# Learning to Disrupt Weight Stigma in Physiotherapy: A Constructivist Narrative Inquiry

by

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## Abstract

Weight stigma is pervasive in healthcare and is often reinforced through weight-centric approaches that pathologize fatness and position body weight as a primary indicator of health. Within physiotherapy, weight stigma has largely been conceptualized as a matter of individual attitudes or bias, with little attention paid to the interpretive processes through which weight-centered practices are normalized or challenged within clinical reasoning. In this study, I explored how physiotherapists make meaning of weight within clinical encounters.

Guided by a constructivist paradigm and Frank's (2010) socio-narratology, I did a qualitative narrative study using data from the Storying Physiotherapy project. Eleven physiotherapists, including four aligned with Health at Every Size® (HAES®), participated in semi-structured interviews. In the interviews, the participants responded to fictional clinical stories provided to them prior and they shared stories from their practice. I analyzed the data using dialogical narrative analysis, attending particularly to Frank's concepts of Trouble and Character.

Findings revealed that while participants often preferred similar stories, they differed in their interpretation of weight and if/how they recognized weight-centered practices as stigmatizing. I argue that weight stigma in physiotherapy is embedded not only in individual attitudes, but also in dominant understandings of bodies, health, responsibility, and "good" care. My study demonstrates how narrative approaches can surface the moral and professional assumptions shaping physiotherapy practice and support more reflective, weight-inclusive care.

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# Dedication

To God and my mother.

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# Introduction

Weight stigma is a significant issue within healthcare (Chrisler & Barney, 2017), directly impacting physiotherapy practice (Jones & Forhan, 2021; Setchell et al., 2015). Physiotherapists often encounter people in bigger bodies seeking expertise in managing pain, rehabilitation, and mobility challenges. An earlier systematic review of physiotherapy literature identified consistent evidence of weight stigma within the profession, including both explicit and implicit negative attitudes held by physiotherapists (Cavaleri et al., 2016). For example, Setchell (2014) demonstrated that physiotherapists exhibit measurable explicit and implicit weight bias, reflected in both attitudinal measures and clinical reasoning patterns. Complementing this, qualitative work has shown that patients perceive weight-related judgment within physiotherapy interactions, including through communication styles, clinical environments, and assumptions about body weight (Setchell et al., 2015). While weight stigma has been acknowledged in physiotherapy, much of the existing research tends to focus on the perception of the phenomenon – including more recent studies exploring how physiotherapists view weight stigma or the biases they harbor (Cavaleri et al., 2016; Groven & Heggen, 2018; Jones & Forhan, 2021; Rompolski & Pascoe, 2024; Webber et al., 2022). Despite this attention, only a few have attempted to explore or address how to disrupt this stigma in clinical settings, with limited effect (Jones & Forhan, 2021; Setchell et al., 2017; Thille et al., 2025).

There is a small subset of physiotherapists who align with the Health at Every Size (HAES®) approach (ASDAH, 2024) a framework developed over twenty years ago that advocates for anti-oppressive, size-inclusive care for people of all body sizes. HAES® practitioners are consciously working to shift the narrative in their everyday practices, attempting to destigmatize their

interactions with people in bigger bodies. However, no studies to date explore HAES® practice in physiotherapy, and more broadly, we lack a critical understanding of how physiotherapists are already actively disrupting weight stigma. This gap leaves us more uncertain about what, specific to physiotherapy, we should address if we aim to disrupt weight stigma in physiotherapy practice on a wider scale.

Learning from those already explicitly practicing in an anti-stigma model can help identify opportunities for future effective interventions in physiotherapy. This thesis explores the influences shaping clinical reasoning and weight-destigmatizing practices in physiotherapy. This thesis study is embedded within a larger narrative project, that included a story completion component, then invited physiotherapists to interpret fictional stories within an interview to explore weight stigma in physiotherapy. Interviews, completed in Nov 2023 – Jan 2024, included 4 HAES®-aligned physiotherapists and 7 who do not identify as such from Canada, Australia, and the USA. For my thesis, I used data from the eleven interviews to:

- explore how physiotherapists interpret weight stigma in the stories,
- compare and contrast interpretations between HAES®-aligned physiotherapists and other participants, and
- compare and contrast influences they perceive as informing their interpretations.

My thesis challenges the current discourse on weight stigma in physiotherapy, by providing valuable knowledge for those seeking to transform the physiotherapy field with the ultimate aim of contributing to the development of more equitable and inclusive clinical practices for patients of all body sizes.

## Literature Review

Weight stigma is a pervasive form of discrimination in healthcare (Chrisler & Barney, 2017; Pearl, 2018; Puhl et al., 2020). It is deeply rooted in societal narratives and reinforced through medical practices that continually monitor, regulate, and shape bodies to fit normative ideals (Lupton, 2018). Like all stigmas, weight stigma is a socially constructed force, meaning it is created and given meaning through shared beliefs, norms, and practices within a society. In this context, societal views of body fat are shaped by cultural narratives, media representations, historical trends, and social norms that determine what is considered ideal or acceptable. Weight stigma is underpinned by dominant discourses that view higher body fat as inherently undesirable and/or in need of correction (Blanchette, 2020; Gailey, 2023; Harjunen, 2023; Lupton, 2018; Rich & Mansfield, 2019).

The process of stigmatization unfolds through a series of social mechanisms (Link & Phelan, 2001). Stigma occurs when groups with a shared characteristic or history are labeled, subjected to negative stereotypes, categorized as "them" (vs "us") and consequently experience status loss and discrimination; these four can only occur when powerful institutions, such as healthcare, reproduce these about groups of people (Link & Phelan, 2001). Said another way, these five elements – labeling, stereotyping, separation, status loss, and discrimination, as reproduced by powerful institutions – work in concert to stigmatize individuals, creating systemic barriers that impact their lives and health. Anti-fat stigma relies on the social construction that higher body weight deviates from the norm and reflects personal shortcomings; individuals in larger bodies are frequently stereotyped as lacking discipline, being lazy, unintelligent, unmotivated, and fundamentally lacking in many ways (Hill, 2023; Lawrence et al., 2021; Puhl et al., 2020; Puhl &

Heuer, 2009). This social construction positions people with bodies with visible fat as problematic, reinforcing systems of bias that manifest in spaces, including those designed to provide care (Harjunen, 2017). Healthcare providers operating within the biomedical framework routinely, sometimes unintentionally, perpetuate weight stigma through their clinical reasoning and practice (Lawrence et al., 2021; Phelan et al., 2015; Puhl et al., 2014).

## Foundations of Weight Stigma in Healthcare

In healthcare, weight stigma is widespread. Research highlights the prevalence of weight-biased attitudes across a wide range of healthcare professions (Alberga et al., 2019; Ryan et al., 2023; Tomiyama et al., 2018), including physiotherapy (Cavaleri et al., 2016; Rompolski & Pascoe, 2024; Webber et al., 2022). Weight stigma manifests in multiple ways, including through attitudes and practices of healthcare professionals (Chrisler & Barney, 2017; Lawrence et al., 2021) which shape patient experiences (Puhl et al., 2021; Ryan et al., 2023). From language use among healthcare professionals to dismissive judgments dished out to patients (Ryan et al., 2023), weight stigma persists in medical spaces. Its effects are profound. A (2019) scoping review explored the impact of weight bias in healthcare, specifically its influence on healthcare utilization among people who have visible body fat. The scoping review identified recurring themes illustrating the detrimental effects of weight stigma in healthcare, including biased assumptions about body weight, poor outcomes due to poorer treatment measures (as found in Tomiyama et al., 2018), clinicians attributing all health issues to ‘excess’ weight, and frequent unsolicited weight-loss advice (consistent with Standen et al., 2024). These practices are ‘weight-centric’, meaning they frame body size as the sole or a primary determinant of health (Phelan et al., 2015), potentially

ousting other relevant factors and consequently leading to inadequate care (Alberga et al., 2019; Ryan et al., 2023). Systemic biases and practices such as these influence patients' care-seeking behaviors, contribute to poorer health outcomes (Phelan et al., 2015), and further, reinforce inequities in healthcare systems (Pearl, 2018).

Weight stigma is expressed in everyday social interactions, but its roots in healthcare relate to a culture that tends to favor a disease/cure way of practice. Biomedical culture imposes order on the concept of health and illness through nosology, a classification system that defines and distinguishes 'being sick' based on detectable traits, shaping not only how conditions are diagnosed and treated but also how health and illness are understood within its context (Singer & Clair, 2003). The biomedical perspective, with its longstanding tendency to pathologize body size, has played a central role in shaping stigmatizing clinical practices (Harjunen, 2017). Biomedicine often equates bodily fatness to a morbid disease (Hofmann, 2016), and it has a given name, 'obesity.' Such medicalization negates fatness as a natural variance in human bodies (Farrell, 2023) and reduces individuals to a numerical value (Ryan et al., 2023), such as Body Mass Index (BMI), which is recognized as a flawed metric but continues to be used (Flegal, 2021; Tylka et al., 2014). 'Obesity,' as higher body weight is often labeled within medicine, has recently been defined as a disease in healthcare and health policy literature (Flegal, 2021). Obesity Canada (2025) calls 'obesity' a "chronic disease," while the World Health Organization (2025) defines it as "abnormal or excessive fat accumulation that presents a risk to health," using the BMI as a marker of what is 'excessive' and not.

The medicalization of bodily fatness rests on a flawed metric: BMI (Harjunen, 2017; Nicholls, 2013). Originally designed as a population-level statistical tool, BMI was never intended

for individual health assessments (Flegal, 2021). Yet, its widespread use as a diagnostic criterion has led to the rigid classification of diverse body types into “normal,” “overweight,” or “obese,” reinforcing the idea that body measurements alone dictate health status. Despite a growing body of research demonstrating the limitations of BMI as an indicator of individual health, such critiques have been actively contested within medical and public health discourse (Brown & Ellis-Ordway, 2021; De Brún et al., 2014), allowing BMI to retain its authority as a clinical and policy tool. In this way, BMI-based categorization persists not because of its scientific robustness, but because of its alignment with dominant biomedical and public health priorities. BMI-based categorization ignores broader structural determinants of health such as socioeconomic factors, systemic inequalities, and environmental conditions which play a critical role in shaping health outcomes (Thille et al., 2017). However, within a medicalized, weight-centric model, these determinants are often sidelined in favor of an individualistic narrative of personal responsibility, which is consistent with the concept of healthism.

Healthism describes the ideology that positions health as an individual’s responsibility and a moral obligation (Harjunen, 2017), emphasising that maintaining one’s health is not only a personal duty but also a duty to others. Health becomes a measure of moral and social worth (Harjunen, 2021; Saguy, 2013). This ideology has deep roots in neoliberalism, which prioritizes self-reliance, personal accountability, and the moral value of self-discipline (Harjunen, 2017) aligning seamlessly with biomedicine’s impulse to classify, control, and manage the fat body (Harjunen, 2017). Healthism perpetuates the pathologization of fatness in healthcare because fatness is culturally constructed as an issue of laziness and/or intelligence, thus a failure of the individual. Healthism legitimizes healthcare practices and policies that center on weight

(Harjunen, 2021). This ideology subjects the fat body to a stigmatizing social gaze, as it is expected to conform to pro-thin ideals – a practice that assumes that weight loss is an attainable and necessary goal (Lupton, 2018). Healthism intersects with biomedical authority to influence decisions made about body fat in healthcare settings (Harjunen, 2021; Saguy, 2013).

My study starts from the understanding that many physiotherapists potentially operate within a biomedical, weight-centric, and healthist framework where bodies are measured, monitored, categorized, and acted upon to conform to a standardized norm (Groven & Heggen, 2018; Nicholls & Gibson, 2010). This monitoring can extend to rehabilitation and fitness programs, where achieving "normal" body weight becomes a central goal, sidelining broader rehabilitative goals. This framework influences the approach to patient care, from diagnostic focus to treatment goals, communication, and recommendations. Stigmatizing care not only compromises the quality of healthcare offered but also contributes to broader societal biases against individuals with larger bodies (Lupton, 2018; Phelan et al., 2015; Rich & Mansfield, 2019). The result is a vicious cycle of marginalization, where stigma in healthcare settings feeds into societal discrimination, further entrenching systemic inequities (Phelan et al., 2015).

## Weight Stigma in Physiotherapy

Physiotherapy promotes movement, function, and well-being across diverse populations. Despite the profession's traditional focus on rehabilitation, physiotherapy has increasingly found itself entwined with weight management efforts (Allison et al., 2019; Bennell et al., 2022; Martinello et al., 2017), particularly in conditions where body weight is perceived to contribute to pain or impaired mobility (Bennell et al., 2022; Hall et al., 2021; Lawford et al., 2022; Sampford

et al., 2023). This shift has been driven by clinical guidelines that recommend weight reduction as a strategy for improving patient outcomes (Thille, 2018), especially in cases of osteoarthritis, metabolic conditions, and cardiovascular disease (Allison et al., 2019; Bennell et al., 2022; Hall et al., 2021; Sampford et al., 2023). The profession's entanglement with weight management may exacerbate a negative reality – the presence of weight stigma in physiotherapy practice. Across studies and countries, some physiotherapists and those in training hold implicit and explicit anti-fat biases (Cavaleri et al., 2016; Elboim-Gabyzon et al., 2020; Rompolski & Pascoe, 2024; Webber et al., 2022), which can manifest through clinical interactions and influence patient care and outcomes (Addington et al., 2024; Setchell et al., 2016).

As in other healthcare disciplines, weight stigma in physiotherapy is not only expressed through clinicians' attitudes, but embedded in the very conditions of care, shaping how patients experience clinical environments, interactions, and their own bodies within treatment spaces. Patients report that physiotherapy settings can make body weight highly visible and consequential, even when weight is not the explicit focus of care (Setchell et al., 2015). Participants in Setchell et al. (2015) described entering physiotherapy with an expectation that weight would be judged or scrutinized, informed by prior healthcare and fitness-related encounters. These anticipatory experiences position physiotherapy as a space where weight is already salient before any clinical interaction occurs. Within the clinical environment itself, physical and material features of physiotherapy practice may inadvertently reinforce stigma. The prominence of mirrors, visibility of exercise equipment, open treatment spaces, and clinic imagery privileging thin bodies can heighten self-consciousness and fear of judgment among patients in larger bodies (Setchell et al., 2015). Similarly, inadequate equipment or furniture that

does not accommodate diverse body sizes may limit participation and signal exclusion, shaping both patients' willingness to engage in care and clinicians' ability to provide it. These features are not neutral; they contribute to a clinical atmosphere in which some bodies are implicitly positioned as normative and others as problematic.

Weight stigma also operates through interactional dynamics. Patients describe physiotherapy encounters as sites where communication styles, assumptions about weight, and the handling of sensitive topics can either mitigate or intensify experiences of stigma. Paternalistic or educative communication – where clinicians "tell" rather than collaborate – has been perceived as dismissive or judgmental, whereas person-centred and collaborative approaches are associated with greater comfort and trust (Naylor et al., 2023). Even beyond explicit discussions of weight, general interpersonal qualities such as empathy, attentiveness, and respect shape how weight-related messages are received (Setchell et al., 2015). These experiences have tangible consequences. Weight stigma in physiotherapy is associated with reduced trust in clinicians, avoidance of care, and decreased engagement in prescribed physical activity (Addington et al., 2024; Setchell et al., 2015). Patients may also internalize negative judgments, experiencing shame, self-blame, and heightened body awareness within treatment contexts, particularly after dismissive or stigmatizing interactions with healthcare providers (Addington et al., 2024). In this way, physiotherapy – despite its rehabilitative intent – becomes a site where stigma is both anticipated and reproduced, with strong implications for patient outcomes and access to care. Despite the established prevalence and significant impacts of weight stigma, the profession has yet to meaningfully break ground in the disruption of weight stigma in physiotherapy. This section

critically examines the existing research, emphasizing the need for a transformative shift in approaching weight stigma in physiotherapy practice.

The bulk of studies about weight stigma in physiotherapy only start to illuminate the problem. Efforts to study weight stigma in physiotherapy have largely focused on evaluating beliefs and attitudes toward people with visibly more body fat (Cavaleri et al., 2016; Elboim-Gabyzon et al., 2020; Jones & Forhan, 2021; Rompolski & Pascoe, 2024; Webber et al., 2022) and they highlight the pervasive nature of bias within both professional training and clinical practice. Weight stigma in physiotherapy does not emerge in isolation within clinical settings – it may have roots in physiotherapy education, where a pro-thinness orientation may be reinforced, and even earlier. Webber et al. (2022) explored weight bias among both physiotherapy students and practicing physiotherapists, arguing that attitudes toward body size do not begin at the point of clinical practice but are already present during training as a result of prior socialisation. Similarly, Rompolski and Pascoe (2024) investigate how anatomical dissection training may reinforce implicit weight bias among physiotherapy students, suggesting that exposure to anatomical variations in cadavers could shape perceptions of body size in clinical contexts. While these studies point to potential origins of weight bias in physiotherapy education, other work surfaces how such orientations are enacted and experienced within practice. Setchell et al.'s (2014) cross-sectional survey provides empirical evidence of weight stigma among Australian physiotherapists, showing that many practitioners hold weight-related biases that can influence patient interactions and treatment decisions. Complementing this, their study on patient perceptions (Setchell et al., 2015) exposes the tangible impact of these biases, with individuals with larger bodies reporting feelings of judgment, blame, and inadequate care from physiotherapists.

Only three published studies have attempted to disrupt weight stigma in physiotherapy (Jones & Forhan, 2021; Setchell et al., 2017; Thille et al., 2025). The first, by (Jones & Forhan, 2021) determined if a one-day educational seminar impacts physiotherapists' attitudes and beliefs about 'obesity'. Taking up a biomedical frame, the researchers presented the complexity of 'obesity' causation and practical strategies for working sensitively with patients with larger bodies. While the seminar modestly improved participants' beliefs about 'obesity' being outside an individual's control via a standardized measure compared pre/post workshop, to the researchers' surprise, it worsened weight-stigmatizing attitudes. The authors highlight the limitations of short-term, knowledge-focused interventions and underscores the critical need for sustained, theory-driven approaches to actively disrupt weight stigma in physiotherapy (Jones & Forhan, 2021). This limitation highlights problems with treating weight stigma as an issue of knowledge deficit rather than a reflection of broader societal and professional power dynamics.

The second, by Setchell & colleagues (2017), takes a different approach from Jones & Forhan's biomedical one. They argue, drawing on Goffman's concept of stigma and Foucault's exploration of power and discourse, that social theory frameworks offer valuable insights into the persistence of weight stigma in physiotherapy. They argue that post-structuralist perspectives, which emphasize the role of language, discourse, and power in constructing knowledge, offer a more nuanced understanding of how weight stigma operates within the profession (Setchell et al., 2017). Applying these theoretical insights, they argue that interventions that merely aim to reduce negative attitudes are not likely to succeed unless they also address the structural conditions that perpetuate stigma. Rather than offering education on 'obesity,' Setchell et al.'s (2017) action research project emphasized the importance of reflexivity and critical engagement

with the determinants of weight stigma (Setchell et al., 2017). By embedding these discussions within a broader critique of how the physiotherapy profession conceptualizes bodies, health, and normalcy, their project aimed to create a more sustained shift in perspective. While their approach was innovative, it was not without limitations. The qualitative study found physiotherapists shifted perspectives but did not explore whether these perspective changes were sustained or led to better non-stigmatizing practices or better patient experiences. Nevertheless, the study provides a starting point for understanding how weight stigma could be challenged within physiotherapy, particularly by highlighting the need for deeper engagement with the profession's underlying values and discourses through active, reflexive learning opportunities.

More recently, Thille et al. (2025) extend this conversation by explicitly situating weight stigma as an ongoing and embedded feature of everyday physiotherapy practice rather than an isolated issue of individual bias. Drawing on critical reflection pedagogy, their workshop-based study aimed to foster "movement" toward anti-stigmatizing practice through reflexivity. Participants engaged with the material, often confronting their own complicity in reproducing stigma and grappling with discomfort, uncertainty, and defensiveness. While most participants demonstrated openness to learning, a key finding was that few possessed concrete strategies to disrupt weight stigma in practice, despite recognizing it as a problem. This study highlights a critical limitation in existing approaches: even when awareness is present, it does not readily translate into practice change. Thille et al. (2025) argue that disrupting weight stigma requires more than shifts in attitudes or knowledge; it requires "disrupting the ongoing flow" of taken-for-granted practices, assumptions, and clinical routines that reproduce stigma in subtle and

normalized ways. In this sense, weight stigma persists not simply because clinicians lack awareness, but because it is embedded within the everyday logics of care that structure physiotherapy practice.

## Disrupting Weight Stigma in Physiotherapy

The studies by Jones & Forhan (2021) and Setchell et al. (2017) represent the primary published attempts to challenge weight stigma in the profession. These studies provided valuable insights into how physiotherapists conceptualize weight and bias, however, they are grounded in different conceptualizations of change. Jones & Forhan (2021) treat stigma largely as a problem of knowledge and attitudes, addressed through educational intervention, whereas Setchell et al. (2017) adopt a reflexive and critical orientation that interrogates how stigma is produced through professional discourse and practice. Despite these differences, neither approach fully addresses how physiotherapists translate these insights into sustained, non-stigmatizing clinical practice. It is not enough to teach physiotherapists to be less biased; they must also learn how to practice in a non-stigmatizing way. Thille et al. (2025) reinforces this gap, demonstrating that even when physiotherapists recognize weight stigma and engage reflexively with the issue, they often lack concrete strategies to disrupt it in everyday practice. Their findings suggest that awareness and reflection alone are insufficient without attention to how stigma is enacted through routine clinical interactions and decision-making.

The limitations of interventions addressing a knowledge-deficit become evident when considering their underlying assumptions. Physiotherapists may intellectually understand that weight stigma is harmful, but without practical guidance on how to apply anti-stigma principles in real-world clinical settings, the knowledge remains theoretical rather than transformative. A

scoping review by Talumaa et al. (2022) found that educational interventions frequently produced mixed outcomes, with some studies demonstrating improvements in beliefs about weight while attitudes remained unchanged or worsened, and others showing effects that diminished over time. Even multi-component interventions struggled to meaningfully shift implicit bias or sustain changes in practice. These findings suggest that increasing knowledge alone is insufficient to disrupt weight stigma, particularly when interventions remain disconnected from the realities of clinical practice. This perspective fails to account for the complexity of how knowledge is received and applied in clinical practice. Physiotherapists are not empty containers waiting to be filled with new anti-bias knowledge, a notion Freire & Ramos (2009) critiques as the "banking" approach to education, where learners are treated as passive recipients of information rather than active participants in meaning-making. Physiotherapists, rather, bring existing beliefs, values, professional experiences, and cultural understandings that shape how they interpret and integrate new information. A one-day workshop, such as that held by Jones & Forhan (2021) cannot produce uniform results across practitioners with diverse backgrounds, as each participant filters the knowledge through their own lived experiences. To disrupt weight stigma, I propose a constructivist approach – one that recognizes knowledge as socially constructed, context-dependent, and shaped by experience. Rather than viewing physiotherapists as passive recipients of anti-bias training, this perspective emphasizes active, experiential learning and practice-based change, building on the reflexive work initiated in physiotherapy (Setchell et al., 2017).

One avenue for advancing this work is to learn from physiotherapists who already practice within a weight-inclusive framework. The Health at Every Size (HAES®) model emerged in the late

1990s from collaborations among healthcare providers, consumers, and activists who reject the reliance on weight, size, or BMI as indicators of health and challenge the misconception that weight is solely determined by personal choices, independent of genetic and environmental factors (ASDAH, 2024). This model emphasizes broader determinants of health, such as equitable and affordable access to care, and offers supports in adopting sustainable practices that enhance personal and community well-being (ASDAH, 2024). Rooted in a social justice framework, HAES® values the healing power of social connections and addresses the diverse experiences and needs of the communities it serves. At its core, HAES® rejects the biomedical, weight-centric, healthist framing that dominates healthcare thinking about weight at present.

In its first iteration, the model advocated for and emphasised supporting health-promoting behaviors – such as balanced nutrition, joyful movement, stress management – and access to quality healthcare without making weight loss the goal (ASDAH, 2024). Its most recent iteration, published in 2024, HAES® challenges healthism more directly; the model de-emphasizes particular health-promoting behaviours, instead recommending the right to access compassionate, bias-free care regardless of health status or health practices (ASDAH, 2024). Healthcare practitioners and educators integrating HAES® principles into their practice recognize that health is far more than numbers on a scale, but a complex, dynamic experience shaped by social, political, environmental, and personal factors (ASDAH, 2024). In this model, health is not a moral obligation nor a prerequisite for dignity and care.

While some physiotherapists have started to adopt this model, how they do so remain unknown; the model is not specifically designed for or with physiotherapy in mind (Tylka et al., 2014). The lack of critical understanding of the effectiveness and nuances of the destigmatizing

practices represents a critical gap, as it leaves physiotherapy practitioners without the tools needed to move their practices into inclusive and accessible healthcare.

## Paradigm

Constructivism asserts that knowledge is actively constructed by individuals through their interactions with information, experiences, and social contexts (Leavy, 2022; Narayan et al., 2012). Constructivism aligns with the study's aim of understanding how physiotherapists make sense of weight stigma in clinical settings through their interactions with stories. Physiotherapists, like all learners, are not passive recipients of information but are active participants in making sense of information and situations. In this study, we have invited physiotherapists into an interpretive process, exploring how their prior knowledge, usual approach to clinical practices, and personal values influence their understanding of weight stigma and its potential disruption. This process reflects the core constructivist principle that knowledge is built through interaction, shaped by a person's prior experiences and cultural context (Leavy, 2022).

The philosophical assumptions of constructivism strengthen its relevance to this research. Ontologically, constructivism embraces relativism, which rejects the notion of a single truth (Narayan et al., 2012), and instead posits that knowledge is relative to the individual, their culture, and their lived experiences. In this study, the physiotherapists' interpretations of how weight stigma manifests and is challenged are not seen as definitive truths, but as subjective constructions informed by their uniquely different contexts, clinically or socially.

## Methodology

Methodologically, the constructivist paradigm employs hermeneutic dialecticism, a process of interpreting individual constructions and comparing them through dialogue and reasoning (Narayan et al., 2012). This qualitative study aligns with this methodological assumption in that hermeneutics allows for a nuanced analysis of the physiotherapists' construction of problems in physiotherapy care (including weight stigma), while dialectical reasoning creates space to compare and contrast the interpretations across participants, identifying patterns and divergences.

As introduced earlier, this study uses stories as a central methodological tool. In the hands of people, stories do more than narrate; they work on and for people (Frank, 2010). Drawing on Frank's socio-narratology theory detailed in *Letting Stories Breathe,* two unique capacities of stories are explored in this study: their capacity to grapple with 'Trouble' and their capacity to reveal and test 'Character' (Frank, 2010). The first capacity is about capital-T Trouble. As Bruner and Burke (cited by Frank, 2010) emphasized, stories center on rupture: they show how people confront, negotiate, and sometimes fail to resolve disturbances. Without Trouble, there is no story to tell. I describe Trouble as a force that acts on a state of inertia, unsettling and then transforming a situation into something story-worthy. Frank then pushes this idea further, noting that stories do not merely represent Trouble; they are themselves agents of Trouble. Stories shape listeners' expectations, rattle certainties, and may even incite action or confusion, depending on how they circulate. In Frank's socio-narratology (2010), the attention centers on how stories depict troubles in the world and how stories themselves become troubling forces, disrupting ideas, beliefs, and social orders.

The second capacity, 'Character,' highlights the moral and positioning work that stories perform. "Stories have a singular capacity to delve the character of characters who deal with trouble" (Frank, 2010, p. 29). According to Frank (2010), stories test and form character from individuals' responses to Trouble. He (2010) highlights that stories not only offer portraits of character but also circulate ideals within groups, teaching what is acceptable or not. As such, listeners come to recognize patterns of responsibility, aspiration, and failure through narratives. Thus, stories act both as mirrors and molds: they show us examples of how to be in the world while simultaneously equipping us to imagine, resist, or accept particular ways of doing life. These two capacities of stories – Trouble and Character - provide a compelling rationale for employing narrative methods within a constructivist qualitative framework.

Narrative methods are particularly suited to the constructivist paradigm as they allow for the exploration of subjective experiences and the processes by which individuals make meaning (Leavy, 2022). In this study, fictional stories offer an avenue for understanding how physiotherapists interpret weight and weight stigma, as well as share assumptions and knowledge that shape their clinical practices.

My MSc thesis is embedded within a larger narrative study, *Storying Physiotherapy*, involving story completion and semi-structured interview methods with physiotherapists from Canada, the USA, and Australia, guided by a public advisory board of eight women with varying backgrounds but who share regular experiences of weight stigma in healthcare. First, fictional stories of weight stigma and physiotherapy were created through a story completion segment in the larger narrative study. Two story prompts were written based on the public advisory board members experiences; both embed an already-recognized way that weight stigmatization occurs

in healthcare. These prompts are a brief start to a story introducing situation, characters, and an emotive tinge, from which participants then complete the story.

> Brenda Story Prompt: Brenda plays hockey and has had several minor injuries. Her knee has been really bothering her lately, so she started seeing a physiotherapist. The therapist gave her a home exercise program to start doing before her next appointment, which Brenda is hopeful will help. The physiotherapist then suggested that losing weight might also help her knee pain. Brenda says, "I don't see how that will help."
>
> Jo Story Prompt: Jo has been waiting for months to see the specialist pelvic floor physiotherapist. After being squished by a waiting room chair, Jo has been left alone in the initial assessment room to change clothes. The room is hard to turn around in, and Jo has spent the past five minutes staring bleakly at an exam room gown that is about four times too small for them. The ties won't even touch when they put the gown on their body. The physiotherapist knocks at the door, and asks “are you ready?"

Physiotherapy participants were invited to complete fictional physiotherapy stories created from those prompts. After the story completion stage, eleven varying stories were selected with the public advisory board with which interview participants would engage (six from the Brenda story prompt, five from Jo story prompt). The fictional stories were then used as a methodological tool to prompt reflection and elicit interpretations from participants in semi-structured interviews, and as a tool to allow for comparison of fiction to their own practices.

## Sampling, Participants, and Setting

Purposive sampling focused on the inclusion of both HAES®-aligned practitioners and those without a background in HAES® in the interviews, enabling meaningful comparisons. The

key purposive sampling criteria was HAES® training; the study recruited four HAES®-aligned physiotherapists for an interview and seven who were not. Gender and nationality were the additional criteria by which purposive sampling shaped the non-HAES® physiotherapist participants. Participants were from Canada, Australia, and the USA to gain access to HAES® physiotherapists (who are rare, in general, and very uncommon in Canada). In the week prior to the interview, the interviewer shared the selected stories (Appendices 1 & 2) and key questions about the stories from the interview guide (questions 1-5, Appendix 3) with the eleven physiotherapists who consented to interviews. The participants received an email (see Appendix 4) to review the story prompts prior to the interview. The study's principal investigator, Dr. Patty Thille, conducted semi-structured interviews between November 2023 and January 2024. The interviews ranged from 60 to 90 mins and were carried out via Microsoft (MS) Teams, allowing for participation from geographically diverse locations.

The interviews addressed five topics: the participants' demographics; how they engaged with and reasoned through the fictional stories; their clinical practice; beliefs about weight and familiarity with weight stigma; and training/philosophies that influence their practice style. By responding to fictional scenarios, participants identify problematic or effective practices and at times, relate their interpretation to influences underlying their professional practice. It is important to note that neither the interview guide nor the interview processes itself explicitly foregrounded concepts such as stigma, discrimination, or systems of oppression. Instead, non-directive language was used to discuss body size and composition, allowing participants to introduce these concepts on their own terms. This approach was consistent with the broader study design, which was framed under the title "Storying Physiotherapy" and did not explicitly

signal a focus on weight stigma in the recruitment ads or consent forms. The interview guide is provided in Appendix 3.

My MSc focuses on a portion of the larger study. My MSc aims to explore the influences shaping clinical reasoning as well as weight destigmatizing practices in physiotherapy. Using data from the physiotherapists' interaction with 11 stories in the interviews, my study specifically:

- explored how physiotherapists interpret weight stigma in the stories,
- compared and contrasted interpretations between HAES®-aligned physiotherapists and other participants, and
- compared and contrasted influences participants perceive as informing their interpretations.

## Ethical Considerations

The execution of the study was guided by a public advisory board of eight women. Each have everyday experience of weight stigma in healthcare and have accessed physiotherapy. They have differing backgrounds. Three are Indigenous, one is Black, and four are White. At the start of the study in 2022, three identified as having a disability and a fourth had mobility challenges. Two were seniors (60 years old or older). The group is co-led by the principal investigator, Dr. Patty Thille, and a lay member of the public with lived experience of weight stigma who had previously participated in a public engagement project. During the course of twelve, two-hour public advisory meetings (at the time of writing), they have shaped the story prompts, the stories chosen for the interviews, the interview topics, and knowledge translation plans and activities. By centering a physically, racially, and experientially diverse public advisory board, this research

acknowledges that marginalized groups possess critical epistemic authority. The collaboration with the public advisory board strengthens the ethical rigor of this study, where their voices are not merely included, but power is structurally redistributed within the research process, producing knowledge that is more accountable to those who have been harmed by weight stigma in healthcare, including physiotherapy.

An additional ethical practice was the choice of data collection method. Fictional stories allow exploration of weight stigma without requiring participants to disclose sensitive personal or professional experiences.

The larger project protected confidentiality in multiple ways. Specific to my thesis data, physiotherapy participants provided written informed consent prior to their involvement, which the interviewer confirmed verbally at the start of the interviews. All interviews were conducted with a focus on confidentiality and respect. Interviews were video-recorded and securely stored within MS Teams (i.e., an ethics-approved, secure cloud platform), with each file assigned an anonymized participant number. To strengthen transparency, participants chose their own pseudonyms, which is used in the transcripts.

The study is approved by the University of Manitoba's Health Research Ethics Board (HS25401(H2022:087)).

## Data Analysis and Interpretation Strategies

This study uses a narrative analysis method grounded in Frank's (2010) socio-narratology, which aligns with the hermeneutic and dialectical assumptions of the constructivist theory. Drawing from Narayan and colleagues' (2012) description of constructivism, this analysis

acknowledges that meaning is actively constructed through engagement with narratives rather than passively absorbed. Physiotherapists' interpretations of weight stigma from the fictional stories, therefore, are not mere reflections of objective reality but are shaped by their professional training, personal experiences, and the discourses that inform physiotherapy practice. Frank (2010) provides an essential lens through which to understand how stories work-on people – provoking reflection, shaping professional identities, and revealing underlying tensions in healthcare discourses.

Consistent with this approach, the analytic process did not adhere to a fixed formula. As Frank writes, socio-narratology "dispenses with the baggage of seeking any formal underlying model of competence" (Frank, 2010, p.13), rejecting bureaucratic forms of analysis, privileging instead a 'dialogical narrative analysis' that involves a thoughtful, reflexive questioning of narrative data (Frank, 2010). This orientation to data analysis is further supported by Eakin and Gladstone's (2020) notion of value-adding analysis, which frames qualitative interpretation as a form of creative presence. Rather than applying a standard analytic template, the researcher is immersed in the data, attending to its nuances through iterative reflection, dialogue, writing, and responsiveness to context. Accordingly, my analytic strategy was developed not as a prescriptive method but as a flexible, critically attentive practice geared toward answering the study's core research questions. I describe this in detail below.

## Data Preparation and Organization

Maintaining consistency in data preparation is essential. After the PI completed the video interviews, I assumed responsibility for developing the transcription conventions (see Appendix 5) that would be used across the dataset. Transcription is one step in qualitative research that

appears to be an administrative or preparatory task, but in fact, constitutes a vital part of the analytic process (McMullin, 2023). Attending closely to how participants narrated their responses, both verbal and non-verbally, was central to the study's interpretive aims. The detail that follows is not merely procedural; rather, it shows how transcription became a site of analytical engagement, deeply informed by the epistemological and methodological commitments of this research.

## Transcription

In qualitative research, transcription of interviews holds paramount importance as it serves as the foundation upon which subsequent analysis and interpretation are built (Altheide et al., 2011; McMullin, 2023). It is widely acknowledged that transcripts are meant to be "verbatim" accounts of what transpired during qualitative data collection (Poland, 1995). Poland (1995) calls that a tacit assumption rather than an observable and verifiable assertion. I initially approached transcription with the expectation that it should reproduce, word-for-word, the audio data. However, after engaging with both the methodological literature about transcription and the data itself, I began to reconceptualize what makes a transcript rigorous. Rather than centering only on "what is said," I shifted focus toward "how it is said," attending to pauses, tone, hesitations, and non-verbal cues; elements that carry meaning but are often lost in text (Altheide et al., 2011). This is not to say that transcripts do not need to accurately represent participants' words, but the quality of a transcript transcends a 'verbatim' written text. The rigor lies in the process (Tracy, 2010).

Transcription is not a research process without flaws (Poland, 1995). The conceptions of verbatim accounts and transcription errors is underpinned by an underlying positivistic ideology,

that assumes perfect accuracy is possible. Furthermore, there is the lack of a standardized convention to ensure word-for-word reproduction in written texts (Altheide et al., 2011). Many standardized transcription conventions co-exist, that emphasize different types of detail regarding what is said and how it is communicated. Yet many researchers develop their own, often using diverse but similar strategies, without showing what informed their decisions (Lapadat & Lindsay, 1998). Researchers must therefore make and justify informed transcription choices appropriate to their methodological and analytical aims.

For this study, I began by familiarizing myself with one interview in full, deliberately setting aside pre-existing models and allowing the data to shape my approach. In a second viewing, I began to pick up on patterns – gestures, silences, and affective expressions that contributed meaningfully to participants' interpretations. These observations informed the development of an initial transcription guide, which I refined in consultation with my advisor who is also the PI. We discussed forms of communication that extend beyond the verbal, including facial expressions, strategic silences, intonation. I reworked the guide to better accommodate these layers of meaning. At this stage, I transitioned to re-working in the MS Teams' auto-transcriptions, expanding them with interpretive detail and consistent formatting to support later analysis.

Consistency in formatting and style is another key aspect of rigorous transcription (McMullin, 2023; Poland, 1995). Consistent conventions minimize ambiguity and facilitate comparative reading, especially when working within a research team. The quality of transcripts transcends mere textual reproduction; it is intertwined with the analytical process from its inception. Decisions about what to transcribe, and how, are inextricably tied to research aims. In this case, the goal is not just to reproduce dialogue but to trace the interpretive work participants

perform as they engage with stories. That means treating transcription as both data preparation and early-stage analysis. Indeed, as I immersed myself further, I found that transcription became an entry point into interpretation. I began noticing patterns, raising questions, and forming early analytic insights. This was not a separate stage of the research; it was the beginning of analysis itself, and I wrote analytic and reflexive memos during this time.

## Immersion

Immersion, often positioned as a preliminary step, is central to the analytic integrity of qualitative inquiry (Braun & Clarke, 2021). Spending extended time with the data helped me tune into the emotions, pacing, and ways physiotherapists made sense of the fictional stories. As I watched and re-watched the recordings, wrote summary memos, and refined the transcripts, I was not simply cataloguing content, I was engaging in a reflexive process of interpretation. Meaning did not arrive fully formed; it accumulated, shifted, and became clarified through sustained attention. In this sense, immersion was not preparatory to analysis, it was analytic.

## Analytic Strategies

To explore how physiotherapists interpret weight stigma in the stories, I first focused on what each participant perceives as the 'Trouble' in the narratives. Frank (2010) describes Trouble as the central element that makes a story recognizable; something must go awry for there to be a story at all. Drawing from Aristotle's concept of peripeteia and Labov's complicating event, Frank (2010) explains that stories both respond to human troubles and create new troubles. In this sense, Trouble is not just the challenge within a story but also the way the story itself generates tension, confusion, or disruption in the listener's or reader's understanding. Applying

this concept to my study, I sought to identify what physiotherapists identify as the key disturbance in the fictional narratives they are presented with. Is the Trouble located in the weight stigma experienced by a patient? Is it in the ethical dilemma or communication problem a clinician faces? Or in the broader social issues embedded in healthcare interactions?

I analysed each physiotherapist's transcript individually to construct a persona that encapsulates their interpretative tendencies. This persona-building focused on explicit mentions of bias, critiques of weight stigma, normalization of stigma, expressions of empathy, and moments where dominant health discourses are reinforced, modified, or rejected. Additionally, I gave particular attention to shifts in thinking, to moments where physiotherapists reconsidered or expanded their perspectives in response to the stories. This process aligns with Frank's (2010) emphasis that stories have the power to evoke emotional responses and prompt reflexivity, leading to potential transformations in understanding.

During the process of constructing individual personas and comparing how participants located "Trouble," I began to notice variability not only in what participants identified as problematic, but in how comprehensively they articulated the processes through which stigma unfolded. While my analytic steps are grounded in Frank's socio-narratology, particularly in identifying Trouble, it became increasingly clear that a conceptual framework would be helpful to foreground how participants understood stigma as a social process. At this stage, I engaged with Link and Phelan's (2001) sociological conceptualization of stigma as an interpretive lens. Link and Phelan's framework was not used as a deductive coding structure or checklist. Rather, it functioned as a concept that allowed me to highlight if/how participants recognized labeling, stereotyping, separation, status loss, discrimination, and the role of power in their interpretations

of the stories. Consistent with a constructivist and dialogical approach, this conceptual engagement emerged iteratively through immersion in the data, shaping subsequent comparative analysis while remaining responsive to participants' accounts.

Building upon this, I conducted a comparative analysis between HAES®-aligned physiotherapists and the non-HAES® physiotherapists with the aim of potentially outlining patterns in language use, framing of weight stigma, and how they construct meaning. The first part of the comparison focused on intra-group consistencies and differences, first among HAES® physiotherapists and then among non-HAES® physiotherapists. Following this, I completed an inter-group comparison to identify potential distinctions in how each group engages with the stories. Some of the key questions that guided this phase include: Did HAES® physiotherapists challenge dominant weight-centric narratives more consistently, as they engage with stories? Were there points of convergence where both groups expressed similar concerns or uncertainties? What rhetorics did they employ in articulating their views? This comparative approach was done to illuminate mechanisms through which weight stigma is embedded as well as disrupted within physiotherapists' clinical reasoning.

My final analytical step involved comparing the influences that physiotherapists named as shaping their interpretations of weight stigma and how they grapple with it. By exploring references to education, clinical experience, professional guidelines, cultural beliefs, and personal values, this phase mapped out the knowledge foundations that inform physiotherapists' perspectives on weight and weight stigma. Are their interpretations predominantly shaped by formal training, experiential knowledge, or peer discourse? How do these influences manifest in

their interviews? By categorizing responses based on these foundations, this thesis explores the underlying frameworks that guide physiotherapists' reasoning and decision-making processes.

## Quality

Ensuring quality in this research is essential to producing findings that are credible, impactful, and ethically sound. High-quality research not only strengthens the credibility of the study's claims but also ensures that the insights gained can be applied meaningfully in clinical practice, health professions education, and policy reform. There are different quality frameworks in qualitative research that help scholars design their studies to maintain transparency, reflexivity, and depth, fostering trustworthiness in their work. I chose Tracy's (2010) "big tent" framework as it provides a structured approach to assessing my research's rigor, ensuring that it is both methodologically sound and socially relevant. This framework is compatible with constructivist-narrative approaches and attentive to methodological fluidity often seen in qualitative research. It aligns closely with Levitt et al.'s (2021) concept of methodological integrity, which emphasizes fidelity to the subject matter and utility in producing meaningful, situated knowledge.

Tracy's eight criteria – worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence – serve as generative heuristics rather than prescriptive benchmarks. They offer a structure that accommodates diverse epistemological commitments while foregrounding the relational, political, and interpretive dimensions of research practice (Tracy, 2010). Below, I highlight how this thesis meets selected criteria most relevant to its design and aims.

## Worthy topic: Why Weight Stigma?

The decision to focus on weight stigma in physiotherapy – particularly through the lens of how some practitioners are actively attempting to disrupt it – is grounded in both scholarly and practical urgency. As outlined in the introductory chapter, existing physiotherapy literature tends to describe weight stigma as a perceptual or attitudinal problem, with little empirical attention paid to what active resistance looks like in clinical practice or the kind of sense-making that supports it. This project responds to that gap by shifting the focus from bias identification to narrative sense-making and disruption. While this background has already been detailed in earlier sections, I reiterate its methodological significance here: the topic's social timeliness, moral weight, and capacity to unsettle entrenched assumptions contributes directly to its worthiness as a site of inquiry (Tracy, 2010). As Levitt et al. (2021) argue, fidelity to the subject matter in critical research is strengthened when inquiry illuminates variation in experience as it intersects with structures of power, in this case, those governing norms around weight, health, and professional legitimacy.

## Sincerity – Self-Reflexivity

"Sincerity means that the research is marked by honesty and transparency about the researcher's biases, goals, and foibles as well as about how these played a role in the methods, joys, and mistakes of the research." (Tracy, 2010, p. 841). Sincerity requires practicing reflexivity, one of the most consistent 'best practices' in the qualitative research world (Tracy, 2010). From the outset, I have practiced ongoing self-reflection about my epistemological stance, analytical decisions, and social positioning. As Braun and Clarke (2021) note, locating oneself within the

interpretive process is not merely a matter of transparency – it is an ethical imperative. Since my initiation in the Storying Physiotherapy project, I have maintained analytic and methodological memos, noting not just what I found striking but why I found it significant. During the bigger project's coding process on which I was a research assistant, the principal investigator and I used annotated memos to record moments of analytic surprise, discomfort, and interpretive divergence to discuss. These conversations often led to deeper insights about the data and about our own assumptions.

In line with Tracy's (2010) emphasis on sincerity, I acknowledge the unavoidable presence of subjectivity in this work. As researchers, it is crucial to remember that we cannot rid ourselves of judgement, and we must acknowledge and report our biases (Tracy, 2010). My role as a Nigerian-trained physiotherapist analyzing data from clinicians in Canada, the US, and Australia raised questions that I had to sit with: How might my professional formation differ from theirs? What reactions are mine, and what are theirs? These reflections were not distractions; they became data points in themselves, prompting a more layered interpretation of the narratives under analysis. The process of transcription, too, became a moment of reflexive insight. As I described earlier, the work of transcribing was not neutral; it required decisions about representation, emphasis, and meaning making, all of which were filtered through my researcher lens.

### *Positionality – Where do I belong in this discourse?*

One of the most challenging questions I have had to answer is, "Who are you?" How do I respond when I am constantly evolving, shaped by new ideas I accept or reject, by experiences that redefine my perspectives, and by the stories of others that expand my understanding of the

world? I would love to say that writing about myself has become easier as I have grown and learned more, but ironically, it has become even more complex. Yet, while ever-changing, my identity remains grounded in certain realities that influence how I engage with this study. For the sake of situating myself within this research, I describe myself as a young Black woman of a slim build. Others have referred to me as vibrant, agile (or "able-bodied"), slim (or "healthy"), confident, educated, and outspoken. While I acknowledge some of these descriptors, I also hold reservations about others – reservations shaped by my educational background and professional experiences. My understanding of health and ability has expanded beyond what is physically observable. What I once believed as an 18-year-old first-year physiotherapy student has evolved significantly, influenced by critical engagement with others' ideas about weight stigma, public health, and patient-centered care. I recognize that my identity, values, and knowledge shape my worldview and the work I do. My perspective on health is no longer confined to traditional biomedical definitions but how I make sense of the world considering the social and systemic factors that impact well-being. This continuous process of learning and unlearning is central to my engagement with this discourse, and it reinforces my commitment to challenging weight stigma and advocating for inclusive healthcare practices. I recognize that I am not personally discriminated against for reasons of my weight, but I have chosen to engage this issue because of its ethical, clinical, and social significance and the opportunity to learn about critical and constructivist research through it. My identity as a physiotherapist – trained in Nigeria but now navigating healthcare in Canada – brings both distance and closeness to the stories in this study. I recognize that I am positioned both within and outside the clinical cultures under examination, a duality that affords a distinct analytic perspective.

## Meaningful coherence

Achieving coherence in qualitative research involves aligning research design, methodology, and analysis with the study's underlying philosophical assumptions (Tracy, 2010). This principle is closely related to Levitt et al.'s (2021) concept of "methodological integrity," which emphasizes that research procedures should not only align with research goals but also respect the epistemological stance of the researcher. Methodological integrity ensures that the chosen approach is suitable for the nature of the subject matter, allowing for a deep and meaningful exploration of the topic at hand (Levitt et al., 2021). My research is rooted in a constructivist paradigm, which aligns with the core objectives of my study. Given that constructivism focuses on how individuals make sense of their experiences, integrating different sources of information over time, it provides an ideal framework for understanding how physiotherapists engage with weight stigma and what informs their clinical reasoning and weight-destigmatizing practices (Leavy, 2022). To further achieve coherence in my analysis, I employ narrative analysis based on Arthur Frank's (2010) socio-narratology. This methodological approach aligns well with hermeneutic and dialectical assumptions of constructivism, as it allows for the examination of how meaning is constructed through stories. Additionally, socio-narratology is particularly relevant to my research because it helps identify what participants perceive as the central "Trouble" in a given narrative.

In this study, physiotherapists engaged with fictional stories that depict weight-stigmatizing situations in clinical settings, and different ways fictional physiotherapists navigate them. By analyzing their responses to these stories, I highlight what they find problematic in these narratives, what assumptions they bring to their interpretations, and how their backgrounds

(including HAES®-aligned and non-HAES® perspectives) shape their understanding of weight stigma. Through this approach, my study maintains methodological coherence, ensuring that both my research questions and analytical strategies align with my constructivist epistemology.

# Findings

In this chapter, I present my findings by describing how physiotherapists interpreted weight stigma as they engaged with fictional stories of physiotherapy practice. I organized the findings to move from surface-level patterns in participants' selections of the fictional stories to deeper differences in how those stories were interpreted. While most of the participants identified similar set of stories as "worst," "best," or closest to their usual clinical practice, my deeper dive into their interpretations revealed meaningful variation in how they located the Trouble, explained its origins, and reasoned through responses and other stories they shared. Through the Character of their stories, participants mapped out their values and expectations in an ideal physiotherapy practice. This chapter therefore proceeds from observable similarities to the interpretive distinctions that became visible through persona-building and comparative analysis.

Before delving into what my study has found from the participants responses, it is important that I introduce them. Participants were asked both some structured questions about themselves (country, years in practice, HAES® background) as well as to describe themselves in their own words. To preserve confidentiality, I share only aggregates here. Of the eleven participants,

- 4 practiced in Australia, 3 in the US, and 4 in Canada.
- 1 non-binary, 8 women, and 2 men.
- 2 self-identified as racialized persons, and 1 as 2SLGBTQIA+.
- Participants' years in practice range from 1 to 20 years with a median of 8 years.

Table 1 presents participants' selections of the fictional stories they identified as representing the "worst," "best," and closest to their usual clinical approach.

*Figure 1-Table of Participants' Evaluations of Fictional Clinical Scenarios*

| | Participant's Chosen Pseudonym | | Worst | Closest | Best |
|---|---|---|---|---|---|
| **Brenda Story** | **HAES®** | **Non-HAES®** | | | |
| | Amina | | 2, 6 | 4b* | 4b*, 3 |
| | Matthew | | 4a*, 5, 6 | 4b*, 3 | 3, 4b*, 1 |
| | Allison | | 6, 3, 4a* | | 1 |
| | Sig | | 2, 5, 6 | 1, 4b* | 4b* |
| | | Ade | 5, 2 | 6, 1, 3 | 1, 6 |
| | | Claire | 6, 5, 4a* | 1 | 3 |
| | | Charlotte | 2 | 1, 3 | 3, 1 |
| | | Kate | 2, 4a*, 5, 6 | | 3, 4b* |
| | | Mary | 2, 3, 5 | n/a | 1, 4b* |
| | | Pablo | 4a*, 5 | 3 | 3, 1 |
| | | Mercedes | 6, 4a*, 2 | n/a | 3, 4b*, 1 |
| **Jo Story** | **HAES®** | **Non-HAES®** | | | |
| | Amina | | 1, 4 | 5 | 5 |
| | Matthew | | 4 | 5 | 5, 2 |
| | Allison | | 1, 4 | 2 | 3, 5 |
| | Sig | | 1, 4 | inconclusive | 5, 3, 2 |
| | | Ade | 1 | 5, 3 | 5, 3, 2 |
| | | Claire | 1 | 5 | 5, 2 |
| | | Charlotte | 1 | 3, 5 | 3, 5 |
| | | Kate | 1, 4 | 5 | 5 |
| | | Mary | 1, 4 | 3 | 2, 3 |
| | | Pablo | 1 | 2 | 2, 5 |
| | | Mercedes | 1, 4 | n/a | 2, 3, 5 |

** In Brenda Story 4 (see Appendix 1), Brenda met with two fictional physiotherapists. In Table 1 above, 4a refers the part of the story where Brenda met with the first physiotherapist while 4b refers to the part where Brenda met with the second physiotherapist.*

When asked to identify which fictional stories reflected the "worst," "best," or "closest" to their usual clinical approach, participants frequently selected similar stories and pointed to comparable narrative moments as problematic. At this level of analysis, there appeared to be broad agreement on which scenarios represented poor or better approaches to physiotherapy practice. An exception to this pattern was Brenda Story 3. Most participants liked Brenda Story 3; they evaluated it positively or identified it as closest to their own practice, noting that the fictional physiotherapists appeared constrained by contextual factors embedded in the prompt. On Brenda Story 3, Amina remarked:

> "Yes, so 3. 3, I felt like was getting close to best practice just because there was some validation of the patient's concerns and they were kind in their delivery and trying to educate the client on something and then they were looking at it from a multidisciplinary perspective and trying to bring in referrals to at least you know again validate the clients concerns that like losing weight is not that easy."

Charlotte also appreciated Brenda Story 3:

> *"I thought scenario 3 was pretty good… asking for kind of informed consent in terms of the education piece. "Are you open to me explaining more?" I like how that question was worded and then just kind of explaining step by step and what else do I like about that one. Kind of got into the biopsychosocial piece of it, which I thought was really fantastic."*

Ditto with Kate:

> *"I really liked this scenario, scenario #3 with Brenda because I felt that she must feel very validated about what she was saying."*

And Pablo:

*"#3 is fairly close to how I might kind of handle that one I reckon… just in the fact they've asked after they've said it and, in the scenario, it comes with a bit of pushback, just the fact that they explained fairly thoroughly, and you know validate the client. Like having a bit more of a redirection is pretty close to the way I'd probably try and handle it."*

In contrast to general consensus, two participants (Allison and Mary) distinctly positioned Brenda Story 3 as unacceptable. Allison interpreted the same story as more troubling, identifying the physiotherapist's weight-centered reasoning as the underlying concern. About Brenda Story 3, Allison said:

*"I think some of it was OK in that they were admitting there's lots of information out there and it's all very contradicting and confusing, and saying it's much more complex etcetera. But I think I didn't like the overall premise, was just 'it's about your weight.' You know, sort of the dialogue is back and forth and that's supportive in a way. But I don't like the dialogue… They're like, 'oh, we're surrounded by this toxic messaging and diet culture.' It's like you're doing, what you're doing is toxic messaging and diet culture. I'm like, that's hypocritical… I found that it's like, well, what you're saying doesn't actually align… And that person could have tried everything, and you know weight loss strategies don't work, but they're still just pushing for it… things may happen, and worst-case scenario she gets an eating disorder from this sort of thing, which is such a, obviously in my field is the highest death rate of any psychiatric illness."*

Mary also thought the "the openness and the consent" piece was good, but the outcome could not make her put Brenda Story 3 in her list of the better ones. Mary said:

*"I think it still didn't focus on helping her now with her knee pain… I still think, for me, that's a later appointment thing if needed, and the focus should be on this person's knee pain."*

While some emphasized validation, consent, and relational care, others remained concerned with the underlying weight-centered reasoning that structured the interaction. The same scenario was therefore read through different lenses, producing different conclusions about what constituted their ideal of a physiotherapy care.

Similarly, while Brenda Story 6 was widely regarded as poor practice, Ade described it as closer to good practice and aligned with what she might get behind, noting that that aspect of the clinical encounter was clinically logical:

> *"I'm gonna be honest, I also loved #6… just alleviating that pain at this point and then decides to delay further talk. I thought that was that was like a no brainer. Like 'at this point you have pain, we're not gonna talk about weight loss'… and the patient was like 'oh, I can't believe how much less pain I have using the cane.'"*

However, other participants described Story 6 as "vague" (Amina), "horrible" (Allison), and not helpful, stating that the clinician's actions were dismissive of Brenda's concern without clear benefit to Brenda in that moment. These differences signaled that story selection alone did not capture participants' analytic orientation.

Thus, agreements or disagreements at the surface did not necessarily reflect agreements of reasoning or what is most at stake in the stories. These surface-level similarities and contrasts therefore functioned as an invitation into exploring interpretation rather than a quantifiable conclusion. The deeper analytic work began not with which stories were selected, but with how participants explained their selections.

## What We Learn from Stories – Trouble

Constructing individual personas allowed the analysis to move beyond story preference and into interpretive depth. When I analyzed each participant's transcript, clear differences emerged in how they located the problem, that is, what constituted the "Trouble" in the stories and what they understood to underpin that Trouble. Across the dataset, participants clustered around four broad ways of locating the problem as: interpersonal failure; ethical issue; epistemic narrowing; or structural reproduction of stigma. While these clusters are analytically distinct, participants could communicate using more than one. However, they were not evenly distributed across HAES® and non-HAES® participants.

### *Interpersonal Failure as the Trouble*

Many non-HAES® physiotherapists located the Trouble primarily within the interaction itself. The problem was often framed as dismissiveness, poor timing, lack of consent, or insensitive communication by the physiotherapist. For example, despite liking the story, Claire described that the issue in Brenda Story 1 as broaching the topic and then carrying on the conversation in a way that "shuts" the patient down, emphasizing the fictional physiotherapist's approach and its relational impact. Claire stated:

> *"this situation's different because the physio brings it up on their own… one problem is that like it's not gone into it all she started with physio sort of immediately shuts it down and goes, 'oh you're right, it doesn't matter let's focus on other things'"*

In her interpretation, the clinician's tone and sequencing of the conversation disrupted rapport and dialogue. The Trouble, therefore, was not necessarily the presence of weight or stigmatization in the conversation, but the manner in which it was introduced and sustained.

Similarly, Charlotte and Kate highlighted moments where the fictional physiotherapist appeared rushed or overly directive, in Jo and Brenda stories respectively. Here, Charlotte, responds to the first Jo story:

> *"#1 made me feel scared… Not acknowledging the patient at all. Just saying, 'no, we need to do this because what I have to say is the most important and I need to have full access for an internal exam' without explaining that that might even need to happen… 'moving through the questions quickly so we can leave the leave today'… and then bunch of questions. You know, 'can you pop up and spread your legs?' Not *shakes head*. Yeah, just, yeah, just *cringes*"*

Kate, addressing the second story in the Brenda set:

> *The second one for sure, the physio was too narrow minded, didn't realize how powerful their words were… the knee issue was changing Brenda's life in that she loved playing hockey… it was what was keeping her active. It was her social interactions, and the physio did not consider that in any way. When the physio spoke to her about 'oh, it's just about your weight' and that she doesn't, you know, feel motivated… things get worse because she's just like, well, 'it's my weight and I can't do anything about my weight, so I'm just giving up and stop playing hockey'... So, I think that one the physio should have been a lot more considerate of their words and… I hate to say this, but my first thought that this physio is was one of those like sporty male physios who is all about treating the athlete and not about treating the regular person."*

In these interactions, the problem manifested when the patient's narrative was cut short, not because of weight stigma. In the same vein, Pablo appreciated the clinician's ability to explain "fairly thoroughly" and "validate" Brenda in Story 3. He described the scenario as the closest to how he would broach the topic of weight in his practice. However, when the interviewer probed about the clinician's comment about toxic messaging in the story, Pablo stated:

*"I'm kind of probably on the other side in terms of um not agreeing with the fact that we're necessarily extremely toxic (globe). I think it is healthy to lose weight in most cases. I probably wouldn't go down that route of exploring that. It's just not my kind of style of things I'd probably just discuss it more within the client's context about how um maybe what their perceptions are about diet and that."*

In the examples above, physiotherapists were concerned that the fictional exchanges did not allow space for the patient's concerns to lead the encounter. Interpersonal failure, which Claire, Charlotte, Pablo, and Kate evoked in their accounts, is understood as a breakdown in communication.

### *Ethical Issue as the Trouble*

In response to Brenda Story 6, Mercedes, stated that "if you're going to have that conversation, you need to be prepared to hold it," positioning the Trouble as an ethical failure of the physiotherapist in how weight was introduced. In Mercedes' response, the issue was framed less as poor communication style, but more as a matter of professional responsibility to do the relational work required when weight is raised. She described introducing weight without sufficient time, preparedness, or willingness to engage the patient's emotional response as ethically inadequate.

*"…but just kind of completely ignore the conversation that really should have been had. And then saying like 'we'll decide to delay and talk about it later'… Like if you dismiss that conversation and then bring it up later, like every single time that person comes in, they're going to think that you just really don't care about what their input is. And I just don't think… it was a very good way to… handle that situation… obviously it's easier to avoid confrontation. But I think if you're going to be the one to bring up that topic, then you need to be prepared to have that*

*conversation and be uncomfortable in that conversation and not just brush it off and then keep bringing up the weight."*

Here, Mercedes tied the Trouble to ethical responsibility and therapeutic integrity. Weight could be discussed, but only under conditions that preserved the patient's autonomy and relational safety. In these responses, discussing weight itself was not necessarily the problem. Rather, the Trouble emerged when weight was addressed in a manner that compromised trust or therapeutic rapport. Ethical positioning, therefore, became central: the clinician's obligation was to manage the conversation responsibly within the interactional frame. Although Mercedes articulated this position most explicitly, similar orientations appeared across other participants. Claire, Charlotte, and Ade also framed the Trouble primarily as a matter of ethical responsibility within the clinical encounters, emphasizing clinician's obligations in navigating conversations about weight.

While interpersonal failure and ethical framings both situated Trouble within the interaction, they differed subtly in emphasis. Interpersonal accounts focused on communication breakdown, that is, tone, timing, and relational rupture. Ethical accounts shifted the frame from technique to obligation, positioning the clinician as morally responsible for how weight conversations were introduced and sustained. In both cases, however, the analytic focus remained within the bounds of the encounter itself rather than extending to broader epistemic or institutional forces.

### *Epistemic Narrowing as the Trouble*

Among HAES®-aligned physiotherapists in particular, one prominent way of locating the Trouble was through what I describe as epistemic narrowing. In these interpretations shared by Matthew, Amina, Claire, and Allison, the issue was not merely how weight was discussed, but

how weight functioned as a default organizing lens that structured clinical reasoning from the outset. The Trouble emerged when weight was assumed to be the relevant explanatory category before other possibilities were meaningfully explored.

Matthew's analysis was particularly strong in this domain. He questioned how evidence about weight and pain was mobilized within the stories, noting the tendency to "quote literature without full understanding," and asking what populations were studied, whether findings were sustainable, and how such evidence was translated into individual prescriptions. While he mentioned that "it's not really what we're thinking, it's how we actually communicated to the patient," his critique did not focus or centralize on tone or bedside manner or consent; it addressed how biomedical evidence, when it is not critically applied, narrows interpretive possibilities and legitimizes weight-centered recommendations.

> *"I think that's where we lack a lot of understanding is what the evidence says and where the pitfalls of it are um, before we can then go quote it willy nilly… there's that study that… if you lose 5 kilos, you have a significant reduction in pain relief in terms of that… what was the patient population? Was that sustainable? What was that compared to? Um, just a lot of those other factors that make it actually translational research, for example, that is actually related to the patient rather than just one piece of information."*

Similarly, Amina described reliance on statistics over patient context as a "lack of curiosity," emphasizing moments where biomedical authority overrode individualized care.

> *"It was like, 'OK, that may be your situation, but this is what the statistics say. This is what I know, so this is really what you need to do'… the reason it was so bad to me is because in the end,*

*Brenda ended up in a worse scenario and stopped playing hockey and had to feel that shame and not being willing to go back and get more help."*

In Amina's account, the Trouble was produced when the physiotherapist treated population-level data as decisive, allowing statistical generalizations to displace patient narrative. Allison's reflection that "someone in a smaller body could have the exact same lifestyle… and you wouldn't comment" further highlighted how weight stereotyping structured the interaction before dialogue began.

Concerns about epistemic narrowing were concerns about one way that weight-centric practice manifests. These participants understood that weight stigma emerges from an epistemic posture: weight became the frame through which symptoms were interpreted, and that framing narrowed what could be seen, asked, or considered. In these interpretations, epistemic narrowing did not simply prioritize weight; it foreclosed alternative lines of inquiry. When weight was treated as the default explanatory category, other potential contributors – social determinants, contextual stressors, biomechanical factors unrelated to body size, or the patient's own account of their experience – were rendered secondary or invisible. The narrowing operated not through overt hostility, but through the quiet authority of what was considered clinically relevant.

### *Structural Reproduction of Weight Stigma as the Trouble*

Beyond epistemic narrowing, HAES®-aligned physiotherapists also located the Trouble within broader structural and institutional dynamics that sustain weight-centered practice. In these interpretations, weight stigma was explicitly mentioned. Weight stigma, in their accounts, was not only about assumptions within a single encounter but about how professional norms, documentation practices, and institutional systems reproduce those assumptions over time. Sig's

interpretation pointed to documentation as one such site. Reflecting on Jo Story 4, in which the physiotherapist described a patient as “difficult,” Sig questioned how this label was produced, noting that the patient’s muscle tension could have reflected discomfort or a physiological response rather than non-compliance. In this account, the Trouble was not only that the patient was misinterpreted in the moment, but that this interpretation was recorded in a way that could shape how the patient is subsequently understood. Sig said:

> *“The whole potentially getting a false diagnosis due to client discomfort… a therapist saying, ‘you're gripping a lot with your muscles,’ like the person may have a spastic levator ani that may be happening, but if they're so scared that they're clenching their legs together or uncomfortable… And I think that recognizing that our diagnoses often do depend on our ability to provide support and comfort is a really important part of being a physio that I feel like a lot of physios absolutely understand, and this particular fake physio learned no lesson. ‘Described the appointment as difficult.’ I hate people who weaponize documentation… bad all around.”*

By drawing attention to how patients are described in clinical records, Sig highlighted how meaning is stabilized and carried forward within healthcare systems. In this sense, stigma was not confined to the interaction itself but was embedded in the practices through which clinicians document and make sense of patient behaviour. Allison similarly emphasized how patients often enter healthcare spaces anticipating judgment, suggesting that stigma is sustained through repeated institutional experiences rather than isolated communicative failures. Allison said:

> *“it's actually just microtrauma every single time someone in a bigger body goes to a waiting room and they can't sit in their chair. So, we have couches for most of our spaces, and that annoyed me because I just think this person's been sitting in a chair. That's so uncomfortable. That's*

*already telling them before they see the physio that they don't in a way belong here because they can't even fit into a chair."*

Amina bridged epistemic and structural analyses by noting how statistical authority and biomedical norms are institutionally sanctioned, making weight-centered reasoning appear neutral or inevitable. Amina said:

*But I think that how the way Physio #2 came in in scenario 4 and making a point to say 'yes there you could pull up some research that says losing weight will help with this.' Right? Now we can dig into the credibility of that research and who's funding it and control what they're controlling for and all of that."*

Although the strongest structural critiques came from HAES-aligned participants, elements of structural awareness were also evident among some non-HAES participants, including Ade, Charlotte, and Mercedes. For example, Ade reflected on institutional pressures and funding models that shape practice, though her observations stopped short of explicitly framing weight stigma as a structural process. Ade said:

*"She apologizes and acknowledged and then went to tell the office manager. And then went to buy larger gowns. Like I like it apart from the part of buying the gowns, I would. It's a slippery slope with systems and buying things with your own money. I just will not cross that boundary like I would rather write a I guess a fiercely worded letter demand a meeting and just keep pushing until they buy. Because the thing about that now is the chairs are too small, the beds are too narrow. Like at what point do you say stop? So, I'm always very *swings head*."*

In Amina's, Allison's and Sig's accounts, in particular, weight stigma is explicitly understood as an issue which was not reducible to interpersonal failure or ethical problems, and

which extends beyond epistemic narrowing. It was reproduced through the alignment of labeling and stereotyping practices in relation to professional authority, documentation systems, and normative expectations about bodies.

### *Participants' confidence in their interpretations of stories*

Beyond differences in analytic framing, participants' responses also revealed varied confidence in their interpretations. This variation was evident in two ways; in the degree of certainty with which participants expressed their interpretations and the depth and focus of their critical engagement with weight-centered practices. Some participants articulated their interpretations with a high degree of certainty, presenting weight-centered reasoning as clearly problematic and, at times, locating its origins within broader systems of oppression. For example, Sig emphasized that:

> *"a lot of weight bias stems from racism… from sexism, from transphobia… they're all so intertwined that it's hard to puzzle and piece out exactly where each thing comes from… once you start really noticing those systems… once the wool is lifted, there's no pulling the wool back down… you see those correlations everywhere."*

For Sig, recognizing these structures was not optional but an ethical obligation within practice. As they reflected, once these patterns become visible, they require active engagement:

> *"if I wanna be a good person… these are tools we have to utilize… these are connections we have to make… these are things we have to dismantle."*

However, certainty did not uniformly correspond with a particular type of critique. While some participants expressed strong, system-level critiques, others offered more focused critiques. Matthew, for instance, demonstrated a confident, critical orientation toward how

clinical reasoning and evidence were mobilized within the scenarios, questioning the application of population-level data to individual patients, expressing a more measured, observation-based certainty in his interpretations.

Others expressed greater tentativeness or ambivalence in their responses, at times working through competing perspectives without arriving at a fixed position. This tentativeness did not necessarily indicate a lack of critical engagement. For example, participants such as Claire reflected critically on the tensions between different discourses about weight and health, while also expressing uncertainty about how best to navigate these tensions in practice:

> *"I listened to a few podcasts and one of them, Maintenance Phase, they're all about like… 'don't go there. It's impossible to lose weight anyway. The negatives of being in a larger body or whatever you want to call it, like oversold.' So, I'll listen to that and be like, okay, I'm never going to mention it…But then I listened to this other one, Barbell Medicine… they sort of also acknowledge basically like 'long term weight loss probably doesn't work and there's too much.' There's weight stigma and diet culture and all that stuff. They sort of acknowledge that as well. But then they're also like in some health conditions, it might be of benefit for the patient to have a lower body weight or lose weight... And so, the way they phrase… 'if it's something that is of value to the patient and the patient brings it up and it's something that they want to pursue, then you could have this conversation with them.' And so, yeah, a part of me feels like I'm cheating the patient if I just put my own bias on it and go, 'oh, it's impossible, don't worry about it,' which is what I've done in the past. That's not actually meeting what they might want. It's sort of just dismissing and then putting my own wants on it."*

Similarly, Charlotte struggled with what she perceived as competing ideals:

*"I mean, maybe sometimes they're really their goal is to lose weight? Because I also don't want to discount what their goals are… let me refer you to a dietician and that kind of stuff and then we'll talk, I'll talk about how, like, different types of exercise may be better or more beneficial for them than others."*

Mary's responses further illustrate this more tentative positioning. While she questioned the assumption that weight necessarily explained Brenda's knee pain, she framed the issue primarily through clinical reasoning and evidence rather than structural critique:

*"weight doesn't always have everything to do with knee pain… there's some research… and on top of that too you can make changes that will provide help for this person immediately."*

Mary's reflection focused on the practical implications of weight-focused recommendations, later noting that if weight loss were presented as the primary solution, the patient might reasonably expect improvement only after a prolonged period of time. In this account, the Trouble emerged less from structural influences and more from the immediate clinical usefulness of the advice being offered.

These moments of reflection did not necessarily alter participants' ultimate interpretations of the stories but revealed the range of certainty in the forms of critique they had. The stories functioned not only as objects of evaluation, but as sites where participants negotiated their own alignment with prevailing clinical logics.

## What We Learn from Stories – Character

As participants worked through the stories, identifying the Trouble in the scenarios often led them to evaluate how the clinician had responded within the interaction. The interviews also showed the second capacity of stories described by Frank (2010): the ability to reveal and test

'Character.' As participants worked through the stories, they did more than identify what had gone wrong in the interaction. Their interpretations also revealed the moral and professional positioning through which they understood physiotherapy practice – including how they position themselves. In this sense, the stories functioned not only as depictions of clinical situations but also as sites where participants articulated expectations about responsibility, legitimacy, and failure within the profession.

Across the interviews, participants frequently swung between identifying the Trouble in a story and describing the kinds of professional conduct they believed were required in response. Their reasonings revealed several recurring orientations toward professional character, including relational attentiveness within the clinical encounter, responsibility for navigating sensitive conversations, epistemic reflexivity in clinical reasoning, and awareness of institutional dynamics shaping patient care.

For some participants, character was expressed through relational attentiveness to the patient's experience within the interaction. Matthew, for instance, described initially struggling with Brenda Story 3 but began to view the interaction more positively when the clinician paused and attended to the patient's response. When Matthew was asked when he started liking Brenda story 3, he noted, "from the physio pauses. Brenda nods her head. And her body softens." In Matthew's response, the shift toward better practice occurred not through the educational content the clinician had given Brenda, but through the clinician's ability to pause, observe, and respond to changes in the patient's comfort. Here, Matthew shared his understanding of good professional conduct as attentiveness to the patient's embodied cues and responsiveness within the encounter.

Other participants emphasized ethical responsibility in navigating conversations about weight. In Jo Story 5, for example, several participants valued the clinician's immediate apology and acknowledgement of the oversight. Sig highlighted the therapist "listening to the client," "providing an apology," and "asking permission before opening the door," while also noting the clinician's recognition of "systemic systems of oppressions and unfair oversight." Amina similarly described the apology as "immediate accountability," emphasizing the importance of acknowledging that the failure lay not with the patient but with the system. On Jo Story 5, Amina said:

> *"It's like the therapist asks, 'are you still in your clothes? Can I come in?' You know, it's very much like and then apologized again acknowledges that it was an unfair oversight that is so powerful to me because I feel like people in large bodies believe that their bodies are their faults and their problems. And when they don't fit something, it's something's wrong with them as opposed to, what I believe is that the world is not, you know, accommodating to you. And that is a systemic problem."*

Apology and acknowledgement also showed up in Mercedes' reflection on the Brenda stories in general. When asked to share other thoughts about the Brenda story before moving on to the Jo stories set, she stated:

> *"Let me just take a quick a boo here. *long pause* Oh, actually, I totally missed the first story. Um. I like the way that this physio acknowledged, um that perhaps like even though it was kind of just like a shotgun response to say, like "your weight might be impacting your pain," she was able to, like, acknowledge and backtrack and say, "you know what? Like, you're right, that probably actually isn't entirely accurate." And then like, acknowledging that we're also human and that as we learn things, it's hard to maybe undo some of that messaging… But like, having the*

*humility to like, acknowledge that you've made a mistake, I think is really, really important. And I think that really builds good rapport with your clients to be able to say, like, you know, "that was maybe incorrect or maybe that was a bias on my part. And I apologize for that". And then, you know, having that conversation, I think goes, it goes a long way into acknowledging our own shortcomings."*

In these interpretations, professional character was expressed through accountability and a willingness to locate responsibility beyond the patient's body.

At the same time, participants also raised questions about where responsibility should ultimately reside when institutional gaps become visible in practice. Ade and Pablo both appreciated the clinician's initiative in attempting to address the lack of appropriate gowns in Jo Story 5 yet expressed hesitation about the implication that individual clinicians should personally resolve structural shortcomings. Ade noted that purchasing larger gowns with personal funds risked becoming "a slippery slope with systems and buying things with your own money," while Pablo similarly observed that although the action reflected "very good care," it "shouldn't be an expectation of employees." In these responses, professional character was expressed not only through attentiveness and initiative but also through caution about normalizing situations in which clinicians personally absorb the consequences of institutional failures.

Across these interpretations, the stories revealed how participants evaluated physiotherapy practice through different moral orientations that manifest in character. In doing so, the stories circulated ideals about what constitutes a "good physiotherapist" in a broader professional sense.

## Named Influences

There were times during the interviews where participants also reflected on how their own understandings of weight, health, and clinical responsibility had been shaped by broader professional and cultural influences. As participants worked through the stories, they occasionally explicitly drew on external sources of knowledge – such as professional training, disciplinary discourse, clinical experience, and media – to explain how they had come to understand weight, weight stigma, and/or the role of physiotherapy within these conversations. In addition, later in the interview, they were explicitly asked about the models that they rely on most. These reflections pointed to the various forms of knowledge, training, and discourse that informed how participants interpreted the scenarios and understood weight stigma within physiotherapy practice.

HAES®-aligned physiotherapists commonly described deliberate processes of learning and reorientation that reshaped how they understood weight and health. Some referenced formal HAES® alignment, trauma-informed frameworks, or interdisciplinary mentorship (a co-worker, an employer, or a personal friend) as pivotal influences. Others described critical moments in practice, such as recognizing unintended harm or realizing how unsustainable the dieting culture is, that prompted sustained reflection. Their accounts often included explicit narratives of "unlearning," in which previously learned and accepted biomedical assumptions were reconsidered. Allison identified critical gaps in physiotherapy education that she worked to fill:

> *"we've learned absolutely nothing about eating disorders, nothing about weight bias, stigma in our undergraduate degree, I don't know, not even a single lecture, which I think is frustrating in itself, but because of that, I'm very mindful that even my amazing physio colleagues,*

*there's so much that they think and say that it's just in my opinion just makes me wanna say something… there would be things that come up that, as said by physios or brought up by physios, that's not them necessarily deliberately being, um I guess, not malicious, but uh unfair or cruel."*

Similarly, Amina shared her personal story:

*"I was working out seven days a week. No breaks, no days off. I was eating all of my food out of like portioned containers every single day and I did this for almost six months straight… I had lost about 20lbs. I was getting tons of compliments, and I woke up one day and I was like I'm tired… I know if I stop, everything's gonna come back… So, I'm just gonna decrease to five days a week of exercise and I'm going to watch my portions… I did not make a significant shift, but just with that small change in my lifestyle, I gained back everything I lost plus more, and I was dumbfounded and I was so disappointed in myself, and I wanted to hide… I stumbled upon the book Health At Every Size by Dr Bacon. And that book changed my entire life because it fed the nerd sciency part of me that, you know, you have to give me some numbers and some data. You can't just say oh feel better and do like I need both like I need the woo woo and the education and that book just did it for me because I was like, "wait a minute. I've been doing this my whole life and it's wrong and it's not healthy and it's not helping me and it's making me at a higher risk of dying from something related to my heart?" Like it, it made me mad because I'm like, "why do we believe this?" You know, when I read the information about, you know, the medical associations decision on the term obesity and making it a medical disease and I was just floored and shocked but hungry for more knowledge. And so, I kept reading. I read all of Dr Bacon's books. I read, fearing the black body. I read body of truth I like. I couldn't stop, intuitive eating all of it, and I made a shift in my personal life to no longer focus on weight loss and to shift to health promoting habits, intuitive eating, managing my mental and emotional and spiritual well being, and then as a result, I could no longer treat patients the same way."*

The HAES® participants described questioning how evidence was mobilized, how professional authority was exercised, and how routine documentation practices might reinforce marginalization. Sig shared:

> *"so much evidence-based research on weight, is inherently biased…an entire group of physios who are learning these things in school and these really smart papers and good evidence and strong correlations and all the good things are values. But they're never once looking at biopsychosocial issues, ever. Like I mean, how many papers are there that show, you know, weight gain and knee pain are correlated?... but at no point are we looking at the correlation between knee pain and living in poverty… And yet we're creating these forms; these are the correlations based on studies. And I found school to be a little narrow, in that view, a little too worshipping of evidence-based research without being too critical of that research. So, I had to I had to unlearn a little bit of article worship. Definitely. [*nodding*] I had to unlearn the concept of fitness, because you know you're in school, like everyone's, you know, for the most part, you know, jacked at 22. And then you realized that the rest of your career, you're just not going to see that many 22-year-olds, And that's the concept of, you know, what is fitness? What is health? These are not words, these are not phrases or questions that have clean answers, right? I love asking my clients, people I lecture too, and myself, like "what is health?" like you get 800 different answers every time. Um and the same thing is true with "What is healthy? What is? What is fit? What is muscular? What is toned? What is trim? What is attractive?" These are all subjective things that we've implied objectivity to and it's a huge disservice."*

Matthew's take on this relates to what he learned in his advanced research degree:

> *"We did some more research sort of things, and I just understood research a lot more and the flaws of research. And I think that was probably a big turning point to go 'well, this is the*

*research and this is the flaws in it and how it doesn't necessarily translate.' And then that probably affected a lot because it made me realise, Um, there isn't a good answer yet. And there might not be one for in my lifetime. Um, so yeah, that was the biggest turning point. And then just helped me really change my practice in terms of I'm gonna do what I think is best practice and gets the best patient outcomes."*

These influences functioned not merely as background biography but as interpretive resources. They supported ways of thinking that speak to how weight becomes an important label, how negative assumptions are normalized, and how institutional practices sustain certain clinical reasonings.

Non-HAES® physiotherapists more frequently referenced general professional education, workplace norms, and accumulated clinical experience as shaping their perspectives. Some mentioned specific podcasts (e.g. Maintenance Phase, Barbell Medicine, and Optimal Body Podcast) or physiotherapist leaders on particular topics that that they follow. Several also drew on personal encounters with patients, body-related commentary, or their own experiences of weight stigma, which appeared to primarily heighten sensitivity to patients' emotional responses. For example, Ade commented:

*"In terms of like sensitivity, now like body sensitivity or just sensitive practice and how, I feel like it's something that I think I take for granted sometimes. If I didn't have my own sensitive weight issues, I wonder if I will be sensitive to people's weight… like I don't know if I would even notice it because now because I have my own issues it made me hyper-aware after I had kids."*

Charlotte shared:

*"I learn from patients a lot. So, what makes them feel heard and feel better and that they're frustrated every time that they go to their doctor and their doctor says, "Oh well, just lose weight or maybe I'll put you on Ozempic or maybe," and then they're like, well, "I don't really want that." Like "I don't want those approaches," so kind of learning from them. I would definitely say, yeah, I've got lots of friends in the healthcare field, so we talk lots about this kind of stuff. Courses I've taken, especially I would say in the public health world, we tend to talk about inclusion and in more ways than some of the more orthopaedic general courses I've taken… I feel like my own brain just went, well, I wouldn't want someone to say that to me. So why would I say that to somebody that I'm trying to help?"*

Mary echoed Charlotte's sense of learning from patients:

*"you learn a lot from your patients, like as a new grad, you know nothing, you know black and white stuff you learn in school. But that person sitting in front of you is different than that person sitting in front of you, and you learn the nuances between people and how to read them and how to speak properly and all those things too."*

Kate connected her own experiences with a structural analysis, but it focused on how practice is typically organized rather than structural influences driving stigmatization:

*"But it makes me really sad too about the state of physio sometimes with the four patients per hour of rushing through of trying to do half hour assessments for very complex cases. Um and I know not every clinic is like that, but… it's very frustrating… because I feel like there's a lot of people falling through the cracks and I have heard for years like from the time I was in school… they would say, oh, "I've been to physio before, it doesn't work" and I'd always get, you know, feel that little ouch… because I knew that it wasn't the physio that didn't work. I knew it was the process of the physiotherapy and how that happened for that patient… I feel often people are let down by*

*the fact that there's not enough time for, you know, effective treatment, and that treatment includes the education… So, I swore that I would be different and I really worked hard to be different, you know in that respect… so I really liked this scenario, scenario #3 with Brenda because I felt that she must feel very validated… I am cis-gendered. I'm a bigger lady, you know, and um it's OK. Um, I've always been. Uh, I'm really active and I do lots of things and so I understand when somebody comes and says, 'well, my doctor said my back pain is because I'm overweight' and I'm like 'you're twenty pounds overweight. Like, really, you're active, you do lots of things. Like, that's not why', and you can see the relief come over them."*

The non-HAES® participants often associated these influences with their relational attentiveness and concern for dignity, trust, and therapeutic rapport. Participants described learning, through practice, the importance of timing, tone, and consent when addressing weight-related issues.

Some of the non-HAES® participants who were pelvic floor therapists showed a particular understanding of trauma- informed approaches in care delivery. For example, Mercedes:

*"I think because I work in an area where I'm working with very vulnerable populations, like I'm in somebody's face and you know, people who have had sexual trauma and things like that, I come from a very trauma-informed background… so, like, consent is a big piece for me… always asking if it's OK to share more information, do they want to know more or are they not interested in that? And then even like having that conversation, 'is it OK that we even broach this topic? Like it, does that feel like a safe conversation for you to have with me?' And then if it is, then I will dive into it more and I will continue to ask, like, 'how much information do you want?' Cuz really, at the end of the day, I'm there for them, I'm not there for me. And they're the ones who have to live in their body, not me."*

Charlotte commented:

> *"I would say in like trauma informed care just generally making sure that like you're not between the patient and the door and that you've got an inviting space that people feel comfortable in."*

At the same time, references to structural or institutional forces were less consistent, though at times present. For example, Charlotte raised problems created by "diet culture", and recognized intersecting forms of discrimination in healthcare, but without developing a deeper structural analysis. More commonly, when broader constraints were mentioned by non-HAES® physiotherapists, for instance, time pressure, resource limitations, or equipment barriers, they were typically framed as situational realities rather than as components of a broader systemic pattern.

## What then, do participants understand about Weight Stigma?

The term 'weight stigma' was not used in ads for the study, the consent forms, or in the interview questions. Some participants explicitly introduced the term 'weight stigma', or used related terms (e.g. weight bias, diet culture). Some used no explicit language that demonstrated awareness of critiques of weight-centricity.

The interpretive clusters suggest that weight stigma was understood (or not) in distinct, patterned ways across the dataset. When the participants situated the problems in the stories within interpersonal failure or ethical misstep, the harm was primarily understood at the level of the interaction – specifically when communication undermines dignity, consent, or relational safety. While these interpretations identified meaningful forms of harm, they did not consistently frame that harm as arising from weight stigma as a social or structural phenomenon. Instead,

weight functioned as the topic through which the interaction unfolded, rather than as a system of bias that shapes the encounter. Consequently, the focus remained on improving communication or ethical conduct, rather than interrogating how anti-fatness itself structured the clinical reasoning and interaction.

When Trouble was located within epistemic narrowing, participants explicitly used the word ‘stigma,’ and other variances like ‘bias’ which they understood as a poor clinical reasoning that privileges weight as the central explanatory lens. The interviewer asked Claire, who had repeatedly used the phrase ‘weight stigma’ in her interview, to “share some stories around how (she understands) weight stigma manifests in healthcare.” Claire responded:

> *“I just know that it's a thing where someone who is in a larger body goes to the doctor and they're told to lose weight and again on Maintenance Phase, she's brought up lots of the lady on it has brought up lots of experiences for her weight. She goes for her ear like an earache, and they tell her she needs to lose weight. Like hectic things like that. Whereas with my patients, it'll be that they've had persistent pain problems and then the doctor tells them it's just because they're overweight and some of them have then lost weight and nothing changed. That's kind of super awful.”*

In contrast to interactionally-focused accounts, Claire explicitly framed weight stigma as a patterned phenomenon in which weight becomes an overgeneralized explanatory factor, leading to dismissal of patients’ concerns. Her examples positioned stigma not simply as poor communication, but as a recurring clinical logic that reduces diverse health issues to body weight.

When situated within structural reproduction, mostly the HAES® participants conceptualized stigma, explicitly named, as a socially and institutionally sustained process,

embedded in documentation practices, professional norms, and the legitimization of weight-centered care. Allison shared:

> *"I'm excited because I think and I hope that the knowledge of, because I saw what I find funny is that I feel like weight stigma and HAES® sort as a pretty much so interrelated this a lot of the time, maybe people develop eating disorders because of this thin ideal or diet culture or this medical bias where they're commented on. And so, it's all just related to the same thing, in a way. Most of my patients, they might have a genetic vulnerability to get an eating disorder there at a time in their life of transition. And then there's a comment made by a doctor, and then it's like, boom, that's the trigger. That's their development of an eating dis, but the weight stigma is there, even in the hospital systems. If you don't have an anorexia diagnosis, you really don't get treatment."*

Similarly, Amina mentioned:

> *"…but when I started learning about eating disorders and the physical ramifications associated with eating disorders, and then of course, in understanding how weight stigma impacts people, and recognizing that that was a group a demographic people in large bodies who were just lost in the medical system and not cared for."*

Some of the non-HAES® participants are aware of the structural examples of weight stigma as experienced by people in bigger bodies but did not as clearly invoke language that suggests familiarity. For example, Ade stated:

> *"I mean acknowledging that is a problem and the problem is the problem of the system. Like it's not a problem of the person [mm], it's a systematic problem. They should have big gowns. It's not because someone is too big that they can't have gowns, like those gowns exist… Like systems should rearrange themselves to cater for people and not the other way around."*

In tune with Ade, Mercedes said:

> *"And then like taking somebody who's in a minority group who already struggles with very simple tasks that we obviously take for granted, whether that be a gender relate like related issue or a size related issue. Um and then like just perpetuating that through like the environment that they have to come into and that we provide care in. Because you're only part of that scenario. Like you're only part of that equation you are. You can control what you say and how you respond and the way that you talk to somebody. But you may not necessarily have you know the control or the authority to make those like big clinical systemic changes for that person. And then like also being able to acknowledge that when it does happen like, and then bring that up and like having, you know the integrity and being able to have those difficult conversations with management."*

In response to the Jo story, where the physiotherapist buys what is needed for Jo's next appointment, Claire shared:

> *"maybe the reason 5 resonated with me was because I that's exactly what I would do. I'd be like, 'Oh my God, I don't have something for this person. I'm gonna rush out and buy it'… I've done, it's not the same, but like super conscious of the weight restriction on the chairs I have at work because heaps of chairs that have a weight restriction of like 120 kilos… just those uncomfortable experiences where you could see someone like really eyeing off the chair, you know, it's really bad. So made a point of buying chairs that would accommodate everybody... But again, I know that working in like a hospital setting, which this reminds me of, I guess, there's often things you kind of have to do… I feel like I have a lot more freedom to practice how I want, which might impact how the physios act in these scenarios"*

In summary, participants did not share a singular understanding of weight stigma. Their interpretations differed in how explicitly they identified and located it within the stories – if they

recognized it at all. For some, harm was understood primarily within the interaction, with emphasis on communication, consent, and ethical responsibility, without necessarily attributing that harm to anti-fatness itself. Others recognized weight stigma more directly as a pattern in which weight became an overgeneralized explanatory lens shaping clinical reasoning. A smaller subset extended this analysis further, situating weight stigma within broader structural and institutional processes that reproduce inequities over time. In this way, recognizing weight stigma was not uniform, but reflected different interpretive orientations brought to the same clinical scenarios.

## Discussion

This study explored if and how physiotherapists interpret weight stigma through engagement with fictional clinical stories, with attention to how they locate Trouble and how their responses reveal Character. The fictional clinical stories explicitly embedded interpersonal and structural examples of weight stigma. The findings highlight important ways that participants' interpretations of stories diverged. These differences were not incidental; they reflected distinct ways of making sense of weight, health, and clinical responsibility within physiotherapy practice. Participants located Trouble across multiple analytic levels – interpersonal, ethical, epistemic, and structural – and, in doing so, showed implicit expectations about what constitutes good physiotherapy practice. Within musculoskeletal physiotherapy literature, the "good" physiotherapist has been conceptualized as one who demonstrates practical wisdom (phronesis), integrating clinical expertise, patient perspectives, and contextual judgment to determine what ought to be done in a given situation (Kleiner et al., 2023, 2024a). Kleiner and colleagues' (2023) conceptualization extends beyond technical competence to include relational and ethical dimensions of care, such as responsiveness, communication, and reflection. In the present study, these expectations were not explicitly stated by participants but became visible through how they interpreted and evaluated the actions of characters within the stories. These expectations, understood through Frank's concept of Character (Frank, 2010), demonstrated that responses to weight-related scenarios cannot be reduced to technical or interpersonal decisions. The responses also reflect moral and epistemic positions shaped by broader professional and social influences. These findings then suggest that weight stigma in physiotherapy is not solely a matter of individual bias or communication style but is embedded in the interpretive frameworks

through which clinicians understand bodies, health, and care. This shifts the focus of inquiry from whether clinicians hold weight-biased attitudes to how they come to see weight as relevant, necessary, or actionable within clinical reasoning.

Building on this insight, I argue, first, that recognition of weight stigma is uneven because clinicians are operating within different interpretive frameworks. This explains why participants often agreed that something was wrong in a story while differing substantially in where they located the Trouble. Thinking with trauma-informed care principles, for example, is different than thinking with personal stories. Second, when stigma is not recognized, physiotherapists mobilise weight through other, established forms of clinical reasoning. For example, physiotherapists may treat weight as an inherently relevant clinical variable, drawing on population-level evidence to justify weight-focused recommendations, or assume that addressing weight is part of responsible physiotherapy practice. This discussion section will also show that these forms of reasoning are socially and professionally constructed rather than evidence-driven; they are shaped by broader narrative, moral, and structural influences, including biomedicine, healthism, and neoliberalism. As a consequence, addressing weight stigma requires more than changing individual attitudes; it involves engaging with and reshaping the interpretive frameworks that underpin clinical reasoning.

## Recognizing Harm is not Necessarily Recognizing Weight Stigma

A key finding of this study is that participants did not share a common understanding of weight stigma, highlighted by their varied interpretations of fictional clinical stories which embedded interpersonal and structural examples of weight stigma. While some participants explicitly named and described weight stigma as shaping the fictional clinical interactions, others

identified concerns with the stories without situating those concerns within a broader framework of anti-fatness or stigma. These interpretations existed along a spectrum of recognition rather than a simple presence or absence of awareness. In these instances, participants drew on familiar clinical evaluative tools such as communication, consent, rapport, and ethical conduct, to assess what was happening in the scenario. Weight was present, and often central to the interaction, but how it was approached in the stories did not consistently emerge as an object of critique.

The distinction of what object is critiqued matters. It suggests that recognizing harm in a clinical encounter is not equivalent to recognizing weight stigma as a social and structural phenomenon. Several participants, particularly the non-HAES® participants, located the problem in the conduct of the interaction rather than in the mobilization of weight within clinical reasoning. Moments of discomfort, dismissal, or patient distress were interpreted as breakdowns in communication or lapses in professional conduct. Within these interpretations, weight functioned as the topic of the interaction rather than as a site of bias shaping how the interaction unfolded. As a result, the analytic focus remained on improving interpersonal practice – speaking more sensitively, obtaining consent, or validating patient concerns – without necessarily challenging the underlying assumptions that positioned weight as relevant in the first place. This aligns with broader critiques that healthcare interactions often individualize harm, that is, reducing complex forms of harm to issues of individual behaviour or communication while leaving structural determinants unexamined (Kaufmann & Bridgeman, 2022; Thille et al., 2017).

Situating this finding within existing literature highlights an important gap. Research on weight stigma in physiotherapy has largely concentrated on identifying negative attitudes or implicit biases among clinicians and students (Cavaleri et al., 2016; Elboim-Gabyzon et al., 2020;

Setchell et al., 2014; Webber et al., 2022). This body of work has been instrumental in establishing that weight bias exists within the profession. However, it tends to presume that weight stigma is a recognizable and coherent phenomenon that clinicians either endorse or resist. What my study shows is that recognition itself cannot be taken for granted. Participants did not simply vary in the degree to which they expressed how they broach the topic of weight in clinical spaces; they differed in whether they conceptualized weight stigma as a distinct issue at all. This echoes broader critiques in stigma research that awareness of inequity is uneven and mediated by social positioning and knowledge frameworks (Brown & Ellis-Ordway, 2021; Link & Phelan, 2001; Talumaa et al., 2022)

This uneven recognition can be understood through Link and Phelan's (2001) conceptualization of stigma as a process involving labeling, stereotyping, separation, status loss, and discrimination, sustained through relations of power. For stigma to be recognized, these elements must be understood as interconnected and socially produced rather than as isolated incidents. In this study, only Sig, Amina, and Allison, whom are all aligned with HAES®, articulated interpretations that aligned with this broader understanding. These participants described weight as an organizing logic within healthcare, one that shapes how patients are categorized, spoken to, and treated across encounters. Others identified elements of harm, such as dismissiveness or overemphasis on weight, but did not link these to systemic processes or to anti-fatness as a structuring force. Similar patterns have been observed in healthcare research (Phelan et al., 2015), where the strategies to move forward may acknowledge patient distress, emphasize interpersonal harm, without recognizing the structural dimensions of stigma that produce it (Puhl, 2026; Talumaa et al., 2022)

The implications of this distinction are significant when thinking about disrupting weight stigma in physiotherapy. When clinicians do not recognize weight stigma as a structural phenomenon, it becomes difficult to address it at the level at which it operates. Interventions are likely to focus on refining communication practices or reinforcing ethical standards, leaving intact the reasoning frameworks that continue to position weight as a primary explanatory factor in care. In this sense, the absence of a shared conceptualization of weight stigma does not indicate an absence of concern but rather reflects differences in how clinical situations are interpreted and understood. Recognition, then, is not a preliminary step that can be assumed; it is itself an outcome of the interpretive frameworks through which clinicians make sense of practice.

## The Role of Clinical Reasoning in Perpetuating Weight-Centric Practice

If recognition of weight stigma is uneven, the question that follows is: what guides interpretation? Participants were not approaching the scenarios without a framework; rather, each drew on their established forms of clinical reasoning to make sense of what was happening. Among those with limited recognition of weight stigma, weight entered as a clinically relevant variable, something to be considered, managed, or addressed within the bounds of professional responsibility. Even when participants expressed uncertainty about the strength of the evidence or the appropriateness of focusing on weight, it remained available as a legitimate line of reasoning. In this way, weight did not need to be explicitly justified in order to be mobilized; it was already embedded within what counted as reasonable clinical thinking.

This aligns with descriptions of weight-centric models of care, in which body size is treated as a primary determinant of health and as a modifiable risk factor within clinical decision-making (Harjunen, 2017; Standen et al., 2024; Tylka et al., 2014). However, the findings from this study

extend this literature by showing how weight-centricity operates at the level of interpretation in physiotherapy. Participants did not necessarily express overtly stigmatizing views. Instead, weight-centricity entered through routine reasoning processes, some of which relied on faulty understandings of population-level evidence or benefits of weight loss (Calogero et al., 2019), and aligning care with perceived professional norms. These processes allowed weight to function as an organizing principle within clinical encounters, even in the absence of explicit endorsement.

Understanding this requires attention to the epistemological foundations of clinical reasoning in physiotherapy. The profession is historically grounded in Western biomedical paradigms, which privilege measurable variables, causal inference, and the identification of modifiable risk factors (Setchell et al., 2017). Within this framework, the appeal of weight as a clinical variable lies partly in its apparent objectivity; it can be measured, tracked, and incorporated into standardized approaches to care. As Jutel (2006) argues, the privileging of measurement in medicine does not merely describe bodily variation but contributes to the construction of clinical categories, transforming attributes such as “overweight” from descriptive characteristics into disease-like entities. Yet this apparent objectivity obscures the interpretive work needed to position weight as causally meaningful in any given clinical context. As critical scholars have argued, biomedical reasoning does not simply reflect biological reality but organizes it in particular ways, privileging certain forms of knowledge while marginalizing others (Brown & Ellis-Ordway, 2021; Harjunen, 2017, 2021).

The findings also point to the moral dimensions embedded within clinical reasoning. Some of the participants’ – Pablo, Kate, Mary – accounts reflected an implicit orientation toward health as something that should be optimized, managed, and, where possible, improved through

individual action. This aligns with the concept of healthism, in which health is framed as a personal responsibility and moral obligation, and body size becomes a visible marker of that responsibility (Farrell, 2023; Lupton, 2018; Tylka et al., 2014). Within this logic, addressing weight can be interpreted as a necessary component of good care, to reinforce personal responsibility, even when its relevance to the presenting concern is uncertain. The emphasis shifts from whether weight is the most appropriate focus to whether it would be remiss not to address it. In this way, clinical reasoning is not only evidentiary but also normative, shaped by expectations about what responsible practice entails.

These expectations are further reinforced by broader professional and institutional discourses. Physiotherapists are positioned within healthcare systems that emphasize prevention, risk reduction, and population health outcomes (Allison et al., 2019; Hall et al., 2021). National-level guidance has, at times, explicitly framed physiotherapists as contributors to reducing the prevalence of obesity through physical activity promotion and related interventions (Martinello et al., 2017). Within this context, attending to weight can appear clinically appropriate and professionally expected. The incorporation of weight into clinical reasoning is therefore not solely an individual choice; it is supported and legitimized by the way professional roles are defined and enacted.

These elements then suggest that weight stigma is sustained through the functioning of clinical reasoning and broader influences in the profession. When weight is positioned as a default explanatory lens, it shapes how problems are defined, which interventions are considered relevant, and how patients' experiences are interpreted. Importantly, this can occur even in interactions that are otherwise characterized by empathy, respect, and ethical intent. The

persistence of weight-centric reasoning, then, cannot be fully addressed by targeting attitudes or communication practices in isolation. It requires attention to the frameworks through which clinical knowledge is produced, interpreted, and applied in practice.

While weight-centric reasoning emerged as a dominant pattern across participants' interpretations, it was not uniformly reproduced. Some participants challenged its epistemic foundations, questioning the reliance on population-level evidence, highlighting the complexity of health, and resisting the reduction of patients to weight-based categories. In their accounts, weight was not a default explanatory factor, but one element within a broader and more contextualized understanding of health and care. These responses reflect an alternative mode of clinical reasoning, one that foregrounds individual experience, attends to structural inequities, and remains critical of dominant assumptions about weight and health. For several participants, they attributed their interpretive orientation to their engagement with weight-inclusive frameworks, including HAES®. Rather than simply modifying attitudes, these frameworks offered different ways of reasoning about bodies, health, and clinical responsibility, enabling participants to reconfigure how and whether weight entered their practice. Participants described arriving at these perspectives through exposure to interdisciplinary mentorship and through experiences in practice that generated tensions between weight-centric beliefs and observed patient outcomes. This cognitive dissonance prompted critical reflection and, for some, a reorientation of their clinical reasoning.

## Knowledge Alone does not Disrupt Weight-Centric Practice: A Constructivist and Pedagogical Account

The persistence of weight-centric reasoning raises an important question: how to create changes in practice? Existing literature has often approached this problem through educational interventions, aiming to reduce weight bias by increasing knowledge, empathy, or awareness (Alberga et al., 2016; Puhl, 2026; Talumaa et al., 2022). While such efforts have demonstrated some short-term shifts in attitudes, their effects on clinical practice have been limited and inconsistent. The findings of this study help to explain why.

Participants in this study did not appear to lack knowledge in any simple sense. Many, though not all, demonstrated awareness of the complexities of weight, the limitations of weight loss as a long-term intervention, and the potential harms associated with stigmatizing care. Yet this awareness did not uniformly lead to a rejection of weight-centered reasoning. Instead, knowledge was taken up in different ways, filtered through existing frameworks that shaped what counted as relevant, credible, and actionable in practice. This suggests that knowledge does not operate as a neutral input that can be directly applied to clinical decision-making. Rather, it is interpreted, organized, and made meaningful within pre-existing ways of thinking.

The need for integration of new information is consistent with a constructivist understanding of clinical reasoning (Leavy, 2022), in which knowledge is not simply transmitted and applied but actively constructed through engagement with experience, training, and context (Freire & Ramos, 2009; Ramos Salas et al., 2017; Unger et al., 2025). From this perspective, clinical reasoning is not a technical process of selecting the correct intervention based on available evidence. It is a situated practice in which clinicians draw on multiple forms of knowledge – formal

education, personal experience, clinical experience, professional norms, and broader social discourses – to make sense of complex situations. The variability observed across participants' interpretations, even when engaging with the same scenarios, reflects this construction process. Clinicians were not arriving at different conclusions because some had knowledge and others did not, but because they were working within different interpretive frameworks that they have each organized over time, that shaped how new knowledge was understood and applied.

Participants' frameworks do not emerge spontaneously; they are developed and reinforced through professional training and socialization (Brown & Ellis-Ordway, 2021; Ramos Salas et al., 2017). Clinical reasoning is learned, not only through formal curricula but also through what has been described as the hidden curriculum of healthcare education (Mackin et al., 2019), which includes implicit messages about what counts as legitimate knowledge, appropriate intervention, and good clinical practice. If students are trained to attend to certain kinds of information (Freire & Ramos, 2009) – measurable variables, modifiable risks, and generalizable evidence – other forms of knowledge, including patients' lived experiences and structural inequities, they may be less consistently integrating the latter into reasoning processes. Within physiotherapy education, biomedical models of health, risk factor identification, and problem-solving approaches have traditionally occupied a central place, although there are growing efforts to incorporate social accountability, systems thinking, and transformative pedagogies into curricula (Unger et al., 2025). These recent efforts, however, continue to face implementation challenges, particularly in supporting learners to translate critical reflection into transformative action (Unger et al., 2025).

The findings suggest that this pedagogical context plays a role in shaping how weight is understood and mobilized in practice. When clinicians are trained to see weight as a relevant risk factor, supported by epidemiological data and professional guidelines, it becomes available as a default line of reasoning. Even when clinicians are aware of critiques of weight-centric approaches, these critiques may compete with more deeply ingrained ways of thinking that have been normalized through education and practice. In this sense, weight-centric reasoning is not simply maintained by a lack of knowledge, but by the durability of the frameworks through which knowledge is interpreted.

The findings also point to the emergence of alternative modes of clinical reasoning within the dataset. Participants who most explicitly named weight stigma and challenged weight-centric practices were those who drew on weight-inclusive frameworks, particularly HAES®. For these participants, weight did not function as a default explanatory category but was situated within a broader understanding of health that attended to context, lived experience, and structural inequities. Their interpretations were characterized by a willingness to question established assumptions, to resist the reduction of patients to weight-based categories, and to critically examine how clinical practices themselves may contribute to harm. It is important to note that this orientation did not emerge in isolation. Participants described arriving at these perspectives through engagement with mentors, from outside physiotherapy, and through clinical or personal experiences that created tension with previously held weight-centric beliefs. As a consequence, it spurred them to critical reflection, particularly when participants recognized the limitations or harms of prior approaches. This orientation shift reflects something beyond gaining new knowledge, it shows an active process of unlearning and re-evaluating established ways of

thinking, consistent with accounts of professional learning that emphasize grappling with the consequences of past practice as a catalyst for change (Thille et al., 2025). Rather than representing a modification of existing reasoning, these responses reflected a reorientation in how clinical problems were defined and approached away from a biomedical one. Hence, alternative, anti-oppressive frameworks such as HAES® do not simply add to existing knowledge but can support the development of different ways of reasoning about bodies, health, and care. Understanding how clinicians come to adopt and enact these frameworks is therefore critical for informing efforts to disrupt weight stigma in practice.

## Narrative, Character and "Good" Physiotherapy Practice

The current study also contributes to understanding weight stigma by foregrounding the role of Character in clinical interpretation. Drawing on Frank (2010), Character refers to the moral and positioning work performed through responses to stories, including how people implicitly define what is acceptable, responsible, or desirable. Participants' interpretations of fictional stories demonstrate that physiotherapists are not only evaluating clinical scenarios but also articulating expectations about professional conduct. Through these interpretations, participants make visible what they understand as good physiotherapy practice. For example, some emphasized the importance of attentiveness, respect, and responsiveness within patient interactions, highlighting interpersonal Character. Others focused on ethical accountability, particularly in how sensitive topics such as weight are introduced and navigated. These expectations reflect what has been described in musculoskeletal physiotherapy literature as the "good" physiotherapist – one who demonstrates not only technical competence but also relational and ethical responsiveness in practice (Kleiner et al., 2023, 2024a). In a recent

hermeneutic phenomenological study with Canadian musculoskeletal physiotherapists, Kleiner et al. (2024b) identified seven characteristics of the "good" physiotherapist: being oriented to care, integrating knowledge sources, competent, responsive, reflective, communicative, and reasoning. Their work importantly challenges technical-rational approaches to physiotherapy by foregrounding relational practice, reflection, care, and practical wisdom. At the same time, concepts related to structural inequity, anti-oppressive practice, or disrupting systemic forms of discrimination were not explicit within these conceptualizations of the "good" physiotherapist. Reflection was described as an important professional quality by Canadian physiotherapists in the phenomenological interview study (Kleiner et al., 2024b), yet the object of reflection was not necessarily directed toward examining how physiotherapy itself may reproduce broader social inequities, including weight stigma. As we see repeated in the present study, some participants' responses suggest that embodying the qualities associated with the 'good' physiotherapist also did not necessarily mean recognizing or interrupting stigma within clinical practice.

The findings suggest that weight stigma is not only a matter of what clinicians know or believe, but also of who they understand themselves to be as practitioners. Clinical encounters become sites where professional identities are enacted and negotiated, and where broader norms about care are reproduced or challenged. This aligns with critical physiotherapy scholarship that conceptualizes practice not as a series of isolated decisions, but as an ongoing "flow" of taken-for-granted activities shaped by professional training and social norms (Thille et al., 2025). Engaging with weight stigma, in this context of disrupting prior understandings and practices, involves confronting how one's prior understanding of "good practice" may be implicated in harm, and reworking one's professional identity in response (Thille et al., 2025).

Within this flow, clinicians may reproduce weight stigma not through explicit intent, but through routine practices that reflect dominant understandings of bodies, health, and responsibility.

Importantly, this work also demonstrates that holding non-stigmatizing attitudes does not necessarily translate into the ability to disrupt stigmatizing practices. Physiotherapists may recognize that weight stigma exists yet remain uncertain about how to act differently within clinical encounters (Thille et al., 2025). This gap underscores that disrupting weight stigma is not simply a matter of acquiring knowledge or changing beliefs. Existing current understandings of the 'good' physiotherapist may emphasize relational and ethical responsiveness without explicitly attending to structural forms of stigma such as anti-fatness (Kleiner et al., 2023). Disrupting weight stigma involves reworking the professional identities and practice norms through which care is enacted. In this sense, clinical reasoning is inseparable from questions of identity: what clinicians see, how they interpret it, and how they respond are all shaped by who they understand themselves to be within the clinical encounter.

## Rethinking Weight Stigma in Physiotherapy

My study draws attention to a gap in how weight stigma is addressed within physiotherapy. Recognition alone does not equip clinicians with ways to work through weight-related tensions in practice. Participants were often able to identify discomfort or problematic interactions, yet this did not consistently extend to questioning why weight was treated as a central explanatory factor in the first place. This finding echoes concerns in the literature that awareness of stigma does not readily translate into changes in practice, particularly when the assumptions guiding clinical reasoning remain intact (Jones & Forhan, 2021; Talumaa et al., 2022; Thille et al., 2025).

What becomes visible is not simply uneven recognition, but a lack of grappling with weight stigma within the profession. Current approaches tend to focus on communication, sensitivity, or attitude change. These are not insignificant. However, they do not provide sufficient direction for navigating how weight is taken up within clinical reasoning. As a result, clinicians may aim to be respectful while continuing to rely on weight as a primary lens for understanding patients' conditions. This pattern reflects broader critiques of weight-centric care, where weight is positioned as an individual risk factor and a target for intervention, often without attending to the social and structural conditions that shape health (Harjunen, 2017; Nicholls & Gibson, 2010; Tylka et al., 2014).

The absence of social and structural consideration is not a random occurrence. Physiotherapy practice is rooted in biomedical and professional norms that privilege measurable variables, risk reduction, and individual-level intervention (Jutel, 2006; Nicholls & Gibson, 2010; Setchell et al., 2017). Within this context, weight appears as a legitimate and actionable clinical variable. Less developed are the resources for critically engaging with what it means to center weight in care, or for working through situations where doing so may produce harm. Participants who questioned weight-centric reasoning often described arriving at this position through experiences that unsettled prior assumptions, including mentorship and difficult encounters that exposed the limits of weight-focused approaches. Similar processes have been described as central to learning to address weight stigma, where clinicians must grapple with the implications of prior practice rather than simply acquire new knowledge (Thille et al., 2025).

My study contributes to the ongoing conversation by showing where the difficulty sits. Through meaning making, this research unveils that the challenge is not only to recognize weight

stigma, but to develop ways of reasoning and acting that allow clinicians to engage without reproducing weight as a default problem. My study invites us to question when weight is relevant, how it is mobilized, and what its inclusion does within the clinical encounter. Addressing weight stigma, then, involves more than individual change. It requires attention to the conditions that shape how clinicians come to understand and use weight in practice, including the forms of knowledge, training, and professional expectations that sustain weight-centered reasoning.

What remains is an open question for the profession: how to support clinicians in working in ways that do not reproduce stigma, while still engaging with the complexities of health and care?

## Study Limitation

I invite you to engage with this section with the understanding that I am a graduate student who carved out and designed this thesis from a larger project led by my advisor, the principal investigator. Study limitations are often framed as uncontrollable variables that shape design and the strategies used to manage them. Here, however, I take a constructivist approach to first think through the perceived limitations of the larger project and focus on the limitations specific to my portion of the project.

This study is situated within the larger Storying Physiotherapy project. A pool of potential interviewees was developed from a longer list of volunteers who responded to a recruitment advertisement for a study completion study, as well as a shorter list of physiotherapists in the US, Canada, and Australia who self-identify online as HAES® clinicians. The story completion advertisement did not explicitly reference weight stigma or use directive language that signaled the study's analytic focus. Instead, it invited physiotherapists to creatively engage with writing

stories about clinical scenarios in physiotherapy practice. The interview recruitment gave a bit more context – that the researchers were interested in studying physiotherapists' ideas about "best practices related to body weight and size". As such, the study may have attracted participants already inclined toward storytelling, reflective practice or interested in examining clinical decision-making. This form of self-selection aligns with qualitative inquiry, where depth of engagement is prioritized over representativeness. Consistent with a constructivist worldview, the sample will not capture the full range of perspectives within the global profession, because perspectives are culturally situated. Notably, however, participants' responses reflected variation in how they interpreted the scenarios, suggesting that the dataset captures a meaningful range of clinical reasoning approaches among physiotherapists from similar countries, rather than a singular or homogenous viewpoint.

The findings are also shaped by the cultural and temporal context in which the data were generated. Participants' interpretations reflect prevailing discourses within physiotherapy at a particular moment and cultural contexts, including dominant understandings of health, body weight, and professional responsibility. These findings are not intended to represent fixed or universal truths, nor would identical responses be expected with a different group of clinicians or at a different time. Instead, the analysis surfaces patterns of reasoning that are recognizable within the profession. In doing so, it offers insight into how weight is currently understood and mobilized in clinical practice, while pointing to broader discursive conditions that continue to shape physiotherapy.

The analysis is shaped by my positioning as both an insider and outsider to physiotherapy. As a physiotherapist by training, I share a professional background with participants, including

familiarity with clinical reasoning, disciplinary norms, and expectations of practice. This proximity supported nuanced engagement with participants' accounts and helped me recognize implicit assumptions within their interpretations. At the same time, my positioning does not fully align with that of all participants. As someone who is thin, my understanding of weight stigma may lack the depth that those with lived experience of weight-based discrimination carry, which was experienced by some participants. Finally, as a Nigerian immigrant to Canada, I have become more familiar with cultural discourses in Canada, but my understandings of ethical obligations of physiotherapists, as well as my own reasoning, has its own cultural location that differs from many participants. This complex positioning required ongoing attention to how my assumptions and experiences shaped what I noticed, questioned, and prioritized in the analysis. I do not treat this as bias to eliminate, but as a condition of qualitative inquiry, where interpretation is shaped by the researcher's standpoint.

To work through these biases, I engaged in sustained reflexive practice throughout the research process. I maintained analytic memos, recorded some audio reflections, and documented evolving interpretations as I moved through the literature, theory, and data. These practices helped surface assumptions, trace shifts in my thinking, and critically examine how my perspectives shaped the analysis. Regular dialogue with my research team supported this process by providing space to test interpretations, identify blind spots, and refine analytic decisions. Over time, my engagement with the data deepened alongside my understanding of critical perspectives on weight stigma. Rather than attempting to eliminate subjectivity, I used these strategies to make the analytic process transparent and accountable, ensuring that the analysis

remained grounded in participants' accounts while critically engaging with the theoretical concerns of the study.

These considerations do not diminish the value of this study; but they clarify the conditions under which its interpretations were produced. The knowledge from this study should therefore be read as contextually situated accounts of how physiotherapists make sense of weight in clinical practice, rather than as generalizable claims about the profession. By making visible the interpretive, relational, and structural dimensions that shape clinical reasoning, this study contributes to ongoing efforts to critically examine weight stigma in healthcare.

## Conclusion

My study suggests that disrupting weight stigma in physiotherapy requires more than increasing awareness or addressing individual attitudes. Because weight stigma is embedded within clinical reasoning and weight-centric pre-licensure professional education, efforts toward change must engage with how clinicians are taught to interpret bodies, health, and care. This includes critically examining dominant frameworks that position weight as a primary clinical concern, such as healthism and neoliberalism, as well as creating space for alternative approaches that foreground relational, contextual, and structural understandings of health.

For physiotherapy education and practice, this means moving beyond communication skills training toward deeper engagement with the epistemic and moral foundations of care. By shifting attention from attitudes to interpretation, this study contributes to a growing body of work that seeks to understand ways to support the disruption of weight stigma in healthcare, offering new directions for research, education, and practice.

# Appendices

## Appendix 1: Brenda's Stories

The eleven physiotherapists who interviewed were provided with the full Brenda and Jo stories sets prior to the interview.

**Brenda – completed stories by physiotherapists**

Key:

- Red font is the story prompt provided to physiotherapists
- Black font is a story written by a physiotherapist to complete the interaction

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1) Brenda plays hockey and has had several minor injuries. Her knee has been really bothering her lately, so she started seeing a physiotherapist. The therapist gave her a home exercise program to start doing before her next appointment, which Brenda is hopeful will help. The physiotherapist then suggested that losing weight might also help her knee pain. Brenda says, "I don't see how that will help."

The therapist then said, "You know, you're actually right. The link between weight and knee pain is being challenged, and we now know that you can be fit and healthy and any weight. Your weight is one of many factors that could contribute to your knee pain. As I think about it more, considering your activity and fitness level and healthy lifestyle choices, it's probably not a significant factor for you. You're actually a very fit and healthy person, and we can work on getting your body better adapted for your sport. Let's focus on optimizing your mechanics and progress your exercise program so that your body is strong enough to tolerate your sport without pain. How does that sound?"

Brenda was relieved to hear that her weight was not likely the main driver of her knee pain. Even though she was hurt by her therapist's initial suggestion that she needs to lose weight, she was thankful that her therapist was thoughtful enough to catch her assumption and then reconsider based on a fuller picture of Brenda's health and fitness status.

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2) Brenda plays hockey and has had several minor injuries. Her knee has been really bothering her lately, so she started seeing a physiotherapist. The therapist gave her a home exercise program to start doing before her next appointment, which Brenda is hopeful will help. The physiotherapist then suggested that losing weight might also help her knee pain. Brenda says, "I don't see how that will help."

The therapist quotes some statistics from research about knee osteoarthritis. Brenda understands these statistics but still feels like losing weight isn't as achievable as the physio seems to think. For starters, Brenda's already very active and can't do any more activity at present due to her knee pain. She also has a friend in a smaller body with knee pain, so it feels a bit like a fob-off by the physio.

Brenda does her daily exercises prescribed by the physio, which help a little. At her next session, she asks if there are any other strategies to help with her knee pain. Her therapist again mentions weight loss. Brenda asks if there is anything that will work in the short term, like taping or a brace. The physio doesn't examine the knee any further before saying taping is unsuitable for her and her knee will be a problem as long as she's overweight. Brenda leaves the session feeling ignored and upset. She doesn't feel motivated to do her exercises because of how her physio focused on her size. Her knee worsens and she stops playing hockey because of it, but she is too ashamed to go back to the physio or find a new one.

***

3) Brenda plays hockey and has had several minor injuries. Her knee has been really bothering her lately, so she started seeing a physiotherapist. The therapist gave her a home exercise program to start doing before her next appointment, which Brenda is hopeful will help. The physiotherapist then suggested that losing weight might also help her knee pain. Brenda says, "I don't see how that will help".

"Are you open to me explaining more?"

"Please."

"What we know from the literature is that extra weight we carry can change our blood chemical balance that increases inflammation in the body and can result in more pain. I'm happy to share some of the research with you if you're interested in knowing more!"

"Biology isn't really my thing", Brenda says, laughing.

"I can always make things more digestible for you, or we can walk through some of it together," the physio explains.

“No, I trust you. I know that extra weight can be hard on my joints, it’s just hard to lose weight. But I didn’t realize it was deeper than that,” Brenda says in a defeated tone.

“It is hard! It’s much more complex than people realize.”

The physio pauses. Brenda nods her head, and her body softens.

The physio continues. “Beyond our joints coping with higher levels of pressure like you said, and reducing the pain of this particular injury, it is about being able support your lifetime of athleticism and function. You have told me previously it is a goal of yours to continue to play hockey for many years to come. I would like to see you be able to play hockey for as long as you would like, as well as reduce your long-term risk for conditions like osteoarthritis. You’re already doing lots to support a healthy lifestyle by exercising and engaging in sport. What do you feel you struggle with most when it comes to managing your health?”

“Food for sure. I love to snack, and even when I feel I’m starving I can’t lose the weight.” Her guard returns and I can tell she’s been told this information before without useful tools or resources being offered.

“I hear that you feel frustrated and that you have to restrict yourself to see change. Is that right?.”

“Yeah, and then I just end up giving up.”

“We are surrounded by a society with toxic messaging and diet culture that really isn’t sustainable for our long-term health and enjoyment. It is really difficult to navigate on our own.”

“I definitely don’t enjoy it.”

“I don’t blame you at all - there’s a lot of information out there and it can feel very contradicting and confusing. Do you find that?”

“Yes! One thing I read says this is the “best” diet and then the next thing I read says it’s terrible for you. Everything I try just leaves me hungry and feeling angry that I can’t figure out how to keep the weight off. It’s not like I haven’t tried”, she exclaims with exasperation.

“That sounds exhausting, I applaud you for continuing to try - but I would love to help you find something that works and is sustainable and supports your health but also your athletic performance.”

She nods in agreement.

“Would you be interested in me referring you to our nutritionist, and for me to contact your family doctor and discuss a plan? I would love to have everyone on board and to work collaboratively to support you. This is a multifaceted situation and deserves multiple eyes and scopes to help you succeed.”

“Yeah, I would really appreciate that.”

“Great, is there anything else you feel I can do to support you at this time?”

“No, I don’t think so, this sounds like a good first step.”

“Great, let’s talk a bit more about your exercise program.” … [end]

***

4) Brenda plays hockey and has had several minor injuries. Her knee has been really bothering her lately, so she started seeing a physiotherapist. The therapist gave her a home exercise program to start

doing before her next appointment, which Brenda is hopeful will help. The physiotherapist then suggested that losing weight might also help her knee pain. Brenda says "I don't see how that will help”

The physio responds by saying, "There is some strong evidence that a reduction of 5kg will have a significant reduction in pain".

Brenda goes home thinking about what the physio had said about losing weight. She's struggled with her weight her whole life. Now her weight is making her knee worse, she thinks to herself.

Over the next week, she is pretty negative about the prospect of fixing her knee pain. She tries some of the exercises, but in the back of her mind, she's thinking about her weight holding her back.

She sees the physio again with minimal improvements in symptoms or strength.

The physio asked how the week went. "I tried the exercises but it's still pretty sore," Brenda responded.

Brenda continues to see the physio for a further 6 weeks, with minimal improvements in symptoms and is unable to play the remainder of the hockey season due to pain.

Prior to the next season, a friend recommended Brenda to another physio. She was hesitant at first, due to her previous failed experience, but went to see physio 2. Physio 2 provides the same diagnosis as physio 1 and asks how she managed it previously. Brenda says, "I some strength exercises and the physio told me to lose weight." Physio 2 asks if anything she did helped at all. "Not really. The exercises didn't work and as you can see, I still have the weight."

The physio 2 responds by saying, "Okay, well your first goal in getting back to hockey is being able to run. To run you need to be able to hop, to hop you need to jump, to jump you need to squat and single leg squat. This will be your progression of exercises to get you back running. Do you have any questions on that?"

Brenda asks, "So I don't need to lose weight?"

Physio 2, "While the previous physio was right about what the research says, there are two issues with that paper. First of all, they did not control for exercises, i.e. they wouldn't be able to tell if it was the exercises that reduced pain or the weight that reduced pain. More importantly, long-term weight loss strategies are ineffective. I want you to control what you can control, and that's working on your knee's ability to take load. To do this, you need to be stronger. There is some excellent evidence supporting this."

Brenda goes home excited that she has a plan to get back to running. It's a slow process, as she hasn't done much exercise since physio 1, but she gets back to pain-free running six weeks after seeing physio 2. She's excited to get back to hockey training to see if she might play this season.

***

5) Brenda plays hockey and has had several minor injuries. Her knee has been really bothering her lately, so she started seeing a physiotherapist. The therapist gave her a home exercise program to start doing before her next appointment, which Brenda is hopeful will help. The physiotherapist then suggested that losing weight might also help her knee pain. Brenda says "I don't see how that will help".

The physio answers “losing weight will reduce the force going through the knee joint, which may help your pain”.

Brenda looks off in the distance and starts to become visibly upset and then starts to cry. She says, “"I'm trying my best, and I don't think I can do anymore! I have hypothyroidism, which I take medications for.” After an awkward pause, she adds “I’ve found a sport I love which I just want to keep playing”.

Denise replies, "I know it's hard, but I'm here to help you, and am happy to give you advice on exercises which may help. Did you know that building muscle tissue can actually help you lose weight and help your knee? So how about you start with the set I gave you and we’ll check in next week?”

6) Brenda plays hockey and has had several minor injuries. Her knee has been really bothering her lately, so she started seeing a physiotherapist. The therapist gave her a home exercise program to start doing before her next appointment, which Brenda is hopeful will help. The physiotherapist then suggested that losing weight might also help her knee pain. Brenda says "I don't see how that will help”.

“You can do a short experiment”, explained the therapist “try using this cane in your opposite hand, like this.”

“Oh wow! I can’t believe how much less pain I have using this cane.”

“Great” said the therapist, ‘Please use it until your next appointment then.” The therapist decides to delay further talk on weight loss advantages until the cane use had been successful.

## Appendix 2: Jo's Stories

**Stories for interview – Jo**

Key:

- Red font is the story prompt provided to physiotherapists
- Black font is a story written by a physiotherapist to complete the interaction

***

1) Jo has been waiting for months to see the specialist pelvic floor physiotherapist. After being squished by a waiting room chair, Jo has been left alone in the initial assessment room to change clothes. The room is hard to turn around in, and Jo has spent the past five minutes staring bleakly at an exam room gown that is about four times too small for them. The ties won't even touch when they put the gown on their body. The physiotherapist knocks at the door, and asks "are you ready?"

Extremely offput, Jo squeaked back through the door. "um can I just wear my normal clothes."

"No we need this on so we can have full access for the internal exam," came the reply from the therapist, glancing at her watch.

"It's just, um, do you have any other gowns, it is a little bit small." Jo replied awkwardly.

"That's the biggest one we have. I've seen it fit some big girls before. Let me get you one more that you could wrap around your back. And don't worry, there won't be anything I haven't seen before," replied the therapist.

Jo swallowed their pride, and not wanting to make a fuss, pushed through anxiety and put the gown on. After doing so, the therapist entered the room, handing Jo a second gown, saying "okay we only have 20 minutes left for our appointment. We'll move through the questions quickly so that you can leave here today with some things to try at home before your next appointment."

After a bunch of questions, the physio asks "Can you please pop up on that table for me and spread your legs?"

Jo's anxiety shot up even more. Trembling they climb onto the table, nervously covering their bare bottom with their hands.

"Please lay back, so I can start to feel different parts of your body"

Finding a spurt of courage and anger, Jo stood up. "NO! You've given me a child's gown, subtly insulted me, continued to be rude throughout, haven't asked me anything about what's happening, and talked about touching me without explaining anything or asking me if that's okay. Please leave."

The therapist stood dumbfounded, then stepped outside the room.

***

2) Jo has been waiting for months to see the specialist pelvic floor physiotherapist. After being squished by a waiting room chair, Jo has been left alone in the initial assessment room to change clothes. The room is hard to turn around in, and Jo has spent the past five minutes staring bleakly at an exam room gown that is about four times too small for them. The ties won't even touch when they put the gown on their body. The physiotherapist knocks at the door, and asks “are you ready?"

Jo opens the door a bit.

The PT quickly takes in that Jo is still dressed, saying ““Hi! I’m Mary your physical therapist. So glad you came!” She opens the door a little wider, slips Jo a lovely very large fuzzy housecoat she keeps handy for just such times as this. “Here’s a comfortable housecoat for you to use to cover up when it’s time to change.” Internally, she thanks the assistant for letting her know to get it.

Stepping in the room, the PT asks, “how was your drive in?”.

***

3) Jo has been waiting for months to see the specialist pelvic floor physiotherapist. After being squished by a waiting room chair, Jo has been left alone in the initial assessment room to change clothes. The room is hard to turn around in, and Jo has spent the past five minutes staring bleakly at an exam room gown that is about four times too small for them. The ties won't even touch when they put the gown on their body. The physiotherapist knocks at the door, and asks “are you ready?"

Jo starts to feel clammy under their arms and between her thighs. They call out "not yet! Can you give me a few minutes?" Their anxiety about this appointment was already so high, not knowing what to expect and how the therapist would treat them.

They take a deep breath and squeak open the door. The physiotherapist is standing against the wall on the other side of the hallway. She perks up when the door opens. "Are you ready?" She asks brightly, but her smile falters when she sees Jo in her regular clothing.

"Is there something I can help you with?"

Jo stammers, "I don't feel well and I don't think I can do this." The physiotherapist takes one step towards the door, then stops.

"Would you like to have a chat about this process before you get changed?"

Jo opens the door a crack wider. They take a deep breath and close their eyes. "I just don't know," the say quietly, uncertainly.

"Why don't we move to an open room and find a quiet corner?" The physiotherapist suggests. "We won't talk about any of your personal information, but we can discuss what the appointment might look like so you can ask any questions you have."

"The gown is too small!" Jo bursts out, opening the door a little wider, as their face reddens.

The physiotherapist frowns slightly. "I apologize. Would you like to have a chat and then we can sort out a new gown?"

Jo moves tentatively into the hallway but is encouraged by the Physiotherapist’s open demeanor.

"Let's start over again," she says. "It's nice to meet you, Jo. My name is Charlotte."

***

4) Jo has been waiting for months to see the specialist pelvic floor physiotherapist. After being squished by a waiting room chair, Jo has been left alone in the initial assessment room to change clothes. The room is hard to turn around in, and Jo has spent the past five minutes staring bleakly at an exam room gown that is about four times too small for them. The ties won't even touch when they put the gown on their body. The physiotherapist knocks at the door, and asks “are you ready?"

Jo panics, grasping at the strings and pulling them desperately behind them. But they can't even reach behind their back to tie the knot -- not like it would fit anyway. "Not yet," they say weakly.

Through the therapist says, "Okay, I'll give you a couple more minutes then".

Once more, they're left in this tiny room alone. On the table, there is paper laid lengthwise down the table, covered by a white sheet that looks no bigger than their waist. They sit down on the narrow table, wincing as their bare skin touches the cold paper. They pull the white sheet over themself, trying to tuck it around their torso in an attempt to hide.

When the physiotherapist knocks again, they tentatively say, "Yes," and watch carefully as the physiotherapist walks in. Their heart is racing and they can feel sweat collecting at the base of their spine.

The physiotherapist introduces herself, and sits down on a stool and starts asking a series of questions. As the physiotherapist asks them to lay down on the bed, Jo realises they've clenching their legs hard -- a desperate attempt to hide the fact that no matter how hard they tried, they just couldn't fit into the gown.

Jo's heart drops into their stomach when the therapist notes, "You're gripping a lot with your muscles." Jo feigns ignorance, and the appointment continues. The physio has difficulty completing the assessment, and by the end, is a bit frustrated. Jo is mortified, their face flushed red from anxiety and embarrassment. The physiotherapist gives them a couple of things to work on and suggests scheduling for a follow-up in two weeks' time.

Jo gets dressed and on their way out, remarks to the front office staff that their experience wasn't pleasant. The staff member promises to relay the remarks to the therapist. Near the end of the day, the staff member tells the therapist about the negative experience and the therapist rolls their eyes. The therapist puts a note in Jo's chart, describing the appointment as difficult.

***

5) Jo has been waiting for months to see the specialist pelvic floor physiotherapist. After being squished by a waiting room chair, Jo has been left alone in the initial assessment room to change clothes. The room is hard to turn around in, and Jo has spent the past five minutes staring bleakly at an exam room gown that is about four times too small for them. The ties won't even touch when they put the gown on their body. The physiotherapist knocks at the door, and asks "are you ready?"

Jo replies to say "no, the gown doesn't fit". The physiotherapist immediately apologises and asks Jo if they're still dressed in their clothes. When Jo says yes, the physio asks if she can come in.

Once in the room, the physio apologises again and acknowledges that it was an unfair oversight and will make sure the business purchases larger gowns. The physio then asks Jo if they would be comfortable with an alternative so they can proceed with today's appointment.

They discuss options and Jo decides that they would be happy to do some standing tests in their underwear, and then drape with a sheet when doing internal tests lying on the plinth.

Leaving the clinic, Jo breathes a sigh of relief, and were glad they got over their embarrassment to be honest with the physio, who had been apologetic and understanding.

The physio lets the office manager know new, larger gowns are a must. Getting a lukewarm commitment, she goes to a medical supply store one evening to buy a few larger gowns.

At the next visit, the new larger gown is in the room when Jo walks in. While getting changed, Jo decides to also mention the chairs are too small and the bed too narrow, hoping the physiotherapist will also fix those in the future.

## Appendix 3: Interview Guide – September 1, 2023

Pre-interview: one week before the scheduled time, circulate the stories to read (Appendix A), with the reflection questions.

**Interview**: **Start recording**

Briefing/orientation to the interview

- introducing self & the study focus
- confirming 90 minutes booked for the interview
- Start recording + re-affirm consent

1) [Demographic background of the PT]: Before we get into the stories, I wanted to ask a few background questions:
   a) In what kind of setting do you practice as physiotherapy? E.g. hospital, long term care, outpatient practice, home care
   b) How long have you been working in that setting?
   c) Do you have a clinical specialty or focus in terms of a population or clinical condition?
   d) In what country did you train to be a physiotherapist?
   e) And when did you graduate?

2) [Thinking with the stories:] First BRENDA, then repeat for JO
   a) Which are closest to what you think of as 'best practice' – and which are furthest?
   b) Prompt (if needed): what makes them best or the worst out of the group?
   c) Which are closest to own practice? How so?
   d) Which stories do you find upsetting or troubling? In what sense?
      i) ?OR what was it like to read these stories? What did they bring up for you?

   e) Are there other thoughts you'd like to share about [Brenda/Jo] stories before we continue?
   **AFTER BOTH BRENDA & JO COMPLETED:

   f) Comparing the two sets of stories, what is similar and what is different across Brenda's and Jo's stories?

3) [Your clinical practice]
   a) In your own practice, how does weight show up as a topic?
      i) Do you ever explicitly measure people's weight?
      ii) Do you ever initiate a conversation about weight? If so, when?
      iii) Do you ever take a weight history? If so, which factors influencing weight do you assess?
   b) How do you approach weight when a patient brings it come up?
      i) What do you emphasize? Or what do you find yourself talking about most often when it comes to weight?

c) How do you adjust your approach for different people, if at all? E.g. with children & parents, by gender, or other background factors?

i) If so, what do you tend to change?

d) How do people tend to react to your approach when talking about weight?

i) Would you please share a story that is particularly memorable in this regard?

e) What informs your approach? And I ask that broadly, knowing it could be from things like learning from your experiences or those of family and friends, podcasts, social media and blogs, formal clinical models you've learned such as cultural safety or motivational interviewing, guidelines, and more.

f) Are there times when your approach comes into conflict with recommendations by others? If so, how do you navigate those differences?

4) [Beliefs about weight/Familiarity with weight stigma/fatphobia/diet culture]

a) Would you please share the factors that influence body weight and composition?

i) In your understanding, which are the most impactful?

b) Have you noticed different treatment of people based on their weight, either in clinical situations or in your personal life? If so, what's different?

i) And what was the result? [implicitly trying to get at whether they perceive this as a problem]

ii) What do you think creates those differences?

5) [Training/philosophy]

***Confirm earlier answer re: training related to weight stigma (e.g. HAES® or another model or self-study). If none, end interview. If some training, continue.

a) How long ago was this training? Have you done any updates since your initial training?

b) What led you to take this training?

c) How well did this training align or clash with your prior physiotherapy training?

d) What key messages from that training did you take into physio practice? Were there some that you decided to not integrate? If so, which ones?

i) Prompt: how did you make those decisions?

e) What did this training change in how you practice physio, in comparison to your prior training? (e.g. communication, assessment, clinic set-up)

f) What have been the impacts on patients? Or, how do people respond to your approach?

g) What is it like for you personally to practice this way? How has it affected you?

h) Are there other courses or forms of learning that complement and support how you have integrated this knowledge?

***For HAES® trained physios specifically, add:

i) As you likely know, HAES® was not designed with physiotherapy in mind. How does it work within physiotherapy, as you practice it?

That brings us to the end of my questions. Is there something you'd like to add, or ask me?

When publishing, we use fake names for participants. Would you like to give me a first name I can use for you, or shall I choose one?

If you think of something later that you would like to add, please email me directly, sending either an audio or written note.

Thank you so much for your time today, and this really rich conversation. From here, I will arrange the *honorarium* and then our team will work over the coming months to develop our findings and ways to share them. We will email you directly when they become available.

## Appendix 4: Email Text

*Thank you so much for agreeing to be interviewed next ___[date/time] _____. As I mentioned when we first scheduled this interview, there is a bit of pre-reading to do before the interview itself.*

*The pre-reading is two sets of brief stories about clinical scenarios written by physiotherapists, which we will discuss. Feel free to mark up your copies, if it helps you gather your thoughts.*

*For each set (1 – Brenda; 2 – Jo), the following questions can help you reflect:*

- *Which are closest to what you think of as 'best practice' and which are furthest? - - What makes them better or worse?*
- *Which are closest to own practice? How so?*
- *What was it like to read these stories? What did they bring up for you?*
- *other thoughts you'd like to share about Brenda's or Jo's stories.*
- *I look forward to talking with you! Of course, if something comes up and we need to reschedule, please just let me know.*

## Appendix 5: Transcription Convention

Step 1: Listen to the interview with the auto-transcript on display.

Step 2: Proofread for spelling errors and represent filler words (see Guideline below)

Step 3: Download transcript to encrypted drive.

Step 4: Upload from encrypted drive to Cleaned transcripts folder on MS Teams and add "In Progress" to the name.

Step 5: Now open Cleaned version in MS Word. Fix text misplacement (i.e., if the auto-transcript misplaced what A said where B spoke) and updated the transcript to be consistent with transcription conventions chosen for the project.

Step 6: Final Proofreading.

Step 7: Rename the cleaned transcript folder by replacing "In Progress" with "Cleaned".

**Guideline**

**Fix Punctuation placement and assign symbols where necessary.**

| Symbol | Description | Meaning |
|---|---|---|
| **,** | Comma | Short pauses |
| **.** | Period | At the end of a phrase or sentence with a pause; intonation falls |
| **?** | Question mark | indicates a question; intonation rises |
| **[** | Left square bracket | indicate the point at which a current speaker's talk is overlapped by another's talk. |
| **[interjection]** | Square brackets | Interjections/Overlapping speech |
| **=** | Equal sign | When someone interjects and then takes over. |

| | | |
|---|---|---|
| ***gesture*** | Star | Indicate body gestures or other actions (e.g., laughs, shrugs, air quote, reads from a screen, etc.) |
| **( )** | Empty parenthesis | Unheard words/phrases |
| **(word)** | Parenthesis | Possible hearings |
| **word** | Underlined word(s) | Emphasis, louder |
| | | |
| **“phrase”** | Quotation marks | Use when a third person is quoted, paraphrased, or mimicked or when the speaker narrates their own words. |

**Differentiate Hesitation, Interjections, Agreement, and Disagreement.**

Uh: Hesitation or looking for words

Um: Hesitation or looking for Words

Oh! – Realization or Surprise

Mm-hm: (i) Agreement. (ii) Carry on, not necessarily agreeing with the things being said.

Mm: Agreement (mostly accompanied by a nod)

nh-nh: Disagreement

Hmm – (i) Realizing something you didn’t think about or know about. (ii) Thinking deeply about a question or response.

Ugh – Annoyed, Disgusted, Upset, Fed-up

Aha – an exclamation of sudden understanding, realization, or recognition

**Represent Necessary Non-Verbal Cues and Body Language**

Leave *false starts* and repetitions as they are.

Describe body gestures and place them in asterisk.

**Hyphenation**

To indicate the successive use of a word (e.g., blah-blah)

When people spell out a word.

**Different numbers in words from numbers.**

**Digits –** In reference to the number of the story that they are specifically talking about from the Brenda/Jo cases.

Number of Years, age, year

**Words –** all other numbers

Example

SIG: And **two**, we have to get … and that like blew my brain at **24**?

Also, if a phrase is said in between saying numbers, especially hundreds and upwards, then numbers are written in words.

Anonymization

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