

# Transforming Health Experience and Action through Shifting the Narrative on Obesity in Primary Care Encounters

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Thea Luig<sup>1</sup> , Louanne Keenan<sup>1</sup>,  
and Denise L. Campbell-Scherer<sup>1</sup>

## Abstract

We sought to understand the impact of primary care conversations about obesity on people's everyday life health experience and practices. Using a dialogic narrative perspective, we examined key moments in three very different clinical encounters, the patients' journals, and follow-up interviews over several weeks. We trace how people living with obesity negotiate narrative alternatives that are offered during clinical dialogue to transform their own narrative and experience of obesity and self. Findings provide pragmatic insights into how providers can play a significant role in shifting narratives about obesity and self and how such co-constructed narratives translate into change and tangible health outcomes in people's lives.

## Keywords

patient–clinician communication; patient-centered care; primary health care; shared decision making; obesity; narrative analysis; qualitative research; Canada

## Background

“What can we do more of, or less of, to make people living with obesity feel supported in their efforts to improve health?” Asked by a well-versed primary care dietitian, her question reflected the frustration and helplessness that patients and providers experience in the face of repeated weight loss attempts. It became the guiding question for an in-depth study to develop an approach to personalized obesity assessment and care planning.

The root causes of obesity include aspects of built and economic environments; social determinants of health; genetic predispositions; effects of medications; socio-cultural practices around beauty, food, and physical activity; mental illness; and other medical and biological conditions (Morris & Lancey, 2015). Furthermore, the effect of distress and stigma of living with obesity affect health and need to be addressed in the management of the condition (Vallis, 2016). These multiple biopsychosocial factors create the complex conditions in which people live their lives, fall ill and become better, eat food, move, and make ends meet.

Interventions to support people living with obesity and obesity prevention span public health policy, built environment, food security, poverty, and health equity (World Health Organization and Metropolis, 2014). Primary care providers are often in a place where people seek care for

concerns about their weight. Family physicians and their teams are in an ideal position to have meaningful and personalized conversations about obesity that consider the complexities of patients' lives: to plan care that makes sense, clinically and personally, is manageable, and addresses the health of the whole person in the context of their lives. However, research reports a number of challenges and constraints for using more patient-centered approaches (Gudzune, Clark, Appel, & Bennett, 2012; Heintze et al., 2010) including weight stigma in primary care (Thille, 2018), lack of obesity training (Dietz et al., 2015), and an emphasis on behavior change to achieve biological outcomes (Thille, Ward, & Russell, 2014). This leads to feelings of frustration for both providers and patients (Dewhurst, Peters, Devereux-Fitzgerald, & Hart, 2017).

The opening question about what a provider should do, can only be answered if we understand what is key in conversations about obesity and how patients integrate

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<sup>1</sup>University of Alberta, Edmonton, Canada

### Corresponding Author:

Denise L. Campbell-Scherer, Associate Dean, Lifelong Learning & Physician Learning Program, Professor, Department of Family Medicine, Faculty of Medicine & Dentistry, University of Alberta, 2-590 ECHA, 11405-87 Ave. NW, Edmonton, Alberta, Canada T6G 1C9.

Email: dlcampbe@ualberta.ca

and use new understandings of themselves and their health in their everyday lives to improve health. We sought to answer this question in a larger research project that used a qualitative, inductive, and collaborative approach to understanding clinician–patient encounters. The larger project identified interpersonal processes that translated into patient-important impacts and tangible outcomes in the weeks after the consultation (Luig, Anderson, Sharma, & Campbell-Scherer, 2018), resulting in an adaptation of the collaborative deliberation model for care communication for the obesity context (Luig, Elwyn, Anderson, & Campbell-Scherer, 2018).

Interestingly, our analysis also uncovered an intriguing transformation of participants' narratives about obesity, life, and self through the conversations with the provider and over time. These narratives reflected how lived experience of obesity is intimately linked to structural and cultural conditions, personal life events and relationships, and how moral judgments that social discourse attached to obesity affect how people imagine themselves, their abilities, and their place in the world (Owen-Smith, Donovan, & Coast, 2014; Thille, Friedman, & Setchell, 2017; Wright & Harwood, 2009). The dialogue during the encounter was a space where some of these entanglements were explored and addressed; the follow-up interviews and daily journal entries illuminated how people negotiated and adapted new understandings about their health and themselves. For this article, we selected three cases and used a dialogic narrative perspective to show how people living with obesity perceived and utilized narrative alternatives offered during clinical dialogue to transform their own narrative and experience of obesity and self. Findings provide pragmatic insights into how providers can play a significant role in transforming people's narrative about obesity and self, and how such co-authored narratives can translate into change and tangible health outcomes in people's lives.

### *The Lives of Narratives*

For the purpose of this article, we draw on understandings of narratives and narrative transformation from anthropology, sociolinguistics, sociology, psychology, nursing, education, and philosophy. Narratives can be understood as “verbalized, visualized, and/or embodied framings of a sequence of actual or possible live events” (Ochs & Capps, 1996, p. 19). Importantly, in the context of a clinical encounter, narratives not only communicate a sequence of events but also use “discursive evaluative devices” (Linde, 1993, p. 21; Ochs & Capps, 1996, p. 26). This means, narratives make a point about the speaker, orient the audience's perception and understanding, and reflect one version of reality that arises from the

intersubjective space of the communicative event (Linde, 1993; Ochs & Capps, 1996).

Narratives are shaped by the multiple relationships we are enmeshed in throughout our lives, including our historical, social, and cultural position. They arise from the intersubjective space that includes the narrator's own ontological horizon, past, present, and future, immediate and imagined audiences, as well as the wider historical and socio-political context. Thus, narrative includes not only the plot of an experience but presents the event in an order and form that draws on socially meaningful signifiers (Mattingly & Garro, 2000). Narratives affect stories, distort content in various ways, and shape it according to values, forms, as well as styles shared within a group of people. As a result, narrative never simply reflects experience but is “a constructive process, grounded in a specific cultural setting, interaction, and history” (Mattingly & Garro, 2000, p. 22).

*Heteroglossia* is a concept used by Bakhtin (1981) to describe the multiple influences that add to or subtract from the meaning of any narrative within a particular context. Whatever story is created in a personal narrative, including the coherence, agency, and causality that is established, is less an exact replication of reality, but rather speaks to what matters to the narrator within a certain social context.

Narratives are always variable, partial, and unfinished. They create distance from a present experience and cast possible pasts and futures (Portelli, 1991). With every occasion, people may change the way they narrate a particular experience. These changes might reflect shifting politico-historical circumstances, identities, relations, and life projects. Depending on these contextual shifts, some narrative elements might be added or emphasized and others may be altered.

The idea that narrating one's experience is beneficial for well-being has been explored in health psychology, the social science, and in therapeutic practice (Lepore & Smyth, 2002; Mattingly & Garro, 2000; Pennebaker, 1997). Informed by the writings of Bruner (1986), narrative is conceptualized as a tool that allows humans to order fragmented experience, to construct reality, and to open up a space for alternative meanings and interpretations. Changing one's narrative offers alternative ways of thinking past, present, and future. In that, narratives shape conduct, behavior, and move to act (Mattingly & Garro, 2000). Studying clinical encounters, Mattingly (2007) suggest that narratives can shift “into this dramatic form, offering the patient images of a possible future worth living” (p. 409).

Narrative inquiry has become increasingly used in health research, especially in nursing research. In this tradition, narrative analysis is grounded in curiosity about how people experience aspects of health and health care,

make sense of it within their social context and lifeworld, and about how narrative shapes and is shaped by their way of living (Caine, Estefan, & Clandinin, 2013). It recognizes the importance of an understanding of human experience as one “in which humans, individually and socially, lead storied lives” (Clandinin et al., 2015, p. 24).

Drawing on these theoretical lenses, we examine how patients’ narratives about themselves, their obesity, and their ability to live the healthy life they desire are negotiated during the dialogue with a provider, and after during interactions with friends, family, and the interviewer, as well as in reflection with themselves. Using three very different examples, we trace how the clinical encounter introduced alternative narrative resources that patients experimented with, incorporated, enacted, or rejected to make sense and meaning of the experience of obesity and health-related changes in their everyday life.

## Research Approach and Methods

### Project Setting and Collaboration

5As Team (5AsT) is a multidisciplinary research program based in the 5As of obesity management (Ask, Assess, Advice, Agree, and Assist) and collaborating with primary care physicians, teams, and patients to improve care for people living with obesity (Asselin, Osunlana, Ogunleye, Sharma, & Campbell-Scherer, 2015; Campbell-Scherer et al., 2014; Campbell-Scherer et al., 2019; Luig, Anderson, et al., 2018; Ogunleye et al., 2015; Osunlana et al., 2015). Our partner is a large, urban primary care organization that enhances family practices with access to multidisciplinary health care providers. Frontline clinicians, organizational leadership, and patient advisors are part of our research team, engaged in defining research questions and methods and involved in interpretation of results.

The majority of patient-provider encounters ( $n=16$ ) and interviews took place in a clinical consultation room with bariatric furniture at the primary care organization. A small number of participants ( $n=4$ ) chose a university office setting for the encounter and the interviews because it was more accessible for them. The interviewer clarified her role as anthropologist and nonclinician several times throughout the study with each participant to mitigate the effect that the clinical setting could have on participants’ perception of the interviewer. Patients prepared their journals in their personal settings.

### Study Design

This article draws on data collected during a larger study to develop the 5AsT personalized approach to obesity assessment and care planning (Luig, Anderson, et al.,

2018). Each encounter began by asking the patient to tell their story of self and health to appropriately diagnose root causes, past and current drivers of weight gain, identify patients’ strengths and value goals, and contextual factors that keep people from living at their best health. After the encounter, we conducted three interviews with each participant and asked them to keep a journal over the course of about 2 months. Findings about key processes of personalized obesity conversations as well as patient impact have been published elsewhere (Luig, Anderson, et al., 2018). This article presents key moments (Frank, 2012) of narrative transformation and illustrates the role narrative plays in the impact a clinical encounter can have for the health and well-being of people living with obesity.

### Participants and Data Collection

The larger study purposefully recruited 20 people living with overweight or obesity for maximum variation in patient context as determined from data collected in a large patient cohort (Campbell-Scherer et al., 2014). A dietitian and physician, both familiar with the 5AsT approach, conducted the encounters. This research was approved by the ethics board of the University of Alberta Pro00062455\_REN2 and participants provided written, informed consent before the initial encounter.

Encounters lasted 45 minutes and were video-recorded. Immediately following, the lead author conducted 1-hour conversational interviews, exploring how participants experienced the encounter, what they understood, emotional and cognitive impacts, to what extent they felt the assessment captured their experience, and how applicable the action plan was for their specific circumstances. Providers were also interviewed about their perception of the conversation. Participants were asked to journal about their everyday life experiences and reflect on emotions, thoughts, and feelings relevant to their action plan. At about 3 and 6 to 8 weeks after the encounter we conducted two 1-hour interviews with each participant, exploring their everyday life experiences and impacts of the encounter. All interviews were audio recorded and transcribed verbatim.

### Analysis and Representation

The analysis draws on aspects of dialogic narrative analysis (Frank, 2012; Sullivan, 2011) and other narrative approaches in medical anthropology (Becker, 1997; Garro, 2003; Mattingly, 1998; Ochs & Capps, 1996) as well as nursing and education research. Narrative analysis aims to explore how people interpret what is happening in their lives and bodies, in health care situations, and how they act upon and integrate new understandings in

their everyday lives. In a clinical encounter both patients and providers employ and negotiate multiple cultural, professional, and idiosyncratic narratives that make sense within their social and professional environment. Stories told in clinical encounters are never final, but always told and retold in response to others and to shifting life contexts. For these reasons, narrative analysis differs from other qualitative approaches. It is fluid and incomplete, demanding empathy and reflexivity of the researcher about themselves and the reflections of their participants. It pays attention to temporality and how narrative links experience to past, present, and future. It engages with the construction of meanings through narrative and the social discourse involved to maintain and translate the narration of experience to others (Holloway & Freshwater, 2007).

The unit of analysis represents an individual participant's evolving narrative within a series of narrative events (Riessman, 2001). In our case, this narrative was developed and transformed in and through the clinical dialogue, the diary, and follow-up interviews. This continued dialogue allowed participants and researcher to "compose a more complex account of the participants' experiences" (Clandinin & Huber, 2010, p. 12), which would not be possible when chunking interviews across different participants into codes (Clandinin & Huber, 2010, p. 13). Narrative analysis is guided by questions such as: What voices are present in someone's narrative? How do they come together to create possibilities of imagining self, past, and future? How does the narrative shift and integrate alternative voices? The result of analysis represents only one way of linking stories to the question at hand.

For this article, we first identified a group of participants with rich and complete data and then selected three examples that illustrate the diversity and complexity with which narrative transformation can occur. As Clandinin and Huber (2010) remind us, the knowledge of these three participants has been "textured by particularity and incompleteness" (p. 14), so saturation, or continuing to interview new participants until there are no new stories, runs counter to the aims of narrative analysis. There are as many stories as there are people who are interpreting their lived experiences in a particular context, by "imagining alternative possibilities" (Clandinin & Huber, 2010, p. 14). The three examples selected all involved an encounter conducted by a physician. Transcripts of sessions, interviews, and diaries were printed to allow immersion in the whole of the dialogue and selection of key moments that speak to the question of interest (Frank, 2012; Sullivan, 2011). The key moments that occurred during the dialogue with the physician were traced through the follow-up interviews and diaries to explore and illustrate their impact on the

transformation of participants' narratives of their obesity, of self, and of their health.

### *Trustworthiness and Reflexivity*

Rigor in narrative analysis differs in many ways from other research approaches and focuses on coherence, consistency, and contextualization (Holloway & Freshwater, 2007). Key for coherence and consistency is a strong theoretical foundation and triangulation of theories, described above, which link research question, methodology, data reduction, analysis, interpretation, and representation. Another aspect of authenticity in narrative research is trust within the relationship between participant and researcher that allows participants to direct the conversation and to share experience in an open, rich, and reflective way. We employed data source triangulation to capture how narrative is constructed in a variety of dialogic situations, with a physician, with a nonclinician interviewer, and with the self and imagined audiences in a diary.

During data collection, analysis, and written representation, reflexivity is of utmost importance (Holloway & Freshwater, 2007). As researchers and providers, we are present with our bodies in research and need to reflect on how this presence, and what we make of it, shapes our interactions and affects the creation of research knowledge (Warin & Gunson, 2013). Early on during data collection, our team engaged in a purposive exercise to reflect on and bring to awareness how our own embodied experiences with weight shapes our research. We learned how some thin bodies never worried about weight, other slim bodies dieted and exercised to achieve thinness, and others had critical life experiences that moved them to focus on health and body acceptance. While this exercise occurred once in a facilitated 90-minute discussion, its purpose was to boost ongoing reflexivity throughout the project. The lead author maintained a record of reflexive notes throughout data collection and analysis. To facilitate critical reflection on the interpretation of these data for both researchers and readers, we carefully selected very different cases, including one where narrative transformation did not result in a positive reconstruction of self and health.

To enhance contextualization, we provide data "as it presents itself" (Holloway & Freshwater, 2007, p. 81). Large excerpts of the encounter dialogue as well as interview and diary narratives are given here to include context for the reader to query the author's insights and interpretations. Narrative work is always co-created, a transformation of the story in dialogue, and a provisional and situated, not absolute, interpretation to illuminate the phenomenon under study (Holloway & Freshwater, 2007).

## Results: Key Moments in Co-Authoring Narratives

Peoples' narratives about health and weight were intimately linked to their perception of what was possible to improve health and their sense of overall well-being. In many encounters, the initial story participants told the clinician had neither a resolution, nor a potential for a future when obesity would not be a puzzling experience and a challenge. In fact, stories often ended in a place where people could not make sense of why obesity was still happening to them, or why they had not been able to achieve the desired weight loss. Many could not imagine what else to do to control weight, or how to manage.

Congruent with our aim to personalize the assessment and care planning, the clinician listened, first, to understand root causes and drivers of weight gain, and second to identify misconceptions about obesity and weight loss. Often, people's narratives reflected a negative, deficiency-based view of the self and internalized weight stigma. Key to our approach was that clinicians countered these self-deprecating narratives and offered alternative narratives by labeling examples of resilience in people's story as personal strengths. Clinicians also interpreted and integrated various life, medical, and context elements into a coherent, nonblaming, and validating narrative of how the past had led to the current health state of the patient. To further make sense of this alternative narrative, clinicians introduced medical explanations and advice. Over the course of three interviews and the journal for each participant, we observed people trying out how the alternative narratives fit their lives, discarding some aspects, and integrating others. As a result, their narratives changed and shifted. In the following, we will focus on key moments (Frank, 2012) for three cases that illustrate the transformation of narratives during and subsequent to the clinical encounter.

### *Trying Out an Alternative Way of Imagining Self and Future*

The first example is from a former dancer and performer, who, now in her sixties, suffers from a chronic medical condition resulting in fatigue and muscle pain, and is in precarious financial circumstances. A key moment in her consultation with the physician:

Participant: Here's my biggest question. Is this body that I now live in, which is totally foreign to me, is that just what happens to all women once they go through menopause? I mean I seem to see a lot of that, that they're, that women in their sixties, around my age, have put on more weight. Their body has changed, their faces have changed. Is that just how

it happens for everyone or is that something that we can actually control?

Physician: Right and that's the crux but from a weight perspective, some of this is a residual effect of the fact that you do have a chronic condition. You do have menopause [ . . . ], where that central weight gain is very common with women.

Participant: Now can I ask you about that before you go on? So when you say that's normal, so normal in the sense that that shifts and stays there, or normal in the sense that it shifts but you can bring it back to where it was?

Physician: You can't bring it back to where it was. Most people can't.

Participant: Okay.

Physician: Most people.

Participant: You're the first person that's finally, finally told me that. You don't know how many times I've asked that question to every single person I've dealt with over the last three years regarding this. [As] the first person you've been able to say that to me. Okay, good.

Physician: [ . . . ] the weight where you plateau is what we call your best weight.

Participant: Okay. I don't, I don't believe I've found that.

Physician: And that may be but, but this is, but this is where . . .

Participant: I'm hoping not. [Laughter] I'm hoping it's less than where I am at.

Physician: Yeah. Okay but, but just be mindful so we go about health, so I'm all about health. So when I hear you tell me that at the moment, you know, to quote you, "I feel like I'm at the healthiest I've [been] in a long time. I feel like I live in a time of abundance. I feel like I have the best relationships I've ever had. I feel like,"

Participant: But not physically.

Physician: No, but I'm just saying but from a health perspective,

Participant: Yeah.

Physician: Health is not—weight is not health, okay.

At first glance, this excerpt is about managing expectations. As a key moment from a narrative perspective, it illustrates a negotiation of narratives that offer the patient alternative ways of thinking about a number of existential

concerns, including making sense of experience, ideas of normalcy and deviance, sense of control, self-acceptance, and personal concept of health and how that shapes personal goals.

In the first part of the dialogue, the patient hopes to find resolution to her struggle with her changing body and her inability to control these changes. Her body feels “foreign” and at odds with her identity as a dancer. The way she asks for what is “normal,” what happens to “everyone,” and what her part should be in controlling these changes, illustrates that what is at stake for her here is finding and accepting a new normal. It seems important to her to receive professional feedback that validates her experience of not being able to change her body back to its previous state. The physician responds to these existential questions by helping her make sense of her experience with her body, validating her as a person who, just as most other women of her age, may not be able to control her physical changes, and offering a narrative that supports self-acceptance and self-compassion. The answer brings about a resolution that opens up a space to put efforts where she may be able to control something. This alternative narrative about self allows for positive emotions and confidence to support these new efforts.

In the second part of the excerpt, patient and provider continue to negotiate alternative ways of thinking about self and health. As the physician introduces the notion of “best weight” (Freedhoff & Sharma, 2010), the patient first doubts and then shifts to “hoping” that her current weight is not her best weight. As we observed with many participants, adjusting unrealistic weight loss expectations was tremendously difficult, and often accompanied by grief. Recognizing this, the physician directs the dialogue to values other than weight and body size. Pointing out positive developments in her mental and social health—the physician directly offers a narrative of health, breaking the negative link between health and weight that was so firmly established in the patient’s narrative.

Two weeks after this encounter, the participant reflects in her journal about different aspects of her health and daily experience, and how her pain, sleep, and eating relate on a day-to-day basis. The following segment illustrates how aspects of her narrative changed. Rather than a simple process of adopting the physicians’ viewpoint and recrafting her narrative accordingly, she is trying them out, much like trying on new shoes and taking them for a walk around the store to see whether they fit. She tries the ways of relating to herself that the physician demonstrated in her daily life, in her dialogue with herself:

You, you know I would say that what had the most impact on me was the session itself and the approach she [the physician] took. Because I’m now taking that approach with myself. So she showed me an approach that was about

compassion, about being gentle with myself, about understanding that there’s lots of different variables that are affecting things and about giving, not being afraid to, and actually trying to ensure that on a daily basis I’m congratulating myself. For, you know, seeing my strengths, looking at the positive things that I’m contributing to what I’m doing right now. So it feels, I’d have to say overall that it just feels like a much gentler process, even though I’ve, you know I’m doing stuff with it, I think my whole attitude to it became much more gentle [ . . . ]

Anyway it [charting] has told me a lot, given me a lot of information and when we add this it’s kind of blown apart, like all of a sudden there’s multi levels and I’m seeing all sorts of stuff I wasn’t seeing before. So it’s good, it’s good. I also still think that it’s really important . . . like I don’t necessarily believe this [one] session [is enough], but you know after doing this for a month, I would be feeling like I want to meet with that doctor again and, and tell her how I’m doing and what I’ve been doing and for us to kind of redo this whole thing right. And to do that for about a year, right, ‘cause *then* I’d be, then I’d have this, I’d be on top of this stuff. I’d really know what I was doing right and that would be [whisper] *so helpful, so helpful*. That could possibly, I believe that that in truth could lead me back to work.

Although this narrative is far from a coherent story that makes sense of everything, it is different in the sense that she paints herself as a different kind of actor. Not one that is in opposition to herself and at the mercy of a body that acts and feels foreign to her, but as someone who is contributing to feeling well, to understanding her illness and health, and who feels in control. Importantly, there is hope: she envisions a possible future, a positive future that includes the activities that are of highest value to her.

Four weeks later, in our last conversation, this new perspective and new voice had become a more established part of her narrative. Previous narratives were still lingering, but now she imagines a future where the old goal of changing her body back to where it was is not part of her story anymore. She tells a story that is hopeful and presents herself as on a good path toward being able to do more and feeling better:

Feeling much, much better about it. There’s been a big shift around that for me so it’s no longer about, you know, why can’t I change this back? I keep trying to do all these things and so it’s no longer about trying to change it back. Now the goal is about being the best I can in this body. . . so I would say I’m not beating myself up as much. I still beat myself up and I’m hoping I’ll be able to let that go.

Walking right now is the main focus, trying to keep walking every day. And that has, with the ups and downs, there still isn’t as many downs or as, or I’m not going down as far as I used to. So I’m generally speaking I am, my activity level is

increasing, and that's huge, that's huge. Something I've noticed with that is that . . . generally speaking I'm better every day like I'm feeling better every day, right. So I'm not getting those great big swings where I'm in tons of pain and *really* fatigued and just can't even function or getting out of bed at all.

In this last passage, fragments of old and new narrative mingle, but a shift is made, opening up a space for options for action.

Over time, this participant's narrative evolved to a point where she was able to imagine a different future, one where she talks about herself as improving, as being able to do more, and potentially being able to reach her goal of going back to work.

### Co-Authoring an Alternative Narrative Through Remembering, Walking, and Writing

The second example illuminates a different trajectory of co-authoring a new narrative and change. It illustrates how dialogue during the encounter sparked remembering and a shift in focus. Both became enacted in walking and negotiated in continued dialogue with self and others through journal writing and experimenting with action. What we learned from this example is significant in a couple of ways. First, the goals set during the encounter were not achieved; in fact, the patient disregarded them. If effectiveness was measured by patient goal achievement, the encounter would be misjudged as failed. A closer look at the narratives over time, however, clearly shows the impact of the clinical dialogue and how alternative narratives offered by the clinician supported the patient in making healthy changes. Second, this example illustrates the interaction of embodied experiences of movement with shifting narratives about health and self.

The following key moments are from the encounter, interviews, and journal with a young woman, who after an abusive situation has worked hard to be in a healthier space, mentally and socially. At the time of the encounter, she felt ready to improve her health physically. As a single mother of seven children, time and financial resources are scarce.

#### Key Moments During the Encounter

We will trace the impact of two key moments from the encounter throughout this participant's changing narratives over time. In the first excerpt, the provider recognized the joy that seemed to accompany the participant's account of the activities of her teenage years, reminding her of her love of being active:

Participant: I was like very competitive with myself. So I did really good with long distance and then high school, oh yeah also ice skating. I used to go ice skating almost every day. [. . .] We lived in the valley so I would walk up the hill, just to go ice skating, around the Legislature there. I used to do that every day almost [chuckles]. I think back, I don't know where I had the energy for all these you know.

Physician: You were a teenager [laughter]

Participant: Exactly.

Physician: And you're, how old now?

Participant: I'm 42 now. And then, kind of from there, things went downhill. 'Cause I remember I was 16 or 17 and that's when I met my boyfriend, and actually this is the one I ended up marrying and having 7 kids with so.

In her summary integration, the provider labeled this aspect of the story as *strength*:

Physician: [. . .] Strength-wise, you have a history in your life of enjoying being outdoors, really enjoying being active and also a lot of resiliency in the face of very difficult situations

Another key moment of the dialogue was when the participant shared her frustration over the lack of results on the scale despite her best efforts. The provider validated these feelings, but responded by shifting the focus on positive outcomes of healthy habits for physical, mental, and social health beyond weight:

Participant: Oh it is because when I try to do the walking—right now I do weight training. I started weight training now for the past month and a half and that's working up pretty good. I was working with a physiotherapist 'cause I had injured myself. So she actually showed me some moves that I could do. So that's helpful but cardio wise, I [have a] very, very tough time doing cardio 'cause I noticed—I do enjoy walking but when I walk it seems to flare up the ligament under my foot and it is really painful. So I just feel like every time I do anything cardio wise, there's always something, [. . .]

Physician: Get some orthotics or something, yea. There's stuff and some things that can be done for plantar fasciitis. And you did share that one of your things you just adore when you were younger was cycling. Do you still have a bicycle or do you have access to a bicycle?

Participant: No, not right now. I think a big part of that too is I would feel self-conscious about being on a bike right now, you know. So a lot of things I think I don't do because I feel self-conscious.

Physician: Thanks for sharing. Thanks for sharing all these, this is really, really helpful. So this is kind a sort of a map of how we've laid things out [ . . . ] it is very multi-factorial, it's not just one stripe, so I was sort of saying that it's kind of a big ball of yarn and you're trying to like unravel it, where you're taking one string and you're making a little skein of yarn and taking another string and another skein of yarn . . .

Participant: Oh yea, that's what I kinda feel like.

Physician: That's what kind of you've been doing. You've done a lot of the work on the mental part, which is really important. Although it sounds like some of the comfort food issues may still be a challenge for you. You've done a lot of work on depression and anxiety and naturally enough, that continues to become an issue. You've treated your sleep apnea, which is tremendous, again, continues to become a challenge. These things have very real relationships with weight [ . . . ]

Participant: Sometimes it's just, you know what you're saying about all the parts, trying to work on my weight issue—I find, as much as it helps me and I come a long way, I also feel like, what's the word, disappointed sometimes and defeated because I feel like I'm still stuck to where I'm at, you know, like weight-wise.

Physician: So let's make sure we come back to that 'cause I think that's really important.

Participant: Exactly, I think.

Physician: [ . . . ] So here doing the weights and doing what you're able to do, you're plateauing, okay. And the challenge is that weight stays stable. You want to be down here, there's this expectation gap. But you're steady here. The flip side of that though is that with all the things that you're doing around your health and getting more healthy, there's really important patient health outcomes that happen. The fact that you are now dealing with your ADHD, which is an important driver of obesity, means you have more structure, you have more focus, you can get more done, helps probably with that feeling of fatigue. You also have been dealing with depression and anxiety and having new skills, which helps you to spend more time feeling better. And as you bring in weight training and the physiotherapy, and as we work on some of the mechanical issues to let you be more active, you start to be able to be out and about more. Doing more things with your kids, things that you identify as being more important. Those things can continue to improve even if your weight stabilizes. So when we talk about goals, we really emphasize goals that are health, not goals that are weights, right.

These two key moments illustrate where alternative ways of narrating the past, present, and future were offered and contrasted. Reminding of past physical activities made remembering the past in a different light possible by

shifting attention to the positive emotional impact of these activities. Similarly, focusing attention to benefits of healthful habits other than weight loss allowed for an alternative interpretation of the present and shifted options for imagining the future.

### *Remembering*

In her interview after this session, her first words were that this was “really good.” Reflecting on her experience and what made this conversation “good,” she said,

Participant: [ . . . ] it also reminded me [of] the good points in my life, 'cause when I was a kid I was very physically active. So I was very into a lot of things like bicycling, ice skating, just walking and hiking all over the place, in the trails. So those are good times so, I kinda forgot about those yeah. So, she talked about those, what we could do to get back to that I guess.

[ . . . ]

Participant: Part of it yeah, 'cause there's a lot of other things too. She did focus a lot on my strengths as well so.

Interviewer: Okay, how did you feel about that? Did you agree?

Participant: Yeah, it kind of reminded me like, you know, I'm still capable of doing things yet, so that helped [chuckles].

While telling her story during the encounter also included difficult past experiences; remembering helped this woman make sense of the how and why of her current situation. For her, this built a necessary foundation to move forward and take on a more active role in shaping her future. Particularly important for her was remembering her joy of being active as a younger person. The clinician was able to pick up on this, link it to her ongoing ability to overcome difficulties in life and, later in the encounter, with thinking about potential actions and goals. This dialogic dynamic opened up a potential for an alternative narrative of the past, the present, and the future. It shifted the patient's attention to what she is capable of, creating hope to succeed with actions in the future.

### *Shifting Attention to Whole-Person Health*

The second key moment during the encounter opened up the space for a shift in focus: away from weight results toward improving health in a holistic way:

I was telling her I kinda felt like I was stuck, feeling a little disappointed and defeated. And she said it was still good because, you know, you're getting more important health



outcomes and wellness from it. Which is true 'cause I am doing weights, and even though like I don't see no pounds dropping, I do feel better strength-wise. Like I noticed I can pick up things without being like [chuckles], you know, "Ugh, this is heavy!" like I have more strength. So I guess I could see her point and the health and wellness outcomes of what you're doing. So, I do want to add in more, so she did offer some suggestions. (post-encounter interview)

This redirected attention to whole-person health benefits of activities supported a change in self-perception and confidence in trying out and sustaining healthful practices.

### *Experimenting, Scrutinizing, and Enacting Remembering and Focus*

This woman's diary reflects the process of trying out, questioning, and incorporating the alternative narratives from the clinical dialogue in her everyday activities and reflection. In her writing, she grapples with the multiplicity of voices that gave meaning to food in the past and stand in opposition with the alternative ways of seeing herself sparked by the dialogue with the physician. The following diary entries illustrate how, through time and in concert with the physical and emotional effects of walking, the new ways of seeing herself and her ability to be healthy began to make more sense and to better align with her embodied experience:

May 19: Feeling tired. I crawl into my warm bed and, with the rain falling outside, I feel cozy. I have some chips because I associate that with relaxation and my guilty pleasure is to feel comfort and not caring and not thinking about anything else. I know this is why I tend to snack more at night in bed. I feel lost and don't know how to stop the cycle and it's hard because it's associated with good feelings.

May 21: Went to bed feeling sad, tired, and worried about the future. Again had some chips and chocolate milk because I feel like I don't care anymore about anything.

May 25: I was thinking about last night and I thought about the walking part. It was 10 p.m. and I thought why not? [It is] cooler in the evening and [will] help me de-stress. I've been wanting to start walking for a while now. So I went. My daughter and my kids' dad went with me. Was good. Except my right knee is now acting up. It's getting painful to walk on. Anytime I try and do anything cardio something hurts or goes wrong. [. . .] On a good note, we walked 30 minutes. I feel proud of myself for getting up and going. The fresh air was nice and less busy in the night. I don't feel as self-conscious walking. The feeling was refreshing. I'm home and I'm tired and going to head to bed. Regardless of my knee, I feel accomplished tonight. It's a good feeling.

June 4: [. . .] We had a welcome home BBQ and by the time everyone left and I cleaned up the dishes and [the] kitchen, I was tired and it was 11:30 at night and I thought, well maybe one night wouldn't hurt me . . . but I didn't want to give up and I wanted to keep my streak going and I needed to unwind, so I went with my other daughter. Best thing ever because prior I was feeling "down" and overwhelmed. Was feeling emotional after the past couple of days. After my walk, my mood changed for the better, I felt refreshed and happy and good. I'm so glad I went.

June 8: [. . .] so with that, and dark rain clouds out, I didn't go. I just loaded up [the] dishwasher and I felt disappointed in myself because I missed another day ☹. Then my newborn grandson was given to me to watch for a bit, so I laid in bed with him, holding him and singing him quietly to sleep. It was a nice cuddle and I felt better about not going out tonight. What matters is that I wanted [emphasis in original diary] to go. That I know it helps me to feel better. Sometimes things are out of my control, but sometimes they needed to be. I needed to cuddle and spend time with my grandson. Was also good for the soul and spirit, like my walks are. [. . .] So time to sleep, and tomorrow is a new day and I will get my walk in ☺ [emoticon in original diary].

These diary entries demonstrate the complex realities that people share about the internal and external struggles they experience, as they try to make changes to improve their health. They also illustrate the impact of multiple relationships of past and present on an individual's perception of difficult situations, and of food or movement as ways to cope with distress. This woman used the awareness and different perspectives triggered by the clinical encounter to shift from food for comfort to experiencing walking as providing a greater physical and emotional benefit. Over time, her determination to walk every day threatened these positive changes by introducing feelings of guilt when she was not able to walk. Eventually, the new attention to whole-person health helped her accept other activities as legitimate ways to take care of her whole health.

Journaling fulfilled an important role for this participant in that it provided an additional space for dialogue with herself and conflicting voices. Importantly, it became a tool for remembering the positive effects of her efforts. Just as the physician triggered her memory of how much she enjoyed being active when she was younger, the journal reminded her of the positive emotions that she experienced during her walks:

When I write about it afterwards, it kind of reinforces like how good I feel. Like how positive I feel about it because yeah. So it kind of helps to "oh this is why I wanna walk" right, so. But yeah it was, I would say awareness, mostly awareness and just focusing more on what I was doing, like the negative versus the positive and kind of acting on it so. (follow-up interview 1)

### *Imagining an Alternative Future*

While this participant did not tackle the goals set during the encounter, she found and achieved a goal that was of great value for her. Narrative analysis can illustrate the impact of the dialogue with the provider and how this person incorporated alternative ways of thinking about self and health that were offered in the encounter. We were able to trace how the transforming narrative was mirrored in not only establishing a new habit of walking, but also in better coping with difficult emotions, and with a new motivation and confidence to continue behavioral change:

Participant: I kind of feel like I'm more wanting to try new things. And actually, what's funny, today, I seen on Facebook there's this dance group, well they're dance, hip-hop, for free.

Interviewer: Oh, great!

Participant: You just pay two dollars at the door and that's it. And they teach you for an hour, it's like every Friday I think 7 to 10:30 for all ages. So I signed up my two kids, they're seven and eight. I figured you know it would be fun for them to learn how to hip-hop dance you know. Today, I was thinking maybe I'll just join them, try something new. (follow-up interview 2)

In the initial encounter with the physician, this participant had talked about wanting to walk. She had also mentioned that she was too self-conscious to take up biking. At the end of the study period, she was excited about trying hip-hop dance. This tremendous change was initiated through subtle shifts in narrative that highlighted positive emotions of movement in her past and shifted her attention to benefits other than weight loss. Experimenting with walking and experiencing the positive effects on mood, in concert with her journaling, where she increasingly incorporated the alternative narrative elements from the encounter, was what helped maintain and strengthen the changes she made.

### **Narratives that Resist Transformation**

The last example illustrates how alternative narratives offered in dialogue with a provider may not resonate, and not be taken up to transform a patient's narrative about self and health. For this healthy middle-aged woman, the voices of past and present relationships and engagements remain dominant, reinforcing her narrative that her weight is not acceptable despite excellent health and health habits. While engaging in regular exercise and diet practice for many years, unhappiness about her weight kept her from experiencing full well-being. The following is a longer excerpt from the encounter where the provider recognizes

how the patient's narrative moved her to consider drastic medical interventions when they were not indicated, indeed potentially harmful from a medical perspective. In response, the physician quite directly attempts to offer an alternative narrative of health as distinct from weight, providing evidence to support her argument (much of the evidence was removed to reduce the length of the quote):

Physician: So I thought maybe we can start with just having you take a little bit of time that we could backtrack to sort of the beginning.

Participant: Okay, just want me to, yea, okay [. . .] talking as a kid, I didn't have a weight problem as a kid, although I always felt I did. As I look back, I didn't. But I grew up in a pretty violent home, lots of abuse of all different kinds. And one of the things that my abuser would do is to tell me that I wasn't loveable because I was fat. That was how he kind of groomed and controlled. So I think probably that's where the mental part of the whole thing started. But as I look at the pictures, I'm like, I kinda look like a skinny kid like everybody else. But I remember comments about my body and comments about being un-loveable

[. . .]

Physician: Okay, so how satisfied are you right now with where you're at?

Participant: Not at all, like no. You know I don't have a desire to be, you know, thin. But I do have a desire to figure out a way of eating and a way of being that's healthy and doesn't make my weight go up. That I can live with, you know. [. . .]

Physician: Yeah, well remind me [. . .] what's your BMI right now, do you have a sense?

Participant: No, I think it is like 34 maybe.

Physician: 33, 34? Now we've talked quite a bit in the past about goals and about objectives and about what we're at and I know that's been a struggle.

Participant: I know. My brain just won't go there, I don't know why it can't get it to go there but.

Physician: [. . .] so if you sort of divide those things into two parts and just think about your health and wellness right now, as distinct from the weight, how do you feel about your health and wellness right now?

Participant: Oh, I think I'm very healthy.

Physician: So you feel you're very healthy?

Participant: Yeah, I mean I don't have any, there's nothing I would say health wise, I really need to work on or you know.

[. . .]

Physician: Where did [commercial weight loss club] put your “goal weight”?

Participant: Oh, they want me 56 lbs lighter.

Physician: Thank you for sharing that ‘cause that is actually, I think, really, really impactful and important. Because it gets back to some of the situations that happened that programmed the fact, you know, [that is] challenging for you. Because you have this, and tell me if I’m paraphrasing incorrectly, but as I understand it you have this sort of dichotomy between the fact that I know, you are incredibly healthy and you’re doing amazing amounts of physical activity. And your weight is stable now, despite the fact when you [go through] menopause and stuff, which is a challenging life phase, and despite the fact you had some major dieting in the past, you’ve maintained a lower weight for nine years. [. . .] yet, you’re not satisfied in the sense that you’re struggling to find a way of being so that you are healthy and just can live with it and have a strategy without having to constantly feel like to [air quotes] “do something.” Am I interpreting correctly?

Participant: Yes, absolutely.

Physician: [. . .] I know that the rest of it is not really an issue, you don’t have mechanical, monetary, and resource, metabolic issues. The main issues come down to things we talked about, would you agree with that?

Participant: Yes.

Physician: One of the things worthwhile thinking about [. . .] the body has a set point where it is trying to get back to and you have to work incredibly hard as you move to maintain a lower set point, right. And in all of the best trials for diet and exercise, the 5% weight loss sustained is incredibly good. [. . .] So the fact that you were able to get lower, and then of course menopause is baseline challenging, and you still maintain actually lower than that, your degree of long-term weight loss is by any definition a huge success. [. . .] So it’s actually quite harmful I would argue for [commercial weight loss program] to set a goal for you of 132, because that represents a 50 lbs change from where you are [. . .] It kind of feeds into all these past thinking you’ve had around weight as distinct from health in a way I would argue in a way is probably not helpful. [. . .] So what we say is you shouldn’t ever do anything that you can’t do forever, which really fits with a way of being healthy that you can live with. But the challenge here is, that we need to confront, is this idea that despite the fact that you are completely metabolically healthy, to you health is defined by a number on the scale and not by how you are in your life.

Participant: That is partially, really, really true, part of me is really proud of my health.

Physician: You’re fit as a fiddle [laughter].

This patient was known to the physician for some time, and both have had previous conversations about weight loss and dissatisfaction with body weight and shape. In this encounter, however, the patient shared, for the first time, some very difficult childhood experiences that helped the physician understand where some of the perseverance with weight loss originated. The patient had also asked about the option of bariatric surgery or medication. The physician interpreted the direction of this dialogue as rooted in a narrative that equates weight with health and identity. She makes this link explicit and offers alternative ways of seeing health and self by highlighting the exceptional health this patient has achieved.

The following quotes from this participant’s diary illustrate the emotional complexity that comes with navigating the multiple narratives that shape her experience of herself and her body. Intersecting in these reflections are narratives of past relations that imprinted on the way she feels about herself, current narratives from the commercial weight loss club she is part of, alternative narratives offered by the physician, and her perception of her own narrative and how it was mirrored through me, the interviewer:

May 17: Another great gym day 3.5 K. Did an hour of cardio and some weights. But [personal trainer is] still sick so I am all alone. Feeling pretty good about this today. I had a bit of an emergency at my home—I had to run home at lunch. By the time I got things sorted around I was starving. I made a poor food choice, not happy with myself and need to learn to wait or be prepared. I wonder why my brain turns off when I get hungry, why does that little voice in my head give me permission to screw up?

May 24: Stellar day. I did 30 minutes of cardio 30 minutes of muscle work. Ate well, drank lots of water. Feeling good when I have a good day like this. Struggling with [commercial weight loss club] commitment. I have had so many derailments with [commercial weight loss club] lately I feel pretty bad about it. Lately there always seems to be an excuse why I didn’t record or I didn’t pay attention. [. . .] but I still feel one day doing good isn’t really enough.

May 25: Today I did not go to the gym as I had an appointment after work with [interviewer]. However, I did eat very well. By that I mean under [food allowance set by commercial weight loss club] and only eat real food that was not over-processed [. . .] Feeling great. I did find talking to [interviewer] that I sound pretty hard on myself. I am not happy unless I’m hundred percent perfect. Well, that sounds like a perfect recipe for being miserable. I feel like I should work on that maybe. It is too hard if I want to have a happy life and after all that is what this is all about. Sweet, just thinking about lowering my expectations raises my anxiety, [. . .], I am already not being perfect when I am shooting for

hundred percent. I am fearful if I say it is okay to not be perfect I will go crazy and gain weight. Just five minutes ago I felt great, but now I am less so.

Each entry begins with a positive evaluation of the day highlighting the positive feelings that this woman experiences by engaging in a variety of healthy habits. Yet, she ends each of the entries with a narrative that assesses herself negatively. The alternative positive narrative that the physician offered did not shift the predominant narrative of her not doing good enough. The negative evaluations reflected societal discourse that blames individuals for their size and attributes their size to lack of discipline, control, and failure of being a good person. Furthermore, the dialogue uncovered the root of these negative narratives to lie in traumatic childhood experiences. Recognizing that in this case, the one-time dialogue would not suffice to shift a narrative so deeply rooted, the physician and patient together decided to include trauma therapy in her personalized plan.

## Discussion

A recent article in the *Lancet* called for a new obesity narrative (Ralston et al., 2018). This change is urgently needed on many levels, including policy, society, health systems, as well as the dialogue in the clinical encounter. This study explored dialogue in care encounters, and traced how narratives of obesity and self are co-constructed through negotiating alternative narratives from clinical voices, past and present relationships, social and personal life context through time after the encounter. These co-authored, alternative narratives had real, tangible impacts on how people imagined and organized their lives, perceived their own well-being, and became activated in making changes to improve health. In this sense, narratives can be understood as an important arena in which primary care providers impact and support peoples' efforts at making positive changes in their everyday lives to improve health.

Primary care has long embraced the importance of narrative as integral to the medical encounter and to practicing medicine (Charon, 2001; Greenhalgh & Hurwitz, 1998). Narrative research enhances our understanding of how both providers and patients during and outside the clinical encounter co-construct narratives that shape decisions about health and health care. In peoples' narratives about weight, a complex mix of voices comes together. They contain moral discourses around weight, eating, control, and discipline; medical discourses around risks; popular discourses on diets and weight loss, and they reflect social practices around eating, coping, and leisure (Forhan & Salas, 2013; Kirk et al., 2014; Ogden & Clementi, 2010;

Salas, Forhan, Caulfield, Sharma, & Raine, 2017). In our participants' narratives, we also recognized voices of past relationships that equated food with love and comfort, or to the contrary, equated being large with being unlovable.

Two examples demonstrated a fundamental shift in the way these individuals perceived themselves, obesity as a condition, and their ability to lead healthier lives. As people evolve and tweak their narratives with every interaction and experience (Mattingly & Garro, 2000), we found that narrative is a space where providers played a powerful role in offering and co-constructing alternative narratives. Alternative narratives focused attention on compassion, on improving health instead of solely on reducing weight, on the complexity of obesity and away from blaming individual behavior, and on abilities, strengths, and opportunities instead of deficiencies and shortcomings.

As the examples illuminate, people negotiate narrative alternatives in vastly different ways resulting in individually diverse strategies, impacts, and outcomes. Constructing and transforming narrative is a complex process that involves relationships, emotions, habits, embodied experiences, and perceptions. Participants partially incorporated narrative alternatives into their own story and experienced positive changes in how they relate to themselves, their ability to be healthier, and in everyday life actions. They were able to experiment with healthy change that fit with their lives, inspired them, and improved their sense of well-being. These positive shifts increased hope, confidence, activity levels, and sense of well-being. However, as the third example shows negative narratives that people were exposed to in their past and present social environment can be deeply rooted and require care beyond what is possible in a primary care encounter. This underpins the value of exploring narrative to appropriately diagnose and direct care.

The therapeutic benefit of transforming experience through narrative, either verbally or written, has been recognized and used in counseling people living with a number of conditions such as posttraumatic stress, cancer, and chronic pain. The interconnectedness of narrative representation of experience and physical and mental health outcomes is well documented (Lepore & Smyth, 2002; Ramírez-Esparza & Pennebaker, 2006; Ullrich & Lutgendorf, 2002). Literature suggests that writing and talking about difficult experiences facilitates cognitive processing, incorporating stressful experiences into existing schemas of self, crafting coherent explanations, ascribing meaning, or finding benefit. The process promotes self-efficacy and mastery (Ullrich & Lutgendorf, 2002). For such positive outcomes to occur, it is vital that reappraisal and a positive reorientation are facilitated (Zech & Rimé, 2005).

In our study, parts of the care dialogue were about making sense of the past, and reappraising root causes as a way of combating negative feelings of blame, shame, and guilt. Other aspects of the conversation were about reorienting to positive and meaningful aspects of self and improving health. Making sense and crafting a coherent narrative is important in alleviating the negative emotional effects of societal ideas of what is normal for bodies and what “normally” leads to large bodies. This new coherent and validated narrative includes a set of reasons for obesity and provides people “with a vocabulary for creating a [better] self” and for use in narrating experience with others (Linde, 1993, p. 189). As others have described, this renegotiation of self with the dominant discourse is a key process toward self-acceptance and reducing negative effects of weight stigma (Dickins, Thomas, King, Lewis, & Holland, 2011).

Cross-cultural research supports the importance of such narrative transformation with evidence that the imperative of this process is to reestablish the self as a good person, valuable member of a community, with some control in their lives, and a sense of agency in inter-subjective relationships (Jackson, 1996, 1998, 2002). These findings also resonate with the model of salutogenesis, an orientation toward “origins of health and assets for health,” which was recently adopted in Scotland’s 2020 Framework for Quality, Efficiency, and Value (Mittelmark et al., 2017, p. 7; National Health Service Scotland, 2015). The salutogenic model, developed by Antonovsky (1979) based on life story research with holocaust survivors, describes the key conditions for health and well-being in the face of challenges as a sense of control over one’s life and a perception of experiences being comprehensible, manageable, and meaningful (Antonovsky, 1979). These three aspects align with our findings of the importance of making sense of personal obesity narratives (comprehensible), of highlighting strengths and capabilities to pursue realistic changes (manageable), and of focusing attention on whole-person health (meaningful).

In this study, we drew on narrative theory to illuminate how providers play a key role in shaping patients’ narratives of obesity and self and how narratives are enacted in health behaviors. Clinicians *can* have tremendous impact in supporting people living with obesity by offering their voices to co-construct narratives that make sense of the multiple factors that contribute to weight and health, reframe the self as one with strengths, capabilities, control, and hope, and shift attention to engaging in realistic, meaningful activities that improve whole-person health.

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### ORCID iD

Thea Luig  <https://orcid.org/0000-0001-8877-5369>

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### Author Biographies

**Thea Luig**, PhD, is a medical anthropologist and research associate with the 5AsT Research Team and the Physician Learning Program at the Faculty of Medicine & Dentistry, University of Alberta, Canada. She completed her doctoral degree in Social and Cultural Anthropology at the University of Alberta and her Masters in Ethnology, Health Psychology, and Eastern European Studies at the Free University Berlin, Germany.

**Louanne Keenan**, PhD, is the Associate Dean of the Division of Community in the Faculty of Medicine & Dentistry, University of Alberta, Canada. She received a Doctoral Degree in Human Ecology and Public/Population Health from the University of Alberta, and has a Master of Adult Education, Bachelor of Arts (Economics) and a Diploma in Dental Hygiene.

**Denise L. Campbell-Scherer**, MD, PhD, is a professor in the Department of Family Medicine, the Principal Investigator of the 5AsT Research Team, the Associate Dean of the Office of Lifelong Learning and Physician Learning Program at the University of Alberta, and a practicing family physician. With a background in evidence-based clinical practice, she has been active internationally in the education of multidisciplinary learners and is an associate editor of *BMJ Evidence-Based Medicine*.