RESISTING MEDICAL DISCOURSES IN FAT SOCIAL WORK PRACTICE

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ABSTRACT

Resisting Medical Discourses in Fat Social Work Practices

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This Major Research Paper conducted an institutional ethnography of social work practice with fat service-users in medical settings, exploring the resistance or conformity taken in clinical settings to medical discourses on fatness. Using a voice-centered relational method, three social workers were interviewed on their experiences working with fat- identified clients within medical settings. The interviews explored the role of social work in medical settings, the operation of power structures and cultural discourses that restrict or limit social workers' capacity for engagement from social perspectives, and the resistance practices workers use to navigate their practices to maintain anti-oppressive social work practice. It was found that there are significant issues with the medical model's engagement with fat service-users and that, while there are significant barriers to fat positive social work practice, it is through the use of language, client- centeredness, teaching moments, and advocacy, that anti-oppressive social workers navigate these spaces.

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DEDICATION

To all the fat bodies that have been problematized, stigmatized, pathologized, and medicalized by the medical institution, this one's for you! In solidarity with you. May we continue fighting for body positivity in medical institutions.

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Chapter 1: Introduction

Throughout this major research paper, I will explore social work and its operation with fatness in medical settings. In exploring this topic, I will attempt to answer the following research question, "How do social workers navigate conversations around fatness with service-users in medical settings from a social perspective?" A social perspective pertains to an understanding of health from a social determinants of health model, acknowledging that health can be impacted by social identities such as race and ethnicity, socioeconomic status, gender and so forth, and that weight does not equate to health and vice versa (Friedman, 2012). Fatness has been a term that has been controlled and pathologized by the medical institution for a long time; through this, the medical institution has produced and reproduced knowledge around how and what bodies should look like, and what bodies are seen as healthy or good, and conversely, what bodies are dirty and unhealthy (LeBesco, 2004). Throughout this paper, I am interested in looking at how social work, a profession where many practitioners and schools of social work pride themselves on social work's anti-oppressive, social justice mandate, navigates conversations around fatness. Specifically, I will be looking at the experiences of social workers who work within a medical clinic at community health centres in downtown Toronto, I am interested to see if social workers resist and challenge medical discourses of fatness and obesity, or whether they become complicit in their practice, reinforcing medicalized discourses on health and weight. I am operating from the assumption that social workers become complicit in their practice working within an institution of medicine and gradually lose touch with the social justice and activist roots of social work, failing to resist and challenge the oppressive language and practices that the medical institution inflicts on fat bodies.

This work is very important to me personally, as well as, to social work practice as a whole.

As a person who identifies as a fat person and who has lived with and continues to live with ongoing experiences of fat oppression, including, but not limited to being medicalized and pathologized for my fatness since childhood, this work is meaningful to me to bring justice and healing to my experiences and hopefully do the same for other fat identified people who read this paper. Professionally, social work practice has a long way to go in recognizing fat oppression as an oppression by social work professionals as this is often left out of conversations around anti-oppressive practice. Fat oppression is an intersection that is often left out of the conversation in social work discussion around anti-oppression and social justice responses. The absence of fat oppression in conversations, as well as the current gap in the literature on fat oppression from social work discourse, allows the continuation of medicalized notions of obesity to pervade discussions and practices by doctors, social workers and other helping professionals. I hope that this research paper will reach social workers engaging in this type of work and can have a transformative effect that can positively affect practice with fat clients in the future.

In the following sections, I will explore and theorize my topic more fully. In Chapter Two, I will explain my theoretical framework and discuss my topic through this lens. Chapter Three will contain a review of the literature that is pertinent to my topic, and in Chapter Four, I will explain the methodology and research methods I have chosen for which I will conduct my research. The remaining chapters will discuss the findings and discuss implications for future research and social work practice.

Chapter 2: Theoretical Framework

For this major research paper, I will be using a radical disability model theoretical perspective to guide my topic in looking at the medicalization and pathologization of fatness within medical settings. As noted previously, I acknowledge that fatness is a form of oppression largely left out of discussions on anti-oppression responses within social work practice. Furthermore, there exists a large gap in literature around weight based oppression within social work research; much of the research existing operates from more social theories such as social model of disability, feminist perspectives or fat studies perspectives. For the purpose of this paper, I will be using Radical Disability Theory to look at fatness from a medical and health lens. Radical disability theory operates from a transformative paradigm, shifting ideas around what is previously known and taken for granted knowledge on subjects such as, body size, transforming knowledge to a newer and subjugated understanding of body size from a social perspective (Withers, 2012). This paper aims to centre fat bodies that are continuously silenced, marginalized and discriminated against institutionally and systemically, and open up avenues for social work practice through an anti-oppressive lens to hopefully benefit fat bodies in future interactions with the medical system. In producing an MRP with a transformative paradigm, seek to provide an anti-oppressive approach to marginalization around fatness, providing a practical avenue for social justice and advocacy around fat issues, and implications for future social work practice and further research in this area.

Radical disability theory rose out of the social model of disability, which argues for inclusion and accessibility for people with (dis)abilities (Withers, 2012). Radical disability model seeks to subvert the sneaky nature of the medical institution as the dominant and hegemonic knowledge producer that has existed to govern and discipline the problematic body through the creation of various laws and institutions, where bodies are contained, punished, medicated and/or

"fixed" (Withers, 2012). Using this theory to guide my work will allow me to take this similar approach to looking at the dominant position the medical institution has been afforded as knower, patroller, and controller of fat bodies, and look at the ways in which knowledges such as, disability studies and fat studies remain subjugated.

I chose to employ a disability school of thought because it is my observation that the many similarities between fatness and disability that transpire in the literature found within the medical and social research, such as fat studies. Many ideas from a medical standpoint suggest bodily defectiveness, mental uncontrollability and disordered thinking, reinforcing ablebodied, sanist, and thin ideologies that are so prevalent in Western medicine (Cooper, 1997). Through the medical model, fatness is viewed as a disability or mental illness by the many pathological ways that it is conceptualized in anti-obesity public health discourse, and through the inclusion of "Binge Eating Disorder" in the Diagnostic Statistical Manual (Lyons, 2009). The reason I chose radical disability model rather than fat studies is because I feel that fat studies provides a more social lens to looking at fatness, focusing on the cultural and media effects on fat bodies. Radical disability model is a preferred theoretical candidate because it specifically looks at the pathologization of bodies and the medical institutions' harmful legacy and grip on problematic bodies and minds of I hope to extend this idea initially provided by disability scholars and align it to fatness without coopting the long and labouring physical and emotional efforts disability scholars have made in transforming ideas about disability.

. I acknowledge that this paper lacks a critical race theoretical orientation which will be further explored in my limitations section; however, this paper is the beginning of my journey into research on fatness. Having lived experience of being a fat person, I decided to begin my journey in utilizing theories that have influence on my life personally as a person that has been medicalized

and pathologized by the medical institution. That being said, in further work, I intend to bring in a critical race and post- colonial theoretical analyses to weight- based oppression, understanding that the predominance of white theorists neglects the experience and voices of Black, Indigenous and racialized folks.

Radical disability theory views disability as fluid and takes a post-structural lens in looking at the body as an object of knowledge through which medical language is discursively used to construct, medicalize and produce disabled, problematic bodies (Withers, 2012). Through this, medicine is the sole master of the language of impairment and continuously requires this sovereignty to name bodily dysfunctions (Hughes & Paterson, 1997). That being said, meaning follows the label, and its iteration and reiteration produces a particular area of body with appropriate signs, symptoms, behaviours and normative expectations, and simultaneously, the creation of disabled is constructed when the body does not fit these constructs (Hughes & Paterson, 1997). Throughout this section, I draw on Foucauldian ideas to further explain fatness because Foucault operates from a post-structural lens like radical disability theory. One major critique that I have with Foucault and radical disability scholarship is the reproduction of whiteness and the lack of attention to race. Further work of mine will implement a focus on race and ethnicity. That being said, his ideas add a slightly different lens in looking at power through looking at politics and economics and the ways that dominant bodies and institutions govern and discipline society through different technologies and practices and the resistance practices people create and recreate to create social change. Further, much of Foucault's work examines power and the production and reproduction of knowledge in relation to sexuality, disability and problematic bodies, and therefore, I felt that his ideas add a more thorough and in-depth analysis of fatness in aligning it with a radical disability model (Foucault, 1984a; 1984b; 1984c).

It is understood that knowledge and power are connected (Foucault, 1984c). Where there is knowledge, there is power, and where there is power, knowledge production is easily facilitated (Foucault, 1984c). It is through language construction that meanings are inscribed on objects, or in this case, bodies about which perspectives become formed, such as the negative connotations that are associated with fatness (Foucault, 1991; LeBesco, 2004). Foucault (1991) described discourse as a group of statements that provides a language for discussing and representing knowledge, relating to a particular topic, at a particular historical moment. These knowledges produced about bodies are privileged actions, dominated by bodies in control of resources, most often reflecting hegemonic ideals, and benefitting those in power (Foucault, 1984c).

The power that the institution of medicine has allows for the continuous governance and control of bodies through a process of governmentality and surveillance. Foucault (1991) asserts that just as a father of a household governs his family and asserts how each member should behave, perform, act and look, this idea then becomes institutionalized in systems as a mechanism to control populations using this moral ideology to ensure the "common good" of the nation. This moral ideology has worked to benefit those in power since the rise of liberalism (Foucault, 1991). Morality has been utilized and institutionalized in medicine as a way for doctors and other medical professionals to control people and their bodies through claims on obesity such as 'The Obesity Epidemic' which arose in the early 2000's as a moral panic to control the rising obesity rates in North America (Lyons, 2009). Foucault theorizes moral ideology through the economics however, it exists in other areas in society such as, medicine and policy (Foucault, 1991). That being said, it is through the moral and deontological ideas generated during the enlightenment era that has become politicized and institutionalized as taken for granted knowledge around how people and their bodies should look, act, and perform (Foucault, 1991; LeBesco, 1993).

Powerful institutions impose laws and norms that reflect moral ideology and implement tactics to survey people to ensure obedience (Foucault, 1991). A docile body is one that is self-corrected and obeys through submission, which includes submission to the white norms of a thin and pure body (Foucault, 1984b). In order to produce the thin, pure and docile body, the medical institution produces discourses around health and fitness that then becomes institutionalized through public health policies, statistics or epidemiology reports as a science to control bodies (Foucault, 1991). The Obesity Epidemic that rose in an alarming manner by public health policy forums in the millennium is a prime example of fatness being framed as a "problem" by health professionals (Lyons, 2009). Obesity Epidemic discourse became the talk of television shows, internet websites and school curriculums that bought into these ideas of fat as dangerous and provided ways to shed the weight and get thin and healthy (Lyons, 2009). The Obesity Epidemic is a prime example of the ways in which fat bodies are surveyed and governed without the presence of the clinic.

Physical spaces can also act as forms of political control; school, social service agencies, community centres, and even places of employment act as institutions of surveillance that exist outside of the clinic that use different means to discipline and/or punish fat bodies (Giovanelli & Ostertag, 2009). Each surveillance technique enforces obedience through tactics that monitor body weight and size. Examples of this include the use of scales in doctors' offices or at the gym, the Body Mass Index, (BMI) as a weight measurement tool on weight loss shows such as, Dr. Oz, and the presence of weight loss "success stories" on television shows such as The Biggest Loser (Giovanelli & Ostertag, 2009). The reproduction of thinness is also employed through the increased visibility and popularity of diets, diet pills, gym memberships, fitness attire and fitness

celebrities that popularize and glamourize dieting through mainstream media, asserting thinness as achievable and necessary (LeBesco, 2004).

Each of these surveillance techniques align with Foucault (1984) idea of, "*Panopticon*" in the prison industrial complex. He describes the Panopticon as a booth situated in the centre of a circular infrastructure with the power and visibility to view all bodies at all times. The viewer is described to be an inspector with omnipotent visibility with the power to govern and discipline (Giovanelli & Ostertag, 2009). This gaze is extended to everyday life through the ways in which people survey and regulate themselves through the internalized belief that the same ocular eye is watching their every movement (Giovanelli & Ostertag, 2009). We often see this very visual in hospitals such as bariatrics and eating disorders units where the nurses' desk is a circular desk situated in the middle of the floor to ensure optimal vision on patients. At the same time, medicine situates itself at the centre of all service provision around healthcare as most powerful of all the disciples and thus, exerts control over both clients and service providers like social work and others, maintaining continual hegemonic dominance (Foucault, 1984c).

At the same time, more formalized laws and policies become institutionalized in society to police fat bodies, and punish bodies who do not conform to the constructs of thinness. The existence of weight restrictions on contraceptives and other feminine products reinforces feminine ideology, who is capable of participating in reproduction, which also serves as the new Eugenics of women's bodies, removing a woman's right to reproduction if she exceeds "normal" body size. It is understood that Eugenics of women's bodies is not a new act however, it has a legacy from where it began as removing reproductive capacity of "disabled" or problematic bodies almost a century ago (Friedman, 2014; LeBesco, 2009). Further, the removal of children from fat households is another way that fat women are punished for being fat by taking away a woman's

right to mother (Friedman, 2015). In this, institutions do not need enforcement strategies such as weapons to exercise power, but instead subversive techniques as mentioned above can act as instruments of surveillance and control to maintain the hegemonic ideological construct (Foucault, 1991).

In looking historically within the global context, bodies have always been fat (Fraser, 2009). Fat was seen as "heathy", beautiful and naturalized and was also associated with wealth due to access to resources that afford a person their fatness (Fraser, 2009). Although this is problematic and is associated with class and race related issues, it demonstrates how the construction of the beautiful and healthy body has shifted overtime and how medical knowledge has produced and pathologized particular body sizes as being overweight and obese (Fraser, 2009). In the rise of modernity and simultaneously, science and rationality, ideas around health began to permeate. Parallel to this, women's bodies began to be thought about in different ways; women's health, relating to reproduction started to get mixed up with weight discourses (Bordo, 1993; Hartman, 2000). Further, these changes were occurring during the rise of capitalism and the production line, and so bodies started to be looked at from an economical lens, as modes of production, which in turn cast a glaring gaze at the fat body as being unproductive and uncompetitive in the booming economy (Guthman, 2009).

If we think historically and even in the present day about who have been the medical professionals and economists, we can generally state that white, privileged, well- to- do men have dominated these fields (Bordo, 1993). These ideas have favoured the medical gaze and have since been embedded in culture, becoming taken for granted knowledge that is privileged in understanding women's bodies and the way that society should operate and perform (Bordo, 1993). These ideas have been key in constructing what women and their bodies should look like: what is

beautiful, desirable, and healthy, and what is not. Thinness is associated with docility in maintaining self- discipline to create the preferred body (the thin body) through dieting and exercising, restricting the self from pleasurable activities such as eating "junk food", and avoiding sedentary activities; failure to self-discipline in these ways is seen as laziness and unfeminine by patriarchy (LeBesco, 2004). Docility has been constructed as feminine by the by the male gaze in creating bodies that are subservient, submissive, take up less space, and restrict behaviour to confine to these standards (Giovanelli & Ostertag, 2009; LeBesco, 2004).

A docile body is also one that is analyzable and manipulable, one that is subjected, used, transformed, and improved (Foucault, 1984b). A docile body behaves, obeys, is disciplined and disciplines the self; conversely, the fat body is deviant, grotesque, disobedient and undisciplined (LeBesco, 2004). In looking at the thin body, dieting and exercise are two tactics commonly used to maintain this idealized body. These tactics signify restriction and discipline, two key components in creating and maintaining the docile body - a body favoured by the medical institution (Giovanelli & Ostertag, 2009). Discipline of the body equates to discipline of actions, which in turn serves to operate as a form of control, another tactic of governmentality to increase self- surveillance without the presence of institutions (Foucault, 1984b). In this, the docile body is constructed as healthy and beautiful this idea then is produced and reproduced in mainstream media as a way for society to adopt this way of thinking to engage in practices to achieve a docile body thus allowing medicine to maintain social control of society and its people (Giovanelli & Ostertag, 2009).

Foucault centers much of his work on power and knowledge production through examining the creation and operation of power through language construction that discursively produces meaningful and material effects on bodies (Foucault, 1984c). Powerful institutions occupied by

powerful bodies have produced and reproduced this knowledge throughout history that now stands as taken for granted knowledge; medicine being one of those powerful knowledge producers (Bordo, 1993; Foucault, 1984c). The tight grip that medicine has had on women's bodies still exists today as there is little room for other forms of knowledge, such as knowledge from a social perspective, including Fat Studies. Fat Studies is a relatively new focus within social discourses, stemming from sociology. Fat Studies is also a field of study predominantly dominated by women and so this brings up additional questions as to how it continuously remains subjugated by medicine, which is, as mentioned above, a male dominated field. Further, Fat Studies is considered to be a counter discourse to medical discourses as it seeks to 'shake up' what is previously known about fatness and transform ideas to a wider understanding that encompasses social determinants of health and body positive politics (Bordo, 1993; Friedman, 2012).

Anti-oppressive social work practice puts clients' decisions first rather than imposing a pathological view of bodies as problematic or abnormal (Friedman, 2012). In looking at fatness, social work is assumed to take a social perspective in practice, maintaining client dignity and choice (Friedman, 2012). That being said, when social work practice enters the clinic, a place that has much more institutional power and "credibility" than social work, it can be difficult to maintain an opposing set of values as a subaltern practice. The medical system, maintaining position as expert through its legacy of hegemonic dominance due to the abundance of knowledge it has produced on a variety of topics relating to health and bodies, is continuously given the freedom to produce knowledge around what is "normal", governing and controlling bodies without being questioned or challenged (Foucault, 1984a; LeBesco, 2004). This makes it difficult for social work to resist and challenge these ontological values on a daily basis, working within the very system that these beliefs operate from. In the following section, I will explore the literature from a medical

and social perspectives on fatness and offer ways in which social work practice can adopt social perspectives to ensure anti-oppressive practice with clients.

Chapter 3: Literature Review

Research around fatness exists predominantly through medical discourses. That being said, I have had to adjust the language in my literature search to more medical language like, 'obesity' in order to find research. I realize this is a drawback because many of the studies in my literature review comes from medical disciplines for the mere fact that this is the predominant knowledge production around fatness. I purposely chose to employ more medical type journals as an epistemological analysis of fatness to subvert and highlight the current overrepresentation of fatness from a medical perspective and to problematize this hegemonic force through constructing my own analysis from a social perspective. In looking at the methodological gaps, I have noticed that the medical studies tended to have positivist paradigms, whereas literature with a social focus tended to be more exploratory papers or opinion pieces.

I also acknowledge that this is a huge gap in my literature review as most of the research studies come from medical journals and contain a more positivist quantitative analysis, rather than employing a more qualitative narrative analysis involving the voices of fat people, who continue to be silenced by medical discourse. Theoretical gaps include the lack of explicitly stated social theories employed in medical journals, which in turn lacks a social justice lens and further individualizes fatness as a problem of the self. That being said, the theoretical perspectives employed in the social journals took a fat studies or feminist lens of study. The theoretical and methodological gaps listed all contribute to my reason for employing my research study using the methodology and theoretical perspectives I have chosen. I wish to add to the literature on fatness from a social perspective and offer a post structural radical disability lens, unlike the majority of the literature that exists. I also use an institutional ethnographic methodology to subvert the medical institutions' pathological grip on fat bodies through quantitative positivist studies that

measure fatness as a physiological disorder. In my research, I seek narratives through interviewing social workers on their experiences working in the field of medicine to shine light on subjugated knowledge and voices.

The dominant themes I have pulled out in the current literature are the medicalization and pathologization of fatness, fat phobia and social stigma, and fat acceptance and body positive politics, which I discuss below.

The Medicalization and Pathologization of Fatness

As mentioned earlier, fatness is a relatively new construct within social studies literature due to the legacy of the medical model being the dominant knowledge production in fat research (Bordo, 1993). The fact that most of the articles found on fatness or 'obesity' were in medical or health-related journals is a clear indication that fatness is highly medicalized. The lack of research on fatness from a feminist or social point of view with the overrepresentation of women's bodies from a medical perspective suggests that obesity health discourses are very gendered and paternal due to the fact that many articles are written by men on women's bodies (Fraser, 2009; LeBesco, 2004). Explaining women's health from a medical perspective reduces what it means to be a woman or "feminine" through idealized body constructs portrayed through medicine (Bordo, 1993). In reviewing the research studies, many topics arose that reinforced that notion of fatness as a pathological and diseased trait stemming from the brain. Cornelis, Rimm, Curhan, Kraft, Hunter, Hu and van Dam (2014) discuss how obesity is a genetic trait located in regions in the brain regulating energy balance, appetite, and reward-seeking behaviour. This study argues that "uncontrolled" and emotional eating, as well as cognitive restraint are positively correlated with one another, and positively associated with BMI, (Body Mass Index) and weight change. This means that "problematic" eating is associated with BMI and so the higher one's BMI, the more

one emotionally eats (Cornelis et al., 2014). In making this assumption, it frames fat people as passive, uncontrollable beings, lacking agency and control around food intake. BMI is used in the majority of the studies as a weight measurement tool to determine the participant sample of only 'obese' participants. It has been noted that BMI is problematic as a weight measurement tool because there are multiple factors that can make a person's BMI higher and since BMI is usually used to assess health, its measurement is assumed to produce meaningful findings about a person's body (Friedman 2012). BMI can be a very problematic labelling tool to determine a person's health through their weight and height without taking other things into account like muscle mass, fat, metabolism, exercise, daily activity narratives and other social factors (Friedman, 2012). Bringing the discussion back to the initial point made, using BMI to explain eating practices pathologizes eating in stating that it is connected to the brain dysfunction and therefore, reinforcing that fat people are not only uncontrollable and defective bodily, but also defective mentally, further perpetuating the medicalization of obesity and control of women and their bodies.

Binge Eating Disorder, (BED), a mental health diagnosis that is included in the Diagnostic Statistical Manual, (DSM), is another way that the medical institution medicalizes and pathologizes fat bodies and minds. Binge eating disorder diagnostic criteria includes, eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone because of feeling embarrassed by how much one is eating, and feeling disgusted with oneself, depressed, or very guilty afterwards (de Zwaan, 2001). de Zwaan (2001) completed a psychiatric study on the epidemiology and demographics related to BED. BED is described as being most common among "obese" individuals and notes that BED is more common in overweight women, affecting 65% of women, versus 35% of men (de Zwaan, 2001). Throughout the paper, the author suggests weight, metabolic characteristics

such as fat distribution and body fat percentage, as well as psychopathology, such as depression as contributors to this "disease" (de Zwaan, 2001). The author offers "self-help" methods, weight loss treatments, anti-depressant medication, and psychotherapy such as Cognitive Behavioural Therapy as "treatment" of BED (de Zwaan, 2001). This article perpetuates fatness as a mental illness that requires medication and therapy to fix the problematic and uncontrollable body. It also perpetuates harmful ideas around women's bodies by suggesting that eating is linked to pathologization and disease, reinforcing ideas around how women should act, perform, and how much space should be taken up, including food intake (LeBesco, 2004). This reproduces the idea that discipline and food restriction is linked to health, beauty, and femininity (LeBesco, 2004).

Fat Phobia and Social Stigma

The second major theme that arose in the literature were articles looking at the prevalence and impacts of fat phobia and social stigma. Fat phobia is a term brought about by Fat Studies scholars to examine societal discrimination towards fat people at individual and structural levels (Friedman, 2015). Individually, women's bodies are discriminated against through the everyday micro-aggressions for exceeding what it means and looks like to be a "normal" and "good" woman (Friedman, 2015). Carrying extra weight implies lack of care about the self, hygiene, sexuality and so on (Friedman, 2014). Sarlio-Lahteenkorva (2001) explores the influence of obesity and being overweight on obese peoples' well-being and quality of life through studying the success and failure to control weight. It was found that excess body weight was associated with social and economic disadvantages, particularly among women. Further, common reasons for dieting were related to fitness, health benefits, professional gains and improved appearance, including the fear of social and professional limitations. This could provide an explanation for why individuals engage in weight loss because of feeling external motivation through feeling societal pressure

rather than internal motivation to lose weight. The findings also stated that dieting can create undesirable emotional responses such as anxiety and depression but states that weight loss is often justified despite negative emotional responses due to the fact that the difficulties that some fat folks experience in finding a partner and decreased chances for marriage are more troubling than effects of depression and anxiety (Sarlio-Lahteenkorva, 2001). This supports the idea that social acceptance and forming emotional and romantic bonds can be more important to some people and outweigh the costs of mental health effects when it comes to weight loss. This can support the idea that quality of life is measured more in social well-being instead of psychological well-being for some people.

Kline (2015) studied the ways in which medical stigmatization of the "adipose" or "fat" body and the ensuing consequences of gendered weight bias have consequences on teen well-being. Findings stated that nearly five thousand teens confirmed that they engage in weight control behaviours such as fasting, vomiting, laxatives, skipping meals or smoking to control appetite; one half of these teens are girls. Research suggests that the relationships between weight status and mental health risks may best be explained by teens' misconception of their weight class contributing to eating disorders and body dissatisfaction (Kline, 2015). Further, data suggests that obese and overweight females base body image on medical definitions rather than self- perceptions and that this can be a risk factor contributing to depression and suicide; ignoring weight class definitions can be a protective factor (Kline, 2015). These are very interesting findings that reinforce the idea that the medicalization and pathologization of fatness has dangerous implications for fat young people that transpire to adulthood, and that the medical institution's disdain for fatness can cause people to engage in unhealthy and dangerous weight management practices that can further increase the risk of eating disorders and mental health issues (Kline,

2015; Sarlio-Lahteenkova, 2001). This study also stresses the importance of valuing self-perceptions of body appreciation without the influence of external factors such as the medical institution or societal notions, which can be particularly harmful for bodies that "exceed" the constructs of body size normalcy. This idea reinforces the notion that taking a social perspective in discussing weight and body size is imperative for social work practice in order to promote positive physical and mental health with clients.

Another major finding within the research that strongly supports the stigmatization and fat phobic discourse that exists is weight bias, which is the negative attitudes and behavioural response towards fat people, in believing that fat is controllable (McCardle, 2008). A surprising finding showed that not only doctors, but also social workers engage in weight bias (Lawrence, Hazlett & Mazur Abel, 2012). Due to the pathologization and individualization of "obesity" through the medical system, it is understandable that doctors would engage in weight bias through believing that fat people are to blame for their fatness and participate in their own oppression by eating poorly and lacking exercise. That being said, findings that support social workers engaging in weight bias are shocking due to the fact that it rejects the general mandate that social work is informed by in its commitment to social justice and human rights. McCardle (2008) conducted research to explore how weight bias among social workers impacts practice with obese clients. It was found that there was a large proportion of social workers that engaged in weight bias and significant findings showed that participants who believed more strongly that obesity is under an individual's control tended to have more negative attitudes towards obese people. Further, social workers with more negative attitudes towards obese people demonstrated more negative practice behaviours in work with obese or overweight clients (McCardle, 2008). That being said, social workers with higher BMI's, a family history of obesity, friends who are obese and/or higher

amounts of obese clients in their practice demonstrated more positive attitudes towards obese people; younger social workers also demonstrated more positive attitudes towards obese people (McCardle, 2008). Overall, it was found that weight bias does exist among social workers and that it can negatively impact practice with obese clients (McCardle, 2008). These findings yield a lot of information about social work practice with fat people. It demonstrates that there is further research needed in this area, especially with older populations of social workers to reduce the amount of weight bias that exists. It appears that there is a relationship between exposure and lived experience of fatness and feelings and attitudes towards fat clients. This finding is interesting as a potential avenue to look at in social work education to promote sensitivity and prevent weight bias and fat phobic attitudes in practice.

Fat Acceptance and Body Positive Politics

There have been different ways that women have resisted the societal constructions of idealized body size. Saguay and Ward (2011) examined women's experiences in 'coming out as fat' to see if there was a drive towards social change, social mobilization, and stigma resistance. The women interviewed were members of the NAAFA, (National Association to Advance Fat Acceptance), a fat activist group. Research found that two thirds of the women used the analogy of 'coming out' when talking about their first experiences identifying as fat and accepting their size. There also is a sense of solidarity in feeling "out" and public. Further, 'coming out' being mentioned by more than half of the members suggests that there is a particular narrative that possibly "helps" fat people feel proud of their body sizes. It can be inferred that the success of this narrative in LGBT communities has allowed it to extend to the fat community. The research also found that 'coming out' narratives enable a positive identification as fat, which can strengthen and broaden support for political and legal claims on the basis of body size (Saguay & Ward, 2011). It

was found that self-identification and identity is a major thread among fat identified folks and further, reclaiming the word 'fat' can allow the word to become less stigmatizing and harmful to fat communities (Saguay & Ward, 2011). This research suggests possible avenues for social workers to engage in body positive talk with clients around issues of fatness in the beginning stages prior to and after size acceptance takes place.

There are meaningful ways that women can resist body dissatisfaction and practice self-love and size acceptance. McKinley (2004) examined the body experience of fat women who endorse fat acceptance. Findings showed that those women who endorsed the need for social change in attitudes towards fat people had higher body esteem and self- acceptance, and lower body shame than those who endorsed personal acceptance of body size only. This may suggest that a collective attitude may be necessary to promote social change and community action towards fat acceptance. Further, social change endorsement was associated with higher levels of body esteem, autonomy, self-acceptance, and personal growth; and lower levels of body shame and smaller weight discrepancy compared to those who endorsed acceptance only (McKinley, 2004). In this, advocating for social change may improve body esteem and psychological well-being, and those who feel better about themselves may challenge cultural body standards (McKinley, 2004). These findings suggest that social workers' engagement in social justice work around fat oppression alongside fat clients can improve structural and micro oppressions towards fat people as well as, improve fat people's bodily self- perceptions.

The previous studies looked primarily at the effect of community and social action on personal body acceptance. The following study looked at the Health at Every Size (HAES) social movement as a paradigm shift to the contemporary medical weight loss focus. In their study, Bacon and Aphramor (2011) found that the HAES approach is associated with statistically and clinically

relevant improvements in physiological measures, such as blood pressure and blood lipids, and health behaviours such as physical activity, eating disorder pathology and psychosocial outcomes such as mood, self- esteem, and body image. This reflects an understanding that taking a body positive and holistic approach to health, rather than a pathological, deficit based approach reinforced by the medical system has physiological, psychological and psychosocial effects on people. This may be due to the fact that people spend less time worrying about how they are "imperfect" to society's standards and instead focusing on their own version of health. This reinforces the idea that taking a social perspective to health and fatness is important and further, that social workers should be promoting a social perspective in practice with clients. This study further explores the protective factors of being fat in stating that "obesity" is associated with longer survival in many diseases such as type 2 diabetes, hypertension, cardiovascular disease and chronic kidney disease. Conversely, weight loss increases the risk of premature death through unhealthy behavioural changes and weight loss techniques that have physiological and psychological detriments (Bacon & Aphramor, 2011). These are very meaningful results as they suggest that the fat can be "healthy" for folks. It also begs the question, why is the medical model promoting weight loss if there are clear indicators of health at a bigger size? And, why does a social approach to health like HAES still remain subjugated knowledge if it clearly stands as valid and true? Further research of a HAES approach to holistic health and living and the outcomes of taking such approach is needed in the literature that exists.

Conclusion

This chapter summarized the literature on fatness looking at the three themes, medicalization and pathologization of fatness, fat phobia and social stigma, and fat acceptance and body positive politics. The first theme highlighted the overrepresentation of medical literature on

fatness that in turn pathologizes and constructs fatness as problematic. The second theme highlighted and discussed the material effects of the pervasiveness of fat phobia and social stigma towards fat bodies in society. Lastly, the final theme discussed the ways in which fat folks have reclaimed their bodies and engaged in resistance techniques and social action to endorse fat acceptance and resist dominant medicalized ideas of obesity.

Chapter 4: Methodology and Research Design

The methodology that I have chosen to employ in this major research paper is institutional ethnography. An ethnographic study seeks to study a culture-sharing group, examining and interpreting the processes, shared patterns, and values within this culture (Creswell, 2013). This idea of cultural study has been expanded to physical spaces that are centered around a particular shared culture, or discourse, such as institutions (Creswell, 2013). Institutional ethnography is connected to ethnography in the way that institutions take on a particular culture of discourse depending on the organization or school or thought that is living within the physical space (Smith, 2005). That culture or discourse then becomes the topic under examination by the researcher quite similarly to an ethnography, the main difference being that an institution or organization is looked at instead of a group of people (Smith, 2005). An institutional ethnography is a qualitative empirical inquiry that was developed by Dorothy Smith, a Canadian sociologist (Smith, 2005).

The aim of an institutional ethnography is to understand how institutions operate and how the people in these systems work, resist, reinforce, or co-opt the discourse guiding the institution (Smith, 2005). Using this approach allows for an anti-oppressive analysis of power and its operation within dominant institutions, making visible the often invisible operation of power and bringing light to voices that are often silenced and/or oppressed within the institution under study. For my MRP, I have decided to look at the institution of medicine in looking at social workers' experiences of the ways in which health professionals work within these health settings and conduct their practice with fat clients, as well as examining social workers' accounts of their resistance or conformity to medical discourse. Institutional ethnography begins with a problematic arc of events that leads to particular relations of power that is embedded within the system (Smith, 2005). This then becomes the research question or topic of exploration of research, revisiting the

issue, having explicated how the experience came to happen as it did (Smith, 2005). Throughout the earlier sections I have described the long and problematic history of medicine and how this institution has had harmful and meaningful impacts on fat bodies, maintaining position as expert knower and knowledge producer on bodies, not allowing for the understanding of other subjugated discourses on fatness such as social perspectives. This then is the problematic of my MRP. The 'problematic' is the unfortunate arc of events experienced by the participants that becomes the first step into inquiry into the topic under study (Smith, 2005). For the purpose of this paper, the problematic arc of events is the pathologization and medicalization of fatness within medical settings.

In undertaking institutional ethnography, researchers first look to boss texts such as policies or reports that govern the system and discursively construct the practices relating to the institution of study (Smith, 2005). I have looked at the understandings of fatness from both a medical lens and social lens and how each institution frames their practice in my literature review section. I have also examined the experience of the social workers I interviewed within the context of the policies and mandates relating to each medical clinic that I recruited participants. Drawing on my knowledge from radical disability theory and the literature review, I reflected on the governing text evident in the medical model approach that rules medicalized practice towards fatness. Using this knowledge I created interview questions that examined the resistance or conformity social workers maintain in working within the institution of medicine. I have interviewed three social workers working within medical clinics in community health centres and hospitals in downtown Toronto with different sites of practice Through these interviews, I have gained an understanding of the way that social work engage with fatness through resisting and/or conforming to medicalized discourses and practices with fat clients. I hope to understand whether social work is in line with

its values of anti-oppression and social justice, in looking at fatness from a social perspective, or whether social workers become complicit in their practice, reinforcing pathological medical discourses with fat clients. The information gained from these interviews may contribute to social work practice in understanding how social workers resist and challenge medical and pathological practices with fat clients, or how social workers can become complicit in their work, which can hopefully become a guide to bettering social work practice to maintain anti-oppressive practice with clients.

Institutional ethnography acknowledges the authority of the experiencer and uses the narratives provided in interviews to subvert the problematic and/or oppressive nature within the system/institution (Smith, 2005). "Knowing how things work, how they're put together, is invaluable for those who often have to struggle in the dark" (Smith, 2005, p. 32). In conducting interviews, I wish to make visible the problematic nature of medicine and explore new ways that social work can resist and/or respond to fat oppression within medical institutions. I have chosen institutional ethnography due to its relevance to my research question in subverting the powerful nature of medicine and the ways that it swallows up other discourses like social perspectives towards fatness. I also feel that the structure of this methodology takes a post-structural lens through putting a spotlight on subversive power relations and looking at the ways in which knowledge is produced and reproduced maintaining hegemonic power around a particular discourse. Furthermore, this approach may be bringing light to marginalized and subaltern voices, such as social workers working in medical practice settings, which may then offer new insights to the issue and ways of responding. This also aligns with my theoretical framework that takes a post-structural and transformative lens of analysis in producing literature that takes an anti-oppressive approach to marginalization around fatness and provides practical avenues for social justice and

advocacy around fat issues, as well as, implications for future social work practice and research in this area.

I acknowledge a gap in research on fatness from a social perspective employing this methodology. However, although often not explicitly stated, it has been noted that much of the research on fatness employs an auto-ethnographic methodology. Many of the theorists thus far have theorized fat oppression through their own lens, grounding it in problematic experiences that they have encountered. I have chosen to veer away from this method for a variety of reasons. For one, I would like to bring the experience away from the self, as this can sometimes be perceived as limiting the utility of the findings beyond highlighting the experience of a single person (Creswell, 2013). Secondly, I acknowledge that as a fat person, using autoethnography can be very labouring and harmful to myself as it involves bringing up negative and sometimes traumatic experiences to further discussion on the topic. As a person who has lived experience with fat oppression, simply writing on fat oppression throughout this MRP is difficult and requires me to engage in much self- care in order to protect myself from being re-traumatized from experiences. Thirdly, as there is a gap in research with an institutional ethnographic methodology on this topic, I would like to contribute to this literature from this methodology and to subvert the problematic nature of the institution of medicine in regards to fatness specifically in regards to social work practice, which has not been done in this way thus far.

In this study, I conducted purposeful sampling as my sampling method due to the fact that I am looking for a certain demographic of participants that I wish to recruit, as well as, the sites from where I am recruiting participants (Creswell, 2013). Due to time constraints, I have conducted a modified institutional ethnographic study, whereby my sample size is much smaller than many other studies that employ this methodology (Paliadelis & Cruickshank, 2008; Smith, 2005). I

acknowledge that this limits the extension of this knowledge to greater populations due to the fact that the small sample size data. I have recruited three social workers with a bachelor or master's degree in social work, that are registered by the College of Social Workers and currently employed and doing direct practice work with clients within a medical clinic in a community health centre or hospital in Toronto, Ontario for one or more years. I recruited through contacting medical clinics by email, asking potential participants to contact me by email if they are interested.

Data collection involved individual face-to-face, semi- structured, open-ended interviews with participants around their experiences working within a medical clinic with fat- identified clients using an interview guide with a total of eight questions with probing questions (Creswell, 2013). Interviews were conducive to my methodology as I was able to capture authentic narratives of the experiences and practices that participants engage in and bear witness to. Interviews are key to institutional ethnographic study. Interviews are constructed and designed for the investigation of organizational and institutional processes within the topic of study; it is the pathway for learning about individual experience within an institution (Gubrium, 2001). Interviews are an entry point into the experiences of specific individuals whose everyday lives are in some way shaped by the institutional relations under exploration. Ethnographic studies call for research methods that can discover and explore these everyday activities and processes and their positioning within extended sequences of action and power structures (Gubrium, 2001). Interviews locate and trace the points of connection among individuals working in different parts of institutional complexes of activity to see if there are similarities or patterns among differing organizations that operate from a similar discourse (Gubrium, 2001). The interviewer's goal is to facilitate discussion that will not only illuminate a particular experience but that will also point towards next steps in an ongoing,

cumulative inquiry into translocal processes, opening up further avenues for study and action to address the problematic under study (Gubrium, 2001).

Each participant was interviewed once and each interview took approximately one hour. Interviews took place in secure locations to protect the confidentiality of participants, and participants had the opportunity to refuse answering questions throughout the interview as well as to review and edit their transcripts, and drop out of the study up to one month after the interview took place. Participants were made aware of confidentiality prior to the interview and were also given a consent form outlining participation expectations and participant rights. The interviews took place in person and were audiotaped with the permission of the participants so that I could have the content to transcribe after the interview. The interview content was stored on a password protected device and the audio files were destroyed after the content was transcribed. Participants' names were made into pseudonyms to protect identity. Participants are referred to as participant one, participant two, and participant three.

I have chosen to use a voice- centered relational method, also known as 'listening guide' as the data analysis technique in this research study. Voice centered relational method allows participants' narratives to be explained in terms of their relationships and the broader social and cultural contexts in which they live (Paliadelis & Cruickshank, 2008). This form of data analysis is compatible in an institutional ethnographic study as it allows for an understanding of the self that is situated in organizational contexts (Paliadelis & Cruickshank, 2008). It looks at how individuals navigate the spaces they occupy, the relationships and social networks they cultivate, and the cultural discourses and structural forces that shape and limit the individual's capacity for action, specifically acknowledging the power relationships that restrict and limit action within these spaces (Walby, 2013). Upon completing the interviews, the content was transcribed

verbatim, using the exact words expressed by both parties during each interview to ensure the nature of the conversation was accurately captured. The transcriptions were then reviewed for the creation of 'I poems', where narrative fragments using "I" statements were pulled out and analyzed for resounding themes, which were coded using different coloured highlighters and then implemented throughout the findings section to accurately capture participants' narratives (Walby, 2013). In Walby's text, he describes 'I poems' as how one "brings one's talk about one's self to the fore, which can not only illuminate aspects of the story not visible when the narrative fragments remain part of the transcript but also help the researcher select narratives to work with" (Walby, 2013, p. 146).

In Walby (2013), he lists a series of steps to follow in this specific data analysis method within an institutional ethnographic framework. Step one involves listening for the plot, including protagonists being described by the participants, and reading for key actors and researcher reactions to the plot. Step two involves listening for contrapuntal voices, or multiple voices within one story that are reflective of broader social relations that the self is enmeshed in, and listening for social networks participants are involved in. Step three involves analyzing the transcripts for traces of how cultural discourses and structural forces shape and limit the participant's capacity for action (Walby, 2013). I adapted these steps so that it would be more conducive to my research study, while using a similar structure to Walby (2013), which will be explained in the findings section.

Chapter 5: Findings

This chapter will present the findings derived from my interviews with three social workers doing direct practice work within medical settings. Participant one shared her experiences working within a community health centre as a social worker in primary care, participant two shared her experiences working as a social worker in in-patient within the hospital with clients who are dialysis dependent and have complex discharge needs as well as her work in end of life care, and participant three, shared her experiences working with children and adolescents in the in-patient and out-patient eating disorders program. Three common themes came out of the interviews with all three participants that I will expand on throughout this section. Those themes are (a) the plot, the problem and the actors (b) power structures and limits to resistance (c) acts of resistance. It was found that even with the limited resources that the participants have in working in medical disciplines, participants navigated the medical system through engaging in daily micro-practices that were conducive to their definitions of anti-oppressive social work.

The Plot, the Problem and the Actors

It is evident that there are a number of positive experiences in working as social workers within medical settings; at the same time, there are a number of challenges and "problems" with this type of work. More specifically, social workers spoke of their experiences working within these settings with fat clients, sharing what drew them to this work, what the work looks like and challenges they face on an ongoing basis, framing the problem in their eyes.

The role of social workers in medical settings. As social workers in medical settings, one is responsible for meeting with clients, documenting, and meeting with other staff members, such as doctors, nurses, dieticians, psychiatrists', occupational therapists, and other allied health professionals to ensure communication of care among team members, as well as the smooth

transitioning of clients to other areas of care. Participants spoke about their motivations for choosing this work and what a typical day on the job looks like.

> I'm very drawn to it, I think there is a lot of opportunity for me to push back and do critical work within this organization. I feel like it's important for me to be there to be bringing viewpoints that aren't necessarily raised a lot of the time. P1

> I put out fires. I run from fire to fire all day. For me a typical day is jumping right into the middle of things to identify where my voice is needed, and where it is not, where I can address a crisis with a family or a client, where I can advocate to a facility or a service agency, or where I can connect the right family to the right resource, and I dive right in. P2

Through these examples, participants one and two described the fast-paced nature of this work but provided powerful narratives of their motivations and drives to do this work as social workers engaging in anti-oppressive practice. Further examples of anti-oppressive practice in clinical settings will be explore further in section three.

The role of medicine. Each participant shared their experiences of the role of medical professionals in their specific workplaces, what the doctor-patient relationship looks like, and any challenges or problems that they noticed with the medical profession's way of engaging with fat-identified clients. Participants shared their understanding of the role of the doctor or medical professionals Participants one, two and three regarded the doctor-patient relationship as very pathologizing in seeing a "problem" with fat clients, and finding ways of "fixing" the problem through various methods.

> I think their role comes from a very medical model lens, specifically in the hospital setting its very much around medication and I feel like before it was mad-identified clients who were being medicalized and now it's fat-identified clients who are being medicalized. When being admitted to the hospital, you are already seen as somebody who is sick, or somebody who is not "normal". So I think the doctor's role in that sense comes from medicalizing the person and treating them with medication. P3

> So, the traditional role of medicine is very top-down, doctor kind of directs things, doctor leads things and we follow suit. P2

> Their role is to make them lose weight, to warn them that they are going to have diabetes if they don't lose weight, or to recommend them to diabetes focused programs. So I think the role is to get them to lose weight using different health scare tactics or to send them to a dietician so that they can start curbing their eating issues. P1

The participants spoke of ways that doctors engage with fat- identified clients through the use of medication or referral, both instances problematizing the fat body and advocating for change. Participants spoke of the discourse of the medical model and how this framework is particularly salient and powerful in their places of work, having to resist or work around this clinical practice that will be explored in greater detail further on. Further, participants shared frustration in the medical professions' emphasis on weight over health, neglecting to ask questions to gain an understanding of a person's daily living or life circumstances.

Responses to the problem. Each participant shared their frustrations with their work within medical settings due to the many barriers in place within hospitals and community. They discussed their expectations of what they thought the work would be like and how it actually looks like

> …Oh yes, here are all these other health issues but let's also talk about how you're fat… let's just ignore the fact that you cannot afford to have anywhere to live right now and talk about how you should be eating better. I have had some discussions with clients around fatness but it doesn't come up too often because I'm just like if they don't see a need to bring it up with me, then I don't think they need to hear it from me as well, and I'm not interested in putting forward that rhetoric. I'm way more interested in finding them housing, getting them access to financial assistance, dealing with the really, what I see is the really immediate problems. Plus, I don't think that anyone should be told to lose weight. P1

> I expected the job to be a lot easier. I guess I expected more from the system. I find with individuals with accessibility barriers and higher care needs, including fat- identified clients, families are just so desperate to place people into continuing care and long term care settings that they surrender people to the system in desperation. I think that speaks to a huge lack of appropriate community care and support. The care just isn't there for individuals who are interjectionally privileged, let alone clients who are marginalized. In fact, I think a lot of people would be able to be much more successfully reintegrated from hospital into the community if systemic barriers were addressed. Particularly for fat-identified clients, I think they face so much stigma before their even able to access the service that being able to advocate for those clients becomes so difficult. P2

> I think as social workers and anyone out there who is in the field of healthcare, when we see individuals, when we see bodies, that is the first impression, that is the first thing we see. We don't see their thyroid, we don't see how their body functions, so, a lot of times, the shape and size becomes a way for the creation of goals and plans. So if somebody identified as fat, whether it be from their own perspective or the healthcare's perspective, then that in itself becomes the primary goal. It's frustrating because fat is not accepted medically, its's not accepted socially, it's just not accepted. P3

Working within the medical sector as a social worker can certainly have some benefits; however, this work can be challenging in regards to weight-based oppression that is enacted upon fat clients through the medical model. In their responses, participants shared the ways their reactions to fat- oppression that they witness and some ways that they manoeuvre their practice in response to weight-based oppression. These findings also suggest an extension of weight-based oppression beyond the medical service sector to within the community service sector that impacts fat clients receiving community supports once out of hospital. More concrete examples of the ways in which strategic action is taken to navigate their practice from an anti-oppressive lens will be discussed in the third section of the findings.

Power Structures and Limits to Resistance

A large theme that came out of the interviews with participants was their frustrations with the medical profession's way of engaging with fat-identified clients and their own limits to intervening from a fat-positive lens. Tying these findings into the description of the problem mentioned earlier in the findings, this section focuses on the ways in which the participants identify the power structures working within their institutions limit or restrict their capacities for resistance or work on fatness from an anti-oppressive perspective.

Role as a barrier to connection. One large theme that came out of interviews was the frustrations that participants expressed around the time constraints and clinical roles that predefine limits around client interactions, which is often reflective of broader neo-liberal power structures

that exist in Western society and medical practice. As social workers in medical settings, time is often limited as there are many different roles that a social worker takes on as mentioned in the previous section. Participants one and three describe their experiences working within these settings and the difficulties they experience in being able to do the work that they want with clients:

> I feel like when you work in clinical settings, it's very boxed; not just for clients but for social workers, where you can't really explore everyday hobbies or things that they like to do. It's boxed in terms of, how are you feeling just in the eating disorder situation?... I thought it would be more humanly, I thought it would be more looking at the individual more specifically because we were working with children and adolescents. I thought that it would be more talking to them about their feelings, about their emotions and trying to figure out the underlying concerns that had started the eating disorders but it was very different for me in that situation. P3

> So I work as a family therapist so I would see families; I would talk to families as well as the children regarding the issues that they are facing, the goals that were reached or why they weren't reached. I would do in-patient and out- patient so a lot of the out-patients would be once a week and the first thing we would do is when the family comes in, we ask the parents to take a seat and we take the child to go and get weighed and then the rest of the conversation would be about weight, not about health. P3

> And sometimes, I feel like I'm making no change, Like, I'm like why am I here? I could be at the '519', or I could be doing something else, but I think there's a really big divide between clinical social work and community development and I think that some of the community development values could really stand to be migrated into clinical work. P1

Participants also mentioned the fast-paced nature of their work that limits the amount of time spent with clients exploring needs and other issues.

> I put out fires. I run from fire to fire to fire all day. So a day for me is no matter what I come in thinking what my day is going to look like, it never looks like that. So for me a typical day is jumping right into the middle of things to identify where my voice is needed, and where it's not. Where I can address a crisis with a family, or a client, where I can advocate to a facility or a service agency or where I can connect the right family to the right resource. And I dive right in. So my typical day is going right down to the unit, checking in with people, whats going on, who needs something, who's in crisis, what do we have planned for today, is it going as planned, and inevitably something that comes up that comes up that completely throws off all day. There's absolutely no planning for what your day will look like. Or accounting for the internal pressure is to meet the hospitals goals as appose to the patient's goals. P2

Further, participants mentioned standardized assessments as being a barrier to gaining a more social understanding of the issues the client is facing. Rather, the hospital seeks a bio-psycho understanding of weight and size, which is privileged over looking at health levels. These medicalized understandings can be difficult to resist asking when it is part of a standardized assessment or a check box questionnaire. The examples provided by participants one and three show that that there is frustration with the limited capacity to engage in anti-oppressive social work practice in these settings as there is emphasis on gaining a clinical and to that end, pathological understanding of client issues.

Time spent on advocacy. A particularly resounding theme throughout participant interviews was the emphasis on advocacy, which. I speak about as being a positive piece to the work. However, one major drawback is the time that is spent on advocating for clients to receive the supports and resources needed, as well as the time and effort that goes into advocating to medical professionals to see an alternative side, such as a social perspective to an issue or barrier that a client is facing in order to gain approval. This is reflective of the hegemonic and subversive power that medicine holds within the institution. This one medicalized focus is automatically understood without often looking at the issue from a social perspective. This leaves a lot of labour on social workers to engage in this work to advocate for an alternative understanding of the problem. Participants two and three discuss their challenges in doing this work regularly:

> …Doctors are going to look at things more from exclusively medical perspectives so I think my job is getting a doctor to see something in a totally different way that they don't usually see. I think my job is to say, here is eight other ways you can look at a problem, and rather than just saying it is the individual's problem, let's broaden that and let's look systemically. Let's reframe the issue rather than providing a medicalized solution to everything because not everything needs a medicalized solution. P2

> …While other workers found it rewarding to be in a [clinical setting] place like that, and there was a lot of educating going on between me and the two other social workers that

> were there, I was letting them know how I thought that it was very oppressive actually for clients to be studied like that and they thought it was just clinical work. P3

These findings suggest that there is a major burden placed on social workers who practice from an anti-oppressive lens to engage in teaching moments with medical professionals to adopt or gain this level of thinking in order to benefit clients. The second narrative also suggests that anti-oppressive social work practice is not something that is practiced by all social workers and so workers who do engage in anti-oppressive practice or take up fat-positive discourse are left teaching others to engage in this work. Although this teaching could have positive and lasting outcomes, because f the limited power of social workers in clinical setting, speaking out in this way still may put social workers at risk of penalty for speaking out (such as reprimand or job loss) and/or burnout as this adds extra work. Further, it limits the amount of work that can be done as the time that is taken to advocate or teach other workers may cut into time spent on making greater amounts or systemic level changes within the institution.

Strength in Numbers

This finding is surprisingly salient; all three participants noted that they graduated from schools that have an anti-oppressive and social justice focus and have found that this has impacted their practices within medical settings and their relationships with other colleagues that have come from more clinical schools. The following narratives from participants two and three demonstrate the particularly frustrating and somewhat alienating effects of coming from a different school of thought than other workers within an institution.

> I think it depends on social workers and I think it also depends on where you graduated from. Somebody who graduates from a very clinical based school is going to operate very differently in a clinical setting than somebody who graduates from an anti-oppressive sort of framework. So, for me because I graduated from a school that's very big on anti-oppressive practice, it was very difficult for me to fit into an environment that is so structured and boxing and that wouldn't let its clients talk about anything else but just shape and weight. P3

> … I think when you work in a multidisciplinary team or an interdisciplinary team where the entire team has already developed a perspective and you go in there with very, very different views and perspectives, there comes a time where you have to change those perspectives because you being on one side of the room and everyone else in the room is saying different things, you can be targeted very, very easily. Not just being targeted but your job is on the line. You can lose your job just for having different perspectives so I think that it can be very difficult sometimes to guide your work with those principles. P3

> As a [name of school] graduate, one of my biggest focuses in practice is anti-oppressive practice. I think there's a real tendency in medicalized social work to reject AOP as unattainable or impossible or idealistic. I think there's a real sort of old mentality in social work that we can fix everything, or that people need or want to be "fixed", and that fat is something that should be "fixed. I think if I were to sit around the lunch table with 20 of my colleagues and say the things that I am saying here, there would be definite push back. P2

The above narratives illustrate the difficulty social workers face in working in medical settings, and further, as social workers with an anti-oppression lens of practice working in medical settings. Participant three talked about feeling pressure to conform to more clinical perspectives in fear of potential job loss or penalty. Participant two spoke about feeling the alienating effect of carrying an anti-oppressive lens of practice and not having fellow staff members to share perspectives with. This can further affect a worker's ability to be able to connect on a client case to discuss potential avenues for action from a social perspective. Conforming to medicalized views of social work practice, such as looking at fatness as a problem, can be beneficial in keeping one's job by not creating conflict; however, this also has negative meaningful impacts on clients' lives by neglecting to resist medicalized views of fatness. Furthermore, with smaller numbers of anti-oppressive practitioners, it is easier to get coopted into medicalized ideology and practices. This also speaks to the hegemonic power that medicine has in its ability to swallow up other practices to maintain one knowledge and one truth.

Disconnects in practice perspectives. A final but significant theme in this area that emerged within the interviews with participants was the tensions felt from operating from different

practice perspectives within medical settings and the restrictedness participants feel when having to adhere to medicalized notions of fatness. Participants one and two share their experiences of the disconnects they face from clinical practice and their own practice that restricts the work that they want to do:

> I think there can be a lot of internal pressure from the hospital system and from the medical system at large to focus on issues that are not where we would necessarily want to be focusing as social work practitioners. It is our duty to reject that to some extent while still working within the system. I don't think as an individual, I have an issue adhering to the ethics and the principles within the college of social work. But I think in looking at it from a broader systems level, there is tension and disconnect in what our goals are. So I think we at least in the workplace that I work, do a very good job referring to college standards and guidelines, having regular education sessions when colleges release new practices, we call the college all the time to consult, but I think as a social work team, but we don't unanimously remain strong around that. The hospital system and the medical system in general would very quickly eradicate those principles, ethics and values, so I think its social works responsibility to fight for those values and I think the moment you stop practicing those values, you need to get out of social work. P2

> I was talking to the health promotion workers and community health workers who are in charge of the programming aspect; we share budgets and discuss programs for the upcoming year. I was talking to one of them and I said, I'd really like to do a body positive program with youth in the neighbourhood or women in the neighbourhood. I mean, I said youth but I'd be open to working with other populations, and she said, the health centre could not be seen as supporting obesity. I was like, I wasn't talking about obesity at all, I was talking about body positivity, but it was like she extrapolated from that. Some anti-obesity mandate that they've got going on. P1

These two narratives highlight the push back social work constantly receives in clinical social work practice around client centeredness, goals, and program development that inhibits the work that could be done with clients. Participant two listed the ways that she navigates her practice to ensure that her practice remains in social work standards however, she also discussed the extra of work necessary to maintain those standards. Participant one discusses the push back she receives within her place of work in wanting to promote body positive workshops with clients but experiencing the misalignment from the medical system that has a very different view of body size

and health than that of anti-oppressive social work practice. This is reflective of broader societal ideology of body size and health, which will be discussed further in the following chapter.

Acts of Resistance

The participants have described the hegemonic institutional power that the medical profession has in medicalized and clinical settings; participants have named this as a "top-down" approach, where doctors are in a sense are the 'gatekeepers' in practice, often directing and leading plans of action with patients. That being said, even with limited or lessened capacity for resistance, participants have named a number of ways that they navigate and manoeuvre their practice in medical settings to ensure that their practice is in-line with their descriptions of anti-oppressive social work practice. Each participant answered what anti-oppressive social work practice with fat clients looked like to them and described ways that they engage in anti-oppressive work:

> When we talk about anti-oppression both as being cognizant of power relations in the micro-interaction, but also like macro dismantling of these structures. I feel like I have a responsibility to not only be politically oriented towards fatness in discussions about fatness with my clients and help them break down those dominant understandings of weight and health, but then to also have those discussions with the doctors, look at the medical guidelines for this, critique those understandings on a broader level. I once had a talk about "Body Mass Index' at the Health Centre. P1

> AOP to me does not have one uniform definition of how I practice. To me, instead it is about meeting clients and individuals where they're at; it's about letting them define what they want to get out of the therapeutic relationship; it's about looking at what are the intersecting vulnerabilities and oppressions and discriminations this individual has faced, and at the same time, what are the intersecting privileges they may have and how can we utilize those to leverage the client to get where they need to get. P2

> I wouldn't define it [AOP] any differently than I define it with any other client. I mean AOP is basically an umbrella to everything else within oppression. When we talk about fat, I think most of the time we forget about other intersectionalities that can be affected…I think we cannot just look at fat-identified individuals without looking at all their other intersectionalities. P3

Language. Participants shared that one way they felt they can shift their practice to a social lens within medical settings is through the use of language. Participants shared that allowing clients to define what language works for them and allowing clients to identify themselves how they wish was particularly important in the therapeutic relationship. Language is often something that is imposed on clients, reinforcing the power dynamic between worker and client, between the doctor and patient. This can have meaningful impacts on a client's person as language has material meaning. Participant two mentioned extensively throughout the interview how much she felt choice of language is important in her practice:

> …Having the client identify what their discourse is, whether you want to be called fat-identified, whether you just want to go by fat, or whether you want to use the term bariatric-whatever the language is that you're comfortable with, you need the autonomy to define that, not the practitioner. I think it's that it's not appropriate that we put language on other people. So for me, I think it's really important to say to a client, You tell me what your language is, what your discourse is, what your barriers are, what your goals are, rather than the hospital saying, this is what our goals are, or the community saying, we want this patient placed, we cannot handle them anymore. P2

Participant two spoke on numerous occasions how the micro act of resistance through choice of language has meaningful impacts on clients. She also spoke of the need for medicalized language within hospital settings as needing to change overall, as she felt that the medicalized language used labels the client as a "medical problem", speaking specifically to the discourse of bariatrics as problematic language. Language choice and construction is one way that social workers can navigate their practice in medical setting with fat clients.

Client centeredness. Another way that participants shared their capacities for resistance within medical settings was through the use of being client, or "patient centered". As mentioned earlier, at times it is necessary for workers to engage in medical discourse as a strategic practice in order to do the work that they want to do. That being said, participants described client or patient- centeredness meant allowing clients to select their own goals in the therapeutic

relationship and being transparent in the process through outlining all of the client's options and barriers. Participants one and two explain how they navigate their practice to be client-centered within their settings:

> I have a different style of how I practice, which is very client- centric. If all clients want to do is come to my office and cry for an hour and leave and discuss nothing with me, and were not working through some Cognitive Behavioural Therapy workbook or something, I'm fine with that. I think people use the space how they need to use it, and I think the tension comes from the doctor's side. There's an expectation that were doing certain things with clients. I am very cognizant that I am not going to push anyone to being there or force them into doing things that aren't necessarily going to work for them. P1

> So for an example, we had a patient who was bed bound, total care, required supports for all of the activities of daily life, and they [the hospital] wanted to offer I think two hours a day community supports with community services. So I went to the client and said, look, I would like your permission to advocate for you based on your bariatric needs, for you to have extra hours of support and access to additional equipment funding. I don't want to smudge the truth and say it's based on your chemo needs; I want to recognize that there are barriers for you that are not in place for other people- what would you prefer? He endorsed this strategy and we were ultimately able to access a donated bariatric bed and a non-for-profit agency to basically redo his entrance hall so we could get the bed in and move it downstairs. We were able to get him eight hours of community service a day, and ultimately- most importantly to him- we were able to get him home. P2

Participant one discusses their practice as being client-centered through allowing the client to use the space and goals for the interaction the way that they see fit. They discuss the importance of allowing the client to select what is important for them instead of pushing a medical plan of action forward with the client. Participant two illustrates ways in which participants navigate their practice with clients to maintain client- centeredness through providing transparency around their options for action, as well as, the structural barriers that exist so that the client is able to make an informed decision about their own care. Each participant narrative discusses ways to push- back against the medical model to maintain client choice and autonomy within medical settings.

Teaching moments. Participants discussed the ways in which their individual discussions with clients around fatness from a social perspective has had beneficial impacts on clients in de-

pathologizing their bodies and normalizing their concerns about their bodies repeatedly being constructed as problematic by others, including the medical institution. Participants discuss ways that they have been able to engage in powerful moments with clients one on one about size and weight from a social perspective, disregarding the medical model's way of viewing fatness. In particular, participant one shared multiple moments of having authentic conversations around body and size, often bringing her own body as reference into the conversation with clients:

> I have had some clients in the past where I have taken up 'Health at Every Size' discussion. I definitely have some critiques of that personally, but I think it's a good bridge for certain people because they might not be ready to necessarily embrace a fat activist or fat positive lens but I think that it is a good start. P1

> I saw someone a couple of years ago who was getting ready to be married and she was getting a lot of negative feedback from her fiancé's family about her weight. There was a lot of focus on her losing weight before the wedding and so she was seeing me during this time, and I guess our plan of action was around me giving her a lot of 'Health at Every Size' resources. I recommended 'Lessons from the Fat-O-Sphere', different books, different websites that she could connect with and so, the plan of action moving forward was to follow-up on these resources, find what speaks to you and how can we bolster a strong sense of self when dealing with your mother-in-law who is being completely fat-phobic and really overtly nasty to you. We also talked about setting boundaries in conversations, exit strategies, and the kind of role that she could reasonably expect her fiancé to play in this too because I was saying that she should also be expecting him to take the lead in telling his mother that that is not appropriate conversation, so we talked a little about that too. P1

> I think in also having those fat related conversations, referencing my own body as well because I feel that my body plays into my practice a lot because I am a fat practitioner working in a health setting. So I think having those discussions with clients in a very honest way, in a way that's dismantling the power structures; we're not necessarily worker and client right now, we're two fat people and let's talk about what that means. P1

These powerful narratives show a rich description of the ways that participant one has utilized fat positive resources, as well as, her body through the use of self- disclosure to have open and honest conversations about body size and weight based oppression. The second narrative also demonstrates the way she was able to tailor her practice to providing support and skill- based resources for her client that was struggling with fat-oppression within her family unit. Each of

these examples demonstrate ways that social workers can engage in discussions around fatness from a social perspective in social work with fat clients within medical settings that can have lasting positive repercussions for clients utilizing services.

Advocacy. Participants shared their acknowledgement of the hegemonic power of the medical institution. They discussed their strengths working within this institution and the work that could be done, as well as, their limits for action. One particular strategic narrative that came out of their narratives was having discussions with doctors about alternative ways of viewing fatness and client barriers in society to get doctors on-side with the workers in order for social workers to advocate and do the work that they want to do. Participants two and three shared ways that they have utilized discussions with medical professionals that have had positive and lasting outcomes for their practices:

> A big part of my job is client advocacy…So if you can get the doctor on side with your goals and the patient's goals, they can be your biggest advocates and your biggest allies. If you have a doctor who is actively working against the client's autonomous goal-setting process, then they can become your biggest barrier. I think it's about framing things right that gets them to understand the different angles, and it's about getting the right doctor who is passionate about advocating for clients. Doctor's letters will get you [clients] places that I could never get you, and I think as a social worker, It's often about who we can draw on that has more power and a louder voice than we do. In reality, in the medical world, those [medical professionals] voices carry immense weight, so if you can get a doctor to advocate in line with the social worker, you'll get much more anti-oppressive social work done. P2

> If you have one on one conversations with the psychiatrists, one on one with the nurse, one on one with the other social workers, letting them know of your perspective, then I think you are sort of planting the seeds that weren't there before. I think for me that was very helpful. I had several conversations with the psychiatrist one on one and most of them he agreed with, and some of the policies were actually changed. P3

Both participants discussed ways to strategically using the tools and resources they had to advocate and make the changes that benefits clients. Although different examples of how they engage in advocacy, both participants shared their ability to navigate within a system to create change and benefit client's lives through getting them the resources needed. It can be difficult to

create macro change within settings right away, especially if there is a long legacy of hegemonic power. That being said, sometimes it may be beneficial to draw on the tools of those in power to make micro changes happen on a daily basis.

Conclusion

This chapter provided narratives of the experiences of three social workers working within medical clinics in Toronto, Ontario. The first section described the plot, the problem and the actors involved in each workplace. In this first section, the I poems were displayed throughout with the inclusion of participant narratives of themselves, their roles, and their experiences as workers in clinical settings. I poems captures how the participant narrates their sense of self (Walby, 2013). "The 'I' refers to a sense of self that is constructed through narrative" (Walby, 2013, p. 146) Workers discussed their roles as social workers in medical clinics, the health professionals' roles, their accounts of and responses to the problem within these settings. In the second section, workers explored the power structures that operate within their settings that limit their capacities for action and social change. Workers discussed their roles as having less institutional power, requiring a lot of extra time to engage in advocacy with medical professionals, limited numbers of social workers in comparison to medical staff, and disconnects in practice perspectives between doctors and social workers as barriers in doing the work that they want to do, to create and enact social change within these settings. Lastly, the third section explored the current acts of resistance that these workers are engaging in to do the work that they want, which includes the use of language that is client centric, client centered practice, teaching moments with allied health professionals, and advocacy. Through each of these ways, social workers are creating and facilitating anti-oppressive social work practice in their settings. The following chapter will unpack and theorize the findings provided by participants.

Chapter 6: Analysis and Discussion

In using institutional ethnography as my methodology to explore the navigation practices of social workers working within the institution of medicine, it was important that I be very intentional in deciding which data analysis method I would use as this would frame how I would organize and analyze my findings in a way that would be conducive to my topic of research. In selecting voice-centered relational method, 'listening guide', I have followed the steps of exploring the plot, the experiences of social workers working in medical settings and the ways in which they frame the problem; the cultural discourses and structural forces limiting participants' capacity for action; and the ways that they practice resistance and challenge the forces to do the work that they want to do in these spaces. In the following section, I will discuss the greatest findings in depth, revisit my theoretical framework with my newfound findings, discuss the strengths and limitations of this research, and the implications for social justice and anti-oppressive social work practice.

Medicine: The Medicalization and Pathologization of Fat Bodies

Participants shared their knowledge and experiences working with medical professionals. One particularly significant finding was participants' framing of the role of medicine with fat clients as coming from a traditional medical model. It was found that participants felt that the role of medicine was very pathological where doctors and other health professionals saw patients as a "problem" requiring medication and weight loss in order to change or be "fixed", becoming thin. Further, clients were referred to dieticians and bariatric surgical units to develop eating plans and remove weight in order to be "healthy" or thin. The pathologization of fat clients is nothing new in the scope of medicine in condemning the fat, problematic body and devising a plan to "fix" the individual (Guthman, 2009).

Participants also spoke about the role of medicine as being most powerful through doctors taking on leadership roles in directing care plans, requiring social workers and other workers with less institutional power to follow suit in action plans. That being said, in looking at participants' responses to the challenges experienced with the medical model's role in practice, it was evident that there was a singular focus on client health from a purely medical focus. Through this, body size is used as a reference to health rather than taking a holistic understanding of health looking at social determinants of health that would improve all forms of health including mental, emotional, spiritual health. Neglecting to take a more wholesome understanding of health reinforces the neo-liberal, Western lens that medicine takes in viewing bodies (Guthman, 2009). Medicine, originating from Europe arose during the Enlightenment era when things began to be quantified and measured (Foucault, 1991; LeBesco, 1993). At that same time, bodies began to be categorized and dichotomized in ways such as healthy and unhealthy, clean and dirty, safe and unsafe (Friedman, 2012). This enlightenment created the societal problem of problematic and disabled bodies, bodies that were watched, patrolled, scrutinized, gawked at and committed to institutions for fixing. As mentioned earlier, fat bodies have not always been problematic. Prior to industrialization, fatness was seen as beautiful, and was a sign of wealth across the world (LeBesco, 2004). With the rise of medicine came the definition of obesity and overweight, which was seen as dirty, disabled, and unfeminine or unmasculine. Therefore, with the creation of problems came the creation of solutions such as the institutionalization of people who needed fixing. Fat people, people with mental health, disabilities, and other problematic bodies were institutionalized and punished through inhumane treatment and attempted to be fixed through medicalized treatments and if unsuccessful, these bodies were condemned and cast aside from society (Withers, 2012). We see this today and in participants' narratives through the presence of

bariatric clinics, as an extremely medicalized and solution focused approach to fatness, placing emphasis on harmful and inhumane treatments such as, surgery, in-house exercise and dieting under monitoring of staff to ensure fast results (Guthman, 2009). That being said, if fat people refuse to undertake these treatments or are unsuccessful in their progress, they become socially rejected similarly to the historical treatment of problematic bodies, failing to get desirable jobs or achieving upward mobility, finding romantic relationships, and even not being able to fit into mainstream society such as trying to fit into clothing, chairs, transit and so forth, that is made for the preferred, neo-liberal thin body (Guthman, 2009). This reinforces the subversive and hegemonic power that medicine has on bodies, continuing to maintain its tight grip on fat bodies, pathologizing the problematic fat body and disciplining bodies through framing goals around weight loss and change, the use of medication, and referral to other health professionals in order to ensure bodily change (Foucault, 1984a).

The emphasis on weight as an indicator to health is harmful on fat bodies as it neglects that health can exist at all sizes. Participant three spoke about the body being the first thing that is seen by medical professionals, which then becomes the primary topic of conversation. She shared that medical professionals do not see how individuals' bodies work internally; instead, they see size and generate ideas about that person based on what is visible to the eye. This reinforces the understanding that the body is an object where knowledge is inscribed upon it, creating meaning that has consequences on individuals (Withers, 2012). As mentioned in the literature review section, health can exist at every size, and research suggests that having more weight can be a protective factor towards certain illness and that health has no bearing on physical activity ability (Bacon & Aphramor, 2011). Therefore, looking at health based on body size and concluding that weight loss is needed in order to achieve health, causes people to undergo harmful dieting and

weight loss procedures without having a wholesome understanding of health and wellness from various perspectives such as social perspectives (Bacon & Aphramor, 2011).

Furthermore, basing health solely on body size can further pathologize folks who experience intersectional oppressions such as living in poverty, living with (dis)ability, or being racialized, gender diverse, and/or queer, those who face multiple barriers in society to accessing food, having disposable time for exercise and other activities that promote the "thin" body (Guthman, 2009). It is important to understand the interplay of marginalization and fatness, and the barriers that exist that prevent access to resources in society (Guthman, 2009). As mentioned by participant one and two, clients were coming with needs around support with housing, financial assistance, accessibility and further that are not being addressed; rather, doctors were opening up conversations around weight, exercise, and eating practices, which neglects clients' needs and blames them for their own oppression (Friedman, 2015). It is important to understand how health can be defined as many factors and can be achieved at every size. Broadening the definition can allow individuals to express what they really need to achieve their own definitions of health and wellness, allowing them to get what they need out of their care.

Further, medicine is given the freedom to assert a singular notion of health and reinforce medicalized weight loss practices with people due to its continued dominance within medical settings. Participants acknowledged the top-down approach medicine takes within these settings with each plan of action being directed by doctors and action plans requiring doctor approval. This not only creates medicalized responses to client issues as mentioned earlier, but also perpetuates the expert knower position that medicine holds in these settings and the taken for granted knowledge produced and reproduced on fat bodies without knowledge or consultation from other perspectives (Foucault, 1984c; LeBesco, 2004). In summary, the body is a marker for knowledge

production, which then reinforces meaning and consequences for those bodies. In shifting whose voices are heard and whose are silenced in this knowledge production process, we can shift responses and care in these settings allowing for a holistic direction of care.

Medicine vs. Social Work: Power Matters

The second section of the findings looked at the power structures and cultural discourses that impact and limit social workers' capacity for action within medical settings. While there was a lot of overlap in issues that came up that coincides with the issues reported in the first section, this section specifically focuses on the broader discourses and forces that are impacting the medical and social work players' actions and practices. There were some particularly salient themes that came up in participant responses around power structures and cultural discourses that impact their practice, specifically in regards to disconnects in practice perspectives, predefined roles of workers, time spent on advocacy, and the limited number of social workers existing in these settings. One particularly large discourse that impacts clients as well as workers in medical settings are the discourses of surveillance and punishment. Using the ideas of Michel Foucault (1991) in his work around governmentality and surveillance, I consider what is happening in these spaces that impact client's bodies and social work's role and work in these settings.

Firstly, there appears to be a large theme around surveillance of client's bodies in medical settings. Participant three spoke about the discomfort she felt in witnessing other workers "studying" clients. She also spoke about her role as a social worker in a medical setting and how that shapes her role and interactions with clients. She shared that as a family social worker within the eating disorders clinic, upon meeting with the client (a child) and their family, the client is immediately taken to be weighed and then the outcome of that weigh-in constructs what the rest of the conversation with the child and family would involve. Further, if the child did not meet their

goals, questions arise around why goals were not met, and then goals would be reframed and/or changed for the following interaction. She also mentioned that the work appears inhumane only being able to focus on weight and goals rather than speaking about feelings or other issues that I client would like to bring up. Participant one also spoke about often feeling like she is unable to do the work that she wants to do and feels that she is not creating positive change for her clients in clinical settings, with a sense that community work values should be migrated into clinical work. This speaks to the discourse of punishment and neo-liberalism. The presence of scales in medical settings can act as a form of surveillance and social control in measuring body size to numerically see whether someone is where they "should" be in attaining their goals of weight loss, or in this space, weight gain (Foucault, 1984b; Guthman, 2009). This highly medicalized practice then translates to discussion around positive reinforcement or punishment depending on what was displayed on the scale. Positive reinforcement acts as a form of behavioural management or control technique that reinforces the desired behaviour through positive actions such as congratulating, praising or rewarding the desired behaviour (Friedman, 2015). On the other hand, punishment also acts as a form of control in disciplining the body that does not meet the goal, desired weight or behaviour (Foucault, 1984b). This is seen through the emphasis on the discussion of asking questions around why goals were not met and reframing goals for the next encounter without touching on emotions or other issues that may be impacting clients from reaching their "goals".

Neo-liberalism is another discourse that plays into social work's role in medicine and impacts the work that can be done in this space. The predefined roles that social have in these spaces dictates what interactions with clients look like, what things are covered and focused on in interactions, and what things are left behind. The institutional and hegemonic power that medical institutions have, including the capital that funds the services, allows medical settings to determine

what service plans look like, what worker roles look like, and allows for the maintenance of a top-down hierarchy of power between different work disciplines in this setting, requiring all things to be passed through and sanitized through medicine before it is delivered to service-users (Guthman, 2009). The medical institution takes a neo-liberal framework of practice in pushing forward health discourses on weight, connecting thinness to wellness and providing multiple services that were mentioned by participants such as surgery, dieting, referral and so forth, to achieve the thin body as quick as possible to remove the client's reliance on the system (Guthman, 2009). Through the use of surveillance and punishment tactics, as mentioned earlier, this can influence the speed of change occurring.

In revising the discourse of punishment, we can see that social workers are impacted by the discourse of punishment. Each participant shared their experiences of being social workers that engage in anti-oppressive approaches to practice. They shared that this work looks very different from clinical practice and that they often experience push back, isolation, or punishment in sharing ideas that differ from the dominant values of medicine. Participants shared that punishment looks like feeling targeted by other workers, fear of job loss, or that there would be push back if they shared their ideas. Participants also shared that they feel like they want to leave their jobs as it is often tiresome in educating and advocating for anti-oppressive practices in medical settings and feel the need to stay silent, or conform to medicalized discourses or practices in order to maintain good standing at their places of employment. These are particularly important findings as it suggests the powerful forces at play such as hegemony and punishment that limit or restricts work with fat clients from a social perspective. Further, the difference in numbers of social workers compared to medical professionals not only makes expressing alternative perspectives to practice difficult based on difference of philosophy but also in terms of feeling outnumbered

Another theme arose around the disconnects in practices among social workers and medical professionals and time spent on advocacy. I tie these two themes together as I feel that this could have a similar result that resonates with the hegemonic dominance of medicine. It was mentioned by participant two that much of her time spent in the day is around advocating for clients to gain access to resources or supports in the community, and showing to doctors that there are a number of other solutions to a "problem" rather than a singular medicalized solution. Further, participant one discussed the challenge she faced in advocating for a body positive program and being told by the health promotion team that the organization could not be seen supporting obesity. These examples plus many more provided by participants illustrates the ongoing struggle that anti-oppressive social workers face in medicalized settings that may have long-term detrimental effects on workers. The time and effort spent on advocacy not only can contribute to the cooptation of medical values and practices as mentioned by participant three, but it can also have detrimental effects on workers' stress levels, causing burnout, as one participant mentioned in her frustration in not seeing change occur, or needing to put in extra work in order to see micro level changes. Although advocacy and social justice can have overwhelmingly positive impacts on clients, this can be at the expense of a workers' mental health. This idea will be explored further in implications for social work practice. This section explored the structural forces impacting and limiting social workers' capacity for action. Discourses around surveillance, punishment, neo-liberalism, and hegemonic power arose within the interviews with participants as significant barriers to engaging in the practices that they want to engage in and create the change that they wish.

Acts of Resistance Unpacked: Using the Master's Tools to Dismantle the Master's House

In interviewing the participants, it was absolutely evident that there are ways that they navigate the spaces that they occupy to do the anti-oppressive work that they want to do and bring

about the changes that they need. My research question asked, 'how do social workers navigate conversations around fatness with service-users within medical settings from a social perspective?' I have found that it is not only the conversations with service-users that are navigated; participants also have shared ways that they strategically navigate their actions with both service-users and medical professionals in these spaces through advocacy, client-centeredness, and teaching moments. Participants shared their knowledge of anti-oppressive practice and what that looks like in practice with fat clients. Participant one shared their political orientation towards fatness from a social perspective in acknowledging the barriers that fat clients face in accessing health services. She shared that she often talks to doctors about fatness from a social perspective and has had a talk on the problematic nature of 'body mass index' at her place of work. Participant two discussed her knowledge of anti-oppressive practice as acknowledging the barriers that fat clients face and using clients' privileges to get them the services and resources that they need through advocacy. Participant three shared her knowledge of anti-oppressive practice as having an in-depth knowledge of intersectionality and understanding the ways that clients are marginalized and experience barriers to accessing health care based on identity. It was necessary to include participants' narratives of how they define anti-oppressive practice with fat clients and what that looks like for them, in order to see if participants engage in this form of social work because if they are not tapped in to this type of practice, it may not have been possible to ask them further questions on fat oppression within their work settings. In receiving their responses, it was understood that each participant has an understanding of anti-oppressive practice and fat oppression and engage in actions to navigate their practice from this lens. Through the use of language, client-centeredness, teaching moments, and advocacy, workers navigate the system of medicine strategically to do the anti-oppressive work that they want to do.

In revisiting radical disability model, this theory understands that bodies are blank and meaningless objects of inscription (Withers, 2012). It is through language, a holder of meaning that is used to discursively constructs meaning on bodies to produce and separate problem and preferred (Withers, 2012). Medical language is not neutral, it holds meaning and through the use of this language in discussing fat bodies, it constructs the fat body as pathological or impaired requiring fixing to be "normal" (Hughes & Paterson, 1997). While language holds negative connotations, it also has the potential to do the opposite. Language can be a powerful tool to reconstruct and reclaim traditionally problematic bodies as powerful, positive and beautiful. Participant two discussed ways that language exchange with clients has been a powerful tool to engaging in discussions from an anti-oppressive social perspective. She shared the importance of allowing clients to name their discourse in discussing their bodies and thus, goals of treatment. In medicine, labels are often placed on patients such as the use of the word, bariatric, obese, overweight, patient, disabled, and further. These words are not neutral, they hold material meaning that not only impacts how the person views themselves, but also how others view and treat that person with that label, and thus the body becomes a visual marker for stigma and discrimination (LeBesco, 1993; Friedman, 2014). That being said, maintaining a client-centric model of treatment, such as allowing the client to choose their discourse and goals for themselves, this gives the client the power to be the decision- makers in their own care.

Client centeredness was also displayed through the use of allowing the client to use the space as needed rather than imposing the organization's agenda for care of the client. Participant one talked about how she allows clients to use their time together as they see fit, allowing them the space to cry even if that means that they do not get through a cognitive behavioural workbook or any other goals set out by the organization. This can be a powerful tool of resistance in resisting

the neo-liberal practices of medicine in pushing clients towards goals and standardized outcomes to achieve a fast turnover of care and instead giving the client the space that they need and allowing them to move at their own pace and direct their own care (Guthman, 2009).

Advocacy was another theme that came up in participant narratives as an act of resistance. Advocacy is discussed in the previous section as a limitation in creating social change within medical settings due to the amount of time that is often spent advocating for clients; however, participants shared the power that advocacy holds in making change happen for clients in having their needs met. Participant two spoke extensively about her role as a client advocate in sharing that much of her day is spent getting doctors to see a client issue from an alternate perspective in order to receive approval on client care plans or for access to resources that require doctor approval. Although this can be a tedious process, it has positive outcomes for clients in achieving their wishes for treatment. This is also a strategic process as it requires workers to navigate in ways that are consistent with medical practices such as buying into "patient" discourse as mentioned by participant two, so that she can do the work that she wants to do.

Teaching moments have been described by participants as powerful moments in creating change within the settings that they work and shifting clients' thoughts about themselves. Participants spoke about having conversations with clients and medical professionals that is consistent with anti-oppressive practice and have had meaningful impacts on clients. Participant one spoke about having a conversation with a client who felt poorly about their weight and was receiving discrimination from their mother-in-law; participant one shared ways that she engaged with this client in providing fat positive resources such as books and 'health at every size' literature, as well as practicing ways that the client can approach her mother-in-law and leave situations when feeling unsafe. This is consistent with anti-oppressive practice and fat positivity

through resisting adherence or conformity to medical discourse around fatness and challenging the pathologization of fatness that this client was experiencing by others in her life. Secondly, participant three discussed a powerful moment in having discussions with the psychiatrist in her place of work around body positivity consistent with anti-oppressive practice, that in turn had policies changed at her place of work. These are rich examples of the ways in which resistance practices can be powerful in creating social change within institutions of power.

In summarizing the resistance practices explained by participants, I draw on a famous quote by Audre Lorde a Black Feminist scholar, "The Master's tools will never dismantle the Master's house. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change" (Lorde, 1984, p. 112). It is evident that there is anti-oppressive, fat positive work that is being done by social workers in these settings; however, large structural forces and cultural discourses act as barriers to bringing about large, macro level changes that is needed to abolish pathologizing discourse and practices on fat bodies that have negative consequences for these folks. Further, the work that is being done is happening on a micro level change that is easy to overlook the achievements made and feel as though no change is happening at all, as mentioned by participant one. These feelings can result in anti-oppressive workers feeling defeated and either give up their connections to anti-oppression and social justice, thus conforming to medicalized practices, or leaving these fields and going towards work that is more consistent with their values, leaving clinical workers in these spaces. "That being said, real genuine change is needed to be made without using the master's tools, without using doctors or within these settings as a strategic act, but rather needs to happen from outside of these intuitions, within the community, and within social work" (Lorde, 1984, p. 112). Leaving the institution of medicine and moving into the community is one way of shifting practice to an anti-oppressive lens by leaving the physical

institution of medicine, making healthcare more accessible to the community, and including more members of subjugated schools of thought such as, social work in these spaces, one example being community health centres. However, there still exists a preference by society of medical institutions such as, hospitals as being the "best" way to access healthcare due to the predominant representation of medical professionals dominating these spaces allowing for the continuation of medicalized discourses and practice to pervade (Lyons, 2009; Withers, 2012). In creating space for anti-oppressive social work practice, more workers can feel comfortable occupying these spaces and bring on the possibility of creating greater change through engaging in resistance for clients without the fearful navigation around medicine or conformity.

Strengths and Limitations

Some major limitations in this research study exist first around my own positionality. As a fat woman who has experience being medicalized and pathologized by the medical institution, I am not without bias in my opinion around fatness and medicine. Although I took every reasonable step possible to reduce bias, in no instances are people without subjectivity. This could have played out during the interviews with my participants as my body is a physical marker for my lived experience as a fat person, as well as my interpretation of participants' narratives.

I feel that there are some limitations existing around the population sample. First of all, it is a limitation that the sample size is so little. Due to time constraints of this MRP, as well as the number of social workers interested in participating, I was only able to recruit three participants which limits the extension of this knowledge to greater populations. Further, due to difficulty recruiting, I had to change the inclusion/ exclusion criteria in my recruitment in order to find participants. In this, I opened up inclusion criteria to social workers working in hospital settings rather than just community health centres, and social work students as well as employed workers.

I feel that this has some strengths however, as hospital work is known for clinical and medicalized practice and so I feel that I was able to get more diverse perspectives than that of community health centre workers, who are known to maintain more anti-oppressive values.

Although there exists diversity in place of work and organizations of the participants I interviewed, which I view as a strength, there are some common factors among the workers that may have influenced the results. As mentioned earlier, all three participants are female- identified, which may also speak to the female- dominated nature of social work practice, however it would have been interesting to hear from a male-identified social worker to see if there is a gender bias existing within discourses on fatness from social perspectives in medical settings. Further, all participants identified as being anti-oppressive practitioners, with critical analyses on fatness and weight- based oppression. I view this as a strength and limitation due to their ability to interview without requiring assistance understanding the questions and provide in-depth knowledge of the operation of medicine on weight- based oppression that may not be achieved with workers without this extensive critical knowledge. However, this may have created biased responses due to their anti-oppressive philosophies and critical engagement that they are already engaging in fat- positive social work practices.

A methodological limitation exists within the data analysis technique that I selected. I chose listening guide as I felt that it fit well with institutional ethnography; however, although I adapted the steps so that it was more conducive with my study, in reality I believe that it made it difficult to organize my findings causing a lot of overlap between the first and second steps in describing the problem and the structural forces that impact and limit social work practice in medical settings. As well, my interview questions did not explicitly ask participants about the

structural forces and cultural discourses that impact their work in their settings which caused me to make inferences on what these structures and discourses are that may not be correct.

Another methodological limitation was the difficulty in fully realizing the promise of institutional ethnography. I had hoped to explore more fully the practices of social workers and the connection of those practices to larger social structures; I also could have more fully explored the ruling relations between physicians and social workers. As a novice IE researcher, this research process has introduced me to IE and I look forward to engaging in similar work in the future, where I can develop my IE skills and knowledge.

Lastly, one fundamental limitation within my research is the lack of analysis on race and colonialism. Understanding that work on fatness has been dominated by white depictions of fatness, and that writings on social and radical disability models have centered many of the ideas on white interpretations of disability, my intention was never to replicate this 'white out ' within my research, leaving out the experiences of Black, Indigenous, and racialized folks. However, I want to acknowledge that embodied experience and social location was not something that I took up in my interviews with participants and so I did not want to speak for them in addressing their social locations within the discussion section. In future work, this would be something to bring into my research by including a section for workers to self- identify and allow folks the space to discuss their embodied experiences and how they feel this does or does not affect their practice.

Secondly, I understand that not including a critical race and/or anti-colonial theoretical framework is a severe limitation to my paper, given the whiteness of how health and body size are constructed by the medical profession and more generally in society. This is something I would be interested in exploring further in future work. However, for this paper, I wanted to begin from the

place of radical disability theory, in response to the over-prevalence of the social model of disability in current scholarship on fatness.

Some strengths that I feel exist from this research study is the theoretical framework and methodology that I selected, which is the first methodology selected for the study of fatness and social work practice in the institution of medicine. Institutional ethnography provided a framework of critical investigation into medicine to subvert the problematic and fat-phobic practices that exist and largely go unnoticed in these settings. Using radical disability theory to theorize my topic and findings fit well with institutional ethnography in studying the discourses and power structures that operates within the institution of medicine that influence practice, while looking at medicalized language on fatness and the meaning that it holds in reinforcing certain philosophies of practice for both medical professionals and social workers. Further, in using interviews as a data collection method, I was able to gain a rich, authentic depiction of workers' experiences with the space to do so, something that may not have been possible if I used focus groups or phone calls. This also gave social workers, a discipline in medicine that is often silenced, an opportunity to share their experiences. Lastly, I feel that this research study overall was a strength as this specific topic has not been explored in the past. This point ties me into the next two sections.

Contributions to Anti-Oppressive Practice

The contributions to anti-oppressive practice and social work are very interlinked in this research study as the data presented findings that is specific to anti-oppressive social work practice. My research question asked, 'how do social workers navigate conversations around fatness with service- users in medical settings from a social perspective?'; this question specifically looks at the operation of anti-oppressive practice in medical settings. Participant responses demonstrated that there is a difference between social work and anti-oppressive social work, separating the two

streams by clinical practice and anti-oppression through their separation and categorization of themselves as anti-oppressive social work practitioners from the other clinical social work practitioners. This is useful knowledge as clinical practice is often seen as most preferred in medical settings, which can explain how clinical social workers have been known to dominate these spaces, which can have meaningful impacts on fat clients' lives and treatment. This research study also contributes to anti-oppressive practice in opening up conversations around fatness, an identity category that is often left out of the conversation around anti-oppression responses to social work practice. As an identity that has recently generated acknowledgement and discussion as a form of oppression and marginalization, research that is centered around anti-oppressive responses that offers practical engagement techniques as presented in the 'Acts of Resistance' section, benefits anti-oppressive social work practice, and more importantly, fat clients.

Implications for Social Work Practice

The greatest implication for social work practice in my opinion, is the addition of scholarly research that is specific to fatness and social work practice. As mentioned earlier, fatness is an oppression that is largely left out of the conversation and so the addition of research specific to this topic may stimulate discussion around anti-oppression responses to weight-based oppression within practice. As a paper that directly centers social workers' experiences working within medical institutions and looking at the way they navigate practice, I feel that this paper may stimulate more research in the area connecting to different nuances on the topic of fatness that will be explored further in the future directions for research section. Lastly, two findings that I feel have come out of this research study is the need for greater numbers of anti-oppressive social work practitioners in clinical spaces, as well as greater supports and resources needed for social workers currently occupying these spaces to continue doing the work that they are doing.

Chapter 7: Conclusion and Future Directions

This MRP explored the experiences of social workers doing direct practice with fat service-users in medical settings. More specifically, this research aimed to explore the ways that social workers navigate conversations around fatness with service-users from a social perspective. Overall, the research provided findings and implications for fat social work practice in medical settings, and for anti–oppressive social work practice overall. Using listening guide as the data analysis method, I was able to capture the rich narrative descriptions and experiences of three social workers working in hospital and community health care settings, the barriers they face and the strategic resistance methods that they employ to do the anti-oppressive and fat positive work that they want to do.

This MRP discussed the ongoing challenges that social workers face, as a subjugated practice in the medically dominated field of healthcare, and the structural forces and cultural discourses that shape and limit social worker's capacity for practice from an anti-oppressive and fat positive approach with fat service- users. This MRP also provided tangible ways for social workers in medical settings to engage in anti-oppressive social work practice with fat clients through strategic acts of resistance and navigation in these settings such as through language, client-centeredness, advocacy, and teaching moments. This research also provides insight for implications of social work practice in these settings in creating space for more anti-oppressive social work practitioners, and offering supports and resources to workers in these settings.

This research study explored the institution of medicine and the resistance practices that social workers take on in these settings; however, it was mentioned earlier in the limitations section that all workers have an understanding of anti-oppressive practice and fat oppression, and identify themselves as anti-oppressive workers. That being said, research in this area would benefit

completing a study in looking at the experiences of social workers who work within bariatric settings, looking at the discourses and practices that these workers take up and how they frame their practice with fat service- users. Bariatrics is a highly medicalized unit within the hospital system that serves "obese" patients through surgery, diet, and further interventions. It may be interesting to explore the role of social workers in these settings and the resistance and conformity these workers take in working with the medical model. It may also be useful to conduct research that explores the experiences of bariatric patients and their interactions with medical professionals and social workers to see what their experiences are like with both disciplines, which may provide meaningful results for clinical social work practice in these settings.

Further, it may be interesting to conduct a study that looks at fatness as an identity rather than a clinical definition. In opening up the criteria within my research study to interviewing a participant that works in eating disorders, which predominantly serves clinically "thin" folks, it provided insight in what fatness as an identity or social construct looks like and how the medical institution interacts and frames service plans with folks who are not clinically fat but identify that way. This research could open up avenues for reframing how we think of fat as a social construction and identity rather than a numeric value. Further, it may be interesting to see what social work's role is in these settings with clients who identify as fat but appear clinically thin.

APPENDIX A

Participants Needed for Research Regarding Social Work Practice with Fat Clients in Medical Settings

I am looking for volunteers to take part in a research study regarding the nature of social work practice with fat clients in medical settings within a Community Health Centre located in downtown Toronto.

Particularly, I am seeking up to 5 participants who:

- Have a BSW or MSW degree in social work
- Have worked as a social worker at the clinic for one year or more
- Are registered by the College of Social Workers
- Are doing direct practice work with clients at the clinic

You will be asked to participate in an interview, where you will be asked general questions about your experiences as a social worker at the medical clinic within a community health centre.

Interviews will take place at a time and location convenient to you. The interview will take 1- 2 hours, although travel time to and from the interview, as well as, addressing any questions before and after the interview may include additional time.

The research is in fulfillment of my, Taylor Thornton's Master of Social Work degree to be completed at Ryerson University.

For more information about this study or to volunteer for this study, please contact me at:

Taylor Thornton
Master of Social Work Student
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042
Taylor.thornton@ryerson.ca
(905) 391-5635

APPENDIX B

Resisting Medical Discourses in Fat Social Work Practice: An Exploration of Social Work Practice in Medical Settings

Interview Guide

1) What is your experience working as a social worker in a medical clinic?
   Probing Question: What are common scenarios you encounter?
   Are there any memorable or meaningful (good and/or bad) experiences that you have encountered on the job? This may involve social workers, medical professionals, fat clients and so forth.

2) What made you decide to work within this setting as a social worker in a multidisciplinary site of practice?
   Probing Question: What did you expect the job to be like?
   Probing Question: Is the job what you thought it would be? How or how not?

3) What does social work practice with fat clients look like in this settings?
   Probing Question: What are some of the barriers that they face or some scenarios that you have come across with these clients?

4) Can you describe what a day as a social worker in a medical clinic looks like?
   Probing Question: What are some of the things that you do on a day to daily basis; your role, responsibilities and so on.
   Probing Question: What types of things are discussed?
   Probing Questions: What would a plan of action with a fat client look like?

5) Can you tell me what the role of a doctor or health professional is in working with fat clients?
   Probing Question: What does the doctor-patient relationship look like?
   Probing Question: What types of things are discussed?
   Probing Question: What would a plan of action with a fat client look like?

6) Do you feel there are any specific problems within the medical profession's way of engaging with fat clients pertaining to weight discrimination?
   Probing Question: Do you think that fat people are treated the same as "thin"/"fit" people?

7) Do you feel there is a sub-culture of social workers within the organization?
   Probing Question: Do social workers and medical professionals have a common understanding of practice and perspectives with fat clients?
   Probing Question: Is there any tension/disconnects between social workers and doctors in regards to practices?

8) Social work is guided by principles set out by the CASW, (Canadian Association of Social Workers), do you feel that it is difficult to uphold these values and principles in this work setting?
   Probing Question: How or how is it not difficult?

9) How would you define Anti-oppressive practice in your role with fat clients?
   Probing Question: How would anti-oppressive practice look with with a fat client?

10) Is there anything else that you would like to discuss?

APPENDIX C

SCHOOL OF SOCIAL WORK
FACULTY OF COMMUNITY SERVICES
Accredited by the Canadian Association of Schools of Social Work

Consent Agreement

You are being invited to participate in a research study. Please read this consent form so that you understand what your participation will involve. Before you consent to participate, please ask any questions to be sure you understand what your participation will involve.

Study: Resisting Medical Discourses in Fat Social Work: An Exploration of Social Work Practice in Medical Settings

INVESTIGATORS:

This research study is being conducted by Taylor Thornton, School of Social Work, Masters of Social Work student. The supervisor of this research study is Susan Preston, MSW, PhD at Ryerson University.

If you have any questions or concerns about the research, please feel free to contact, Taylor Thornton, 350 Victoria Street, Toronto, ON M5B2K3, taylor.thornton@ryerson.ca

PURPOSE OF THE STUDY:

This study is designed to explore the experiences of social workers working with fat service-users in medical settings. The research question that guides my work is, 'How do social workers navigate conversations around fatness with service-users in medical settings from a social perspective?'

I am conducting this research to complete my major research paper, a requirement of my Master of Social Work degree.

There will be up to 5 research participants being recruited for this study. The eligibility requirements to identify prospective participants are: The research participants must be currently employed in a medical clinic at a community health centre in downtown Toronto, Ontario with a bachelor of social work degree or master of social work degree that is registered by the College of Social Workers. Participants must be doing direct practice work with clients at the community health centre. Participants may be of any age working in the organization for at least one year. Participants will not be students completing placement at the organization or working at the organization for less than one year, participants will not be workers of any other field other than social work. Participants will not be social service workers.

EXAMPLE INTERVIEW QUESTIONS:

The following are a few examples of questions that you can expect to be asked in the interview should you agree to participate:

11) What is your experience working as a social worker in a medical clinic within a community health centre?

12) What does social work practice with fat clients look like in this setting?

13) Can you tell me what the role of a doctor or health professional is in working with fat clients?

WHAT YOU WILL BE ASKED TO DO:

If you volunteer to participate in this study, you will be asked to do the following things:

CONSENT FORM

1) Sign the Ryerson University consent form. Take the time to read this form and ask questions about anything that you do not understand. After you have read the consent form and if you accept to be a participant in the study, please sign the areas requiring your signature.

ARRANGE A TIME TO MEET

2) You and I will arrange a time to meet for the interview. The interview can take place at Ryerson University in a private room that is secured with aural and visual privacy to ensure confidentiality. This is especially important due to the sensitivity of the information that may come up in the interview. You also have the option to choose a location that you would like to meet other than Ryerson University. The preferred location should be in a secured place with aural and visual privacy to ensure confidentiality. Public areas like coffee shops with not be used for interviews due to the sensitive nature of the research topic.

MEET FOR THE INTERVIEW

3) You will meet with me, the researcher, at the agreed interview time. Interviews will last between 1 to 2 hours in length with each participant. There will only be one interview per each participant for this research study.

REVIEW TRANSCRIPTION

4) Once I, the researcher, transcribes the interview, you will have an opportunity to read the transcription if you so wish. If you wish to review the transcript, I will either send you the transcript to you by email to review or I will set up an appointment with you to review the transcription together. During this time, you have the opportunity to approve or

remove any part of the interview that you wish. If I send you the transcript by email, you have one week to review the transcript and make any changes or approve from the day that it is sent. Once you approve the transcription, I will delete the transcription and proceed to complete the research paper. After the transcript is finalized, you can no longer withdraw from the research study or make changes to your responses in the transcript. Please indicate your wishes for transcript reviewing below.

FINAL COPY OF THE RESEARCH PAPER

5) Upon completion of the final major research paper, you will be sent a final copy of the research paper by any method of you choosing if you so wish. Please indicate below.

REVIEW TRANSCRIPTION AND FINAL MRP

□ I would like to review my transcript

□ I would like to set up an appointment to review the transcription with the researcher

□ I would like to be sent the transcript by email to review

□ I would like a copy of the final Major Research Paper

POTENTIAL BENEFITS:

I cannot guarantee, that you will receive any benefits from participating in this study. However, this study aims to bring light to the voices of social workers working in a medical setting within a community health centre, which can potentially give voice to issues that are not previously discussed in current literature.

WHAT ARE THE POTENTIAL RISKS TO YOU AS A PARTICIPANT:

Psychological risk (e.g. feeling anxious, upset or uncomfortable)

During the interview there is a risk that the social workers may experience psychological discomfort while they disclose experiences about their work in the often very challenging field of social work practice. Participants may also experience psychological discomfort if subject matter, either questions being asked, or recalling experiences present as triggering. The risk of this happening is low/minimal and community resources will be provided at the start of the interview to each participant to utilize if support is needed after the interview. If any questions make participants uncomfortable, participants can skip those questions and stop participation in the interview at any time.

Social risk (eg. Being exposed or embarrassed, potential loss of privacy, damage to reputation)

During the interview, there is the potential of a social risk in participants disclosing information that goes against the policies and procedures of the organization that they work in that may result

in disciplinary action or compromise their employment. The risk of this happening is low/minimal and participants will be given pseudonyms and information will be stored on a password protected device and destroyed after the study is complete. Participants will also have one month after the interview to drop out or remove information.

Personal identity being revealed (e.g. participant being identified either directly or inadvertently)

At the time of the interview, there is a chance that participants may be identified by people that they know at our meeting place. There is also the possibility of a participant being recognized by a co-worker or friend in the final research paper if they share an experience that was specific and identifiable to them. The risk of this happening is low/minimal and the interview location will be held in a private room that is secured with aural and visual privacy at either Ryerson University or a place of your choosing to maintain confidentiality. No personal information will be used in the research study and all information will be stored on a password protected device and participants will be assigned pseudonyms.

Financial risk (e.g. risk of job loss)

As mentioned under the social risk section, if a participant discloses information about their place of employment that conflicts with the organizational values, policy etc. They can face disciplinary action and/or risk of job loss. The risk of this happening is low/minimal and information will be stored on a password protected device as well as, participants will be assigned pseudonyms to maintain confidentiality. Participants will also have the opportunity to review their interview transcript to remove any information that they are uncomfortable with.

Legal risk (e.g. duty to report abuse or illegal activity discovered during the research process)

During the interview, participants may disclose information of illegal practice with clients or practice that compromises the values of the College of Social Workers that I have the duty to report. The risk of this happening is low/minimal and participants will be reminded of the duty to report prior to the interview.

CONFIDENTIALITY:

Everything pertaining to the study will be kept confidential and all transcriptions will be kept in a password protected file. All names will be made into pseudonyms and I will remind you about confidentiality before and after interviews to ensure that you understand that your name will not be used in the study and that their information will be stored on a password protected device. The interview will take place in a safe and secured location with aural and visual privacy at Ryerson University or a location of your choosing. If there are more than one interviews scheduled on one day, there will be a one-hour gap in between interviews to maintain confidentiality of participants. You will be advised that if you have any questions or concerns that you can contact the me, the researcher at any time. No personal information of identity will ever be included in the completed research publication. You will be asked to review/edit their interview transcripts to ensure you are comfortable with the information that you have provided.

The audio recordings and interview transcriptions will be kept in secured file on a computer in my home that only the myself, the researcher has access to. These files will be password protected in addition to the password needed to be able to log onto the computer. These files will remain on my computer until the final draft of the major research paper is complete (estimated completion August 2017). Once the final draft is submitted to school of social work, all files and transcriptions will be deleted from the computer and deleted a second time if they are put in the recycling bin. The audio files will be deleted once the transcriptions have been approved by the you. I anticipate completing the transcriptions within one to two weeks of each interview. The data will to be kept until the final paper is submitted for me to go back and make necessary changes with the information.

PARTICIPATION:

You will not be paid to participate in the research study.

COSTS TO PARTICIPATION:

If interviews are held at Ryerson University, there will be parking costs. You will be reimbursed of these costs the day of the interview.

VOLUNTARY PARTICIPATION AND WITHDRAWAL:

As a research participant, your participation is entirely voluntary. You have the right to remove yourself from the study up to one month after the interview. Withdrawal from the study will not influence future relations with the researcher, Taylor Thornton or Ryerson University. Should you choose to remove yourself from the study, all data be destroyed and not used in the study. During the interview, you have the right to refuse to answer any questions that you do not want to discuss or makes you uncomfortable.

QUESTIONS ABOUT THE STUDY:

If you have any questions about the research currently or in the future, please do not hesitate to contact me and ask any questions, Taylor Thornton, Social Worker, 350 Victoria Street, Toronto, Ontario M5B 2K3, taylor.thornton@ryerson.ca, or Susan Preston, Research Supervisor MSW, PhD, susan.preston@ryerson.ca

This study has been reviewed by the Ryerson University Research Ethics Board. If you have questions regarding your rights as a participant in this study, please contact:

Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042
rebchair@ryerson.ca

Resisting Medical Discourses in Fat Social Work Practice: An Exploration of Social Work Practice in Medical Settings

CONFIRMATION OF AGREEMENT:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to participate in the study and have been told that you can change your mind and withdraw your consent to participate up to one month after the interview. You have been given a copy of this agreement. You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

PSEUDONYM FOR NAME

Your signature below indicates that at no time, do you want your name to be used in the study and a pseudonym will be used instead.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

AUDIO-RECORDED

I agree to be audio-recorded for the purposes of this study. I understand how these recordings will be stored and destroyed and only the researcher, Taylor Thornton will have access to them.

_____ _____
Signature of Participant Date

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