scan.; 2013.
27. Heijnders M, Van Der Meij S. The fight against stigma: An overview of stigma-reduction strategies and interventions. Psychology, Health & Medicine. 2006;11(3):353-63.
28. Guttman N, Salmon C. Guilt, fear, stigma and knowledge gaps: Ethical issues in public health communication interventions. Bioethics. 2004; 18(6):531-552.
29. Puhl RM, King KM. Weight discrimination and bullying. Best Pract Res Clin Endocrinol Metab. 2013; 27(2):117-27.
30. Bourgeault I, Dingwall R, de Vries R. The SAGE handbook of qualitative methods in health research. London, UK: SAGE; 2010.
31. Willig C. Discourse analysis. In: Smith J, editor. Qualitative psychology: A practical guide to research methods. Los Angeles, California: SAGE Publications; 2003. p. 160-165.
32. Parker I. Social constructionism, discourse and realism. London, UK: SAGE Publications Ltd; 1998.
33. Wigginton B, Lee C. "But i am not one to judge her actions": Thematic and discursive approaches to university students' response to women who smoke while pregnant. Qualitative Research in Psychology. 2014; 11(3):265-276.
34. Lupton D. Discourse analysis: A new methodology for understanding the ideologies of health and illness. Australian Journal of Public Health. 1992; 16(2):145-150.
35. Antaki C, Billig M, Edwards D, Potter J. Discourse analysis means doing analysis: A critique of six analytic shortcomings. DAOL Discourse Analysis Online (Online Version). 2003; 1(1).
36. Hannem S, Brauckert C. Stigma revisited. Ottowa: University of Ottowa Press; 2012.
37. Salter C, Holland R, Harvey I, Henwood K. "I haven't even phoned my doctor yet." The advice giving role of the pharmacist during consultations for medication review with patients aged 80 or more: Qualitative discourse analysis. BMJ. 2007; 334(7603):1101.
38. Setchell J, Leach L, Watson B, Hewett DG. Impact of identity on support for new roles in health care: A language inquiry of doctors' commentary. Journal of Language and Social Psychology. 2015; In Press.

39. Smith J. Critical discourse analysis for nursing research. Nurs Inq. 2007; 14(1):60-70.
40. Laitinen-Vaananen S, Luukka M, Talvitie U. Physiotherapy under discussion: A discourse analytic study of physiotherapy students' clinical education. Advances in Physiotherapy. 2008;10:2-8.
41. McPherson K, Kayes N. Qualitative research: Its practical contribution to physiotherapy. Physical Therapy Reviews. 2012; 17(6):382-389.
42. Greenfield BH, Jensen GM, Delany CM, Mostrom E, Knab M, Jampel A. Power and promise of narrative for advancing physical therapist education and practice. Phys Ther. 2014.
43. Higgs J, Refshauge K, Ellis E. Portrait of the physiotherapy profession. Journal of Interprofessional Care. 2001; 15(1):79-89.
44. Plummer-D'Amato P. Focus group methodology pt 1: Considerations for design. International Journal of Therapy and Rehabilitation. 2008; 15(2):69-73.
45. Carpiano RM. Come take a walk with me: The "go-along" interview as a novel method for studying the implications of place for health and well-being. Health Place. 2009; 15(1):263-72.
46. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (coreq): A 32-item checklist for interviews and focus groups. International Journal of Quality in Health Care. 2007; 19(6):349- 357.
47. Hayfield N, Huxley CJ. Insider and outsider perspectives: Reflections on reseracher identities in research with lesbian and bisexual women. Qualitative Research in Psychology. 2014; 12(2):91-106.
48. Puhl RM, Kyle TK. Pervasive bias: An obstacle to obesity solutions. Washington, DC: Institute of medicine of the national academies; 2014. Available from: http://www.iom.edu/weightbiascommentary.
49. Himmelstein M, Tomiyama AJ. It's Not You, It's Me: Self-Perceptions, Antifat Attitudes, and Stereotyping of Obese Individuals. Social Psychological and Personality Science. 2015;In Press. DOI: 10.1177/1948550615585831
50. Street Jr. RL, Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician–patient communication to health outcomes. Patient Education and Counseling. 2009; 74(3):295-301.
51. Edwards I, Jones M, Higgs J, Trede F, Jensen G. What is collaborative reasoning? Advances in Physiotherapy. 2003;6(2):70-83.
52. Andreyeva T, Puhl RM, Brownell KD. Changes in perceived weight discrimination among Americans, 1995-1996 through 2004-2006. Obesity. 2008; 16(5):1129-34.
53. Puhl RM, Heuer CA. The stigma of obesity: A review and update. Obesity. 2009; 17(5):941-64.
54. Naylor PE, Byrne KA, Wallace HM. Impact of situational threat on the behavioral activation system. Personality and Individual Differences. 2015; 74:1-5.
55. Puhl RM, Moss-Racusin CA, Schwartz MB, Brownell KD. Weight stigmatization and bias reduction: Perspectives of overweight and obese adults. Health Education Research. 2007; 23(2):347-358.
56. Nicholls DA, Gibson BE. The body and physiotherapy. Physiother Theory Pract. 2010; 26(8):497-509.
57. Trede F. Emancipatory physiotherapy practice. Physiother Theory Pract. 2012; 28(6):466-473.

Table 1: Demographic characteristics of participants[+].

Variable	Quantity
Total number of participants	27
Sex (female/male)	18/9
Age (y), mean (range)	39(23-72)
Years of experience, mean (range)	15(1-36)
Area of employment (city/rural)	23/4
Country of undergraduate physical therapy training:	
Australia	19
Singapore	2
Ireland	1
Scotland	1
Canada	1
New Zealand	1
Brazil	1
South Africa	1
Main sub-discipline:	
Rehabilitation (including neurology, geriatrics,	4
orthopaedics)	11
Musculoskeletal (including sports)	3
Neurology	1
Rheumatology	1
Outpatients	2
Pediatrics	3
Orthopedics	2
General rotation	
Main health sector:	
Public hospital	4
Private hospital	7
Public and private hospital	1
Private clinic	7
Community	1
Schools	1
Teaching and hospital or private clinic	3
Teaching	3
Participants with post graduate qualifications	12

[+]The BMI of participants was not measured, however, most participants were likely 'underweight' or 'normal weight', with less than five likely to be considered 'overweight' or 'obese' by BMI category.

Table 2: Results: overview and description of main discourses identified in the focus group data.

Discourse[+]	Description
1. Patients who are overweight are little affected by stigma	Most participants demonstrated *some* understanding that larger patients might feel discomfort in physical therapy interactions. Around one third of participants had not considered how overweight patients might feel and had little or no idea that they might feel discomfort. This can be contrasted with other literature on weight stigma that indicates people who are overweight report often being affected by stigma, including in a healthcare context.
2. Patients who are overweight are difficult to treat	Participating physical therapists portrayed patients who are overweight as difficult to treat particularly in the areas of palpation, manual handling and sourcing of equipment.
3. Weight has simple causes (diet and exercise)	While some brief acknowledgement was usually given to the complexity of the determinants of weight, participants overwhelmingly placed emphasis on lifestyle factors as the causes of body size and the way to address it.
4. Weight is important in physical therapy	Weight was frequently talked about as: • an important contributing factor to pain or illness experienced by patients • a factor that requires addressing • a factor that physical therapists should address

[+]for the purpose of this study discourse is defined as: distinct ways of thinking or speaking about a topic.

APPENDIX 1.

Focus Group Guide

1. Guidelines for group:

- no right or wrong answers
- confidentiality
- allow others to speak

2. Introductory question

Can you give us a very brief outline your physical therapy work history (give example)?

3. Guiding questions for discussion:

Have you ever discussed weight with a patient?

- Can you give more detail on….?

Do you think it is important to discuss weight with your patients?

- Can you give more detail on….?

Can you describe what it is like to treat a patient who is overweight?

- Can you give more detail on…..?

What do you think are the main reasons that people might be overweight?

- Can you give more detail on….?

How do you think an overweight person might feel coming to physical therapy?

- Are there any elements of the physical therapy environment that may be relevant to body weight?
- Is there anything about the physical therapy profession 'brand' that may have some relevance to body weight?
- Can you give more detail on….?

Do you think that weight management is part of physical therapists' scope of practice?

- Can you give more detail on….?

4. Summary

Present a quick summary of topics discussed to the participants

5. Anything else

Ask if there is anything anyone else would like to add on the topic of weight in physical therapy?

Physical Therapy
Journal of the American Physical Therapy Association

Physical Therapists' Ways of Talking About Overweight and Obesity: Clinical Implications

Jenny Setchell, Bernadette M. Watson, Micheal Gard and Liz Jones

PHYS THER. Published online December 4, 2015
doi: 10.2522/ptj.20150286