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Original Article

Men living with obesity in New Zealand: What does this mean for health care in general practice?

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ABSTRACT

Introduction: More men than women live with overweight and obesity in New Zealand, yet we know little about their everyday lives or their weight management experiences in primary care. This study sought to link the weight management experiences of these men in primary care, with their experiences of life in general as big men.
Methods: Semi-structured interviews with participants selected purposively based on a priori criteria were conducted. Interviews were either face to face or via telephone. Interviews were digitally recorded and transcribed and text coded into a priori codes where established.
Results: Fourteen men were interviewed. Analysis of text data revealed three overarching themes. The first, social experience of life as a big man highlighted the significance of social transitions as times of weight gain. The second theme related to experiences of weight management in primary care, with communication the largest sub-theme. Finally, stigma materialised as a key and widespread issue.
Conclusion: Scant attention has been paid to the experiences of overweight and obese men in primary care or the impact of their size on their daily lives. Effective, tailored communication by health professionals in primary care is sorely needed. Times of social transition can be exploited as appropriate instances to offer advice on effective strategies to reduce the risk of weight gain. Men also need to be made aware of their vulnerability for weight gain at these times through effective, gender specific health promotion messages. The widespread nature of stigmatising experiences within personal networks was a concerning finding.

Introduction

Obesity is the cause of major health issues globally, accompanied by increased morbidity and mortality and greater health service utilisation [1,2]. New Zealand is in the unenviable position of being ranked third in terms of obesity prevalence behind the United States and Mexico [3], with 1.2 million adults or 32% of the population obese in 2018, up from 29% in 2011/12 [4].

The issue of male obesity is frequently overlooked [5], yet between 1980 and 2013 NZ experienced one of the largest increases in male obesity globally [1]. More men in New Zealand over the age of twenty live with overweight or obesity (large men), compared to women [1]. Furthermore, information regarding men's experiences of living with obesity is limited [5] and men are poorly represented in weight loss studies internationally [6].

Knowledge of large men's particular preferences regarding weight management in primary care consultations is scant. Information of the impact of size on their daily lives is also lacking. A recent study explored the experiences of New Zealand women living with obesity in primary care [7]. Studies in Australia and Sweden have explored obese men's experiences with their weight [8,9], and Monaghan has written about the tensions that exist between masculinities and medicalised normal weight [10,11]. To date no study has sought to understand the primary care weight management experiences of New Zealand men.

Most people in New Zealand first come into contact with healthcare services via key primary care providers [12], but these services are acknowledged as poorly meeting the needs of men in New Zealand and elsewhere [13,14]. With general practitioners (GPs) and practice nurses (PNs) reluctant to raise the topic of weight [15–17] it is important to better understand the experiences of overweight and obese men, both in their daily lives and their engagement in primary care settings. Excess body weight has physical, emotional, psychological and social impacts [8], and these have

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the potential to influence the primary care encounter. This paper reports key findings from a study exploring large men's perceptions of weight management in primary care and the influence of their size on their lives.

Methods

A qualitative semi-structured interview methodology was chosen for this study. Recruitment of participants was based on a generic purposive sampling strategy, with criteria for selection established a priori to ensure diversity [18]. Inclusion criteria comprised: male; BMI $\geq 30\,kg/m^2$; $\geq$18 years and had visited the general practitioner (GP) or practice nurse (PN) in the last six months. The sampling matrix encompassed the following: ethnicity (Māori, Pacifica, non-Māori, non-Pacifica); age ranges; BMI ranges; rural or urban settings.

Multiple recruitment strategies were used including word of mouth and community advertising. Face to face and telephone interviews were used, enabling access to participants across a wide geographical area [19]. Potential participants were assessed over the phone. Those deemed to meet study criteria were sent an information sheet and consent form. All who met the criteria agreed to participate.

A literature search informed the interview schedule. An initial draft schedule was developed which considered the rationale for possible questions in relation to the aim of the study. This was refined and the penultimate interview schedule was pilot tested by FDN (see Appendix). The schedule was pilot tested with three men, of varying ages, who lived rurally. These men were consented as the researchers considered the interview schedule was essentially finalised, however, these men were also asked three questions at the end:

- Do you feel all these areas are relevant?
- Are there any other topic areas we should consider raising for discussion?
- Did you find any of the questions offensive?

All questions were considered relevant and inoffensive. One key area of omission emerged, that of clothing. This topic was evident in one paper included in the literature review but within this study only five of the thirty six participants considered it an issue, hence it was not included in the penultimate interview guide. It was however, added to the final interview schedule.

All interviews were digitally recorded and participants were given a thirty-dollar ($NZ) fuel voucher as a token of appreciation. Interviews were completed by two of the researchers (FDN and DF). All recordings were transcribed by professional transcribers and transcripts checked against digital recordings by FDN. All transcripts were de-identified and formatted in a common fashion for ease of uploading into NVivo 10 [20] for data management and analysis.

The data was coded into higher level a priori codes where established. These higher level a prior codes were driven by the research question itself and were are related to the participants' experiences in primary care and their daily lived experiences. Data saturation for the a priori codes was reached between interview twelve and fourteen [21]. Sub-themes emerged which underpinned the a priori codes. These developed through the use of general thematic analysis [22].

As well as identifying sub-themes that were linked to the two a priori codes, a further (unanticipated) key code emerged from the data related to stigma. This higher order code was also underpinned by sub-themes.

All authors were aware their potential biases could influence this research at a number of time points- developing the interview schedule, conducting or analysing the interviews or deciding which data to present. A number of strategies were employed to reduce the influence of bias in this study. The interview schedule was pilot tested, consistency checks [22] of the data analysis were undertaken within the team and stakeholder checks [22] of the data analysis were undertaken to confirm credibility. Ethical approval for this study was given by the Multi Region Ethics Committee (MEC/12/EXP/041).

Results

Of the fourteen men interviewed, twelve were New Zealand European, one was Samoan and one Tongan. Nine lived rurally, with five living in urban centres. Educational achievement ranged from high school certificate to university degree and body-mass indexes (BMIs) went from BMI 31 to 52. Participants ranged in age from 18 to 75+ years, with most being between 35 and 65 years. Eleven interviews were face to face and three via telephone.

Findings

In all, three main themes ('social consequences of obesity', 'experience of weight management in primary care'; and 'stigma') emerged from the data.

Theme 1: social experience/consequence of life as a big man

The positives of 'bigness' for men evident in the literature [23] were not immediately evident in the conversations with these men. The undesirable consequences of being larger for men have been well documented in other studies within the male health and social science literature [8,24]. The multidimensional impact of being larger for these men confirms that size in the 21st century is not just a female issue. The negative consequences described related to functional limitations and health and social consequences. The social consequences were particularly significant for these men.

> *I guess it just can hold you back from, I guess participating in activities that you really wanna, get more involved in. (Participant 12)*

> *You're, you're always sweating away when. . .everyone else is sort of sitting around relatively comfortable. . .and you think, oh god this is not good, . . .so there's that sort of social embarrassment. (Participant 4)*

Most found it challenging to correctly perceive their body size. Photographs acted as a reality check in two ways; by enabling men to compare themselves to others and reminding them of how they used to look.

> *In fact we found a photo a while ago, [huh] and we're looking at it, . . .we're trying to work out who it was, and then someone said that's you, and I said, no, no it's not, then I had a look and thought, oh, oh it is. (Participant 4)*

Men spoke of responsibility in relation to their weight. Some staunchly considered it was their personal responsibility.

> *Hey the fact that I am where I am at, I have got no-one else to blame but ** because I am the one that did it, um, and it is a cop out to try and blame, use media and advertising. (Participant 7)*

Others were less single minded.

> *I think that personal responsibility ultimately,. . .you are responsible for your body, that is the bottom line. However, the way that you think about what you put in your mouth is . . .influenced by all sorts of messages that you get from the environment around you. (Participant 13)*

Sub-theme: social transitions. These men pinpointed the time they started to gain weight. Times across the life-course varied but in each case it was at a point of social transition, for example, starting employment; marriage; change of job; having a family or retirement.

> *Remember years ago I was thirteen stone, and I just stayed at thirteen stone for years and years and then suddenly after I retired it started to go up you know. (Participant 10)*

While overeating and inactivity were considered to be by far the most common cause of weight gain, the stimuli for these behaviours varied across interviewees and included the environment; emotions; working life; psychological status; socioeconomic status; low nutritional literacy and physical limitations.

Participants were motivated by different stimuli to make a weight loss attempt; so they could participate in a sport, for health reasons, due to a discriminatory experience, feeling morally obliged to or for family.All had made at least one weight loss attempt. The strategies employed to lose weight varied but included increasing physical activity; eating less; using a smaller plate; a nutritionist or life coach; Weight Watchers on-line, and budding with a friend. Trying to lose weight just by increasing exercise was recognised as being ineffective due to the amount of exercise required and the time that involved. Social support was identified as a key enabler. This could be via a nutritionist or life coach or support from a friend or family member. One man identified the lack of support from his wife as a key barrier to initiating and maintaining weight loss attempts.

The significance of social support re-surfaced when participants were asked what they thought men would like to see in a male weight loss programme. All agreed a successful programme needed to include the following components:

- Ability to do it with mates;
- Nothing too flash;
- Would have to include some exercise;
- Would have to include a competitive element;
- Provide some dietary advice;
- Provide information on meals you can eat with your family;
- Ability to involve partner so she knew what was involved and could provide support.

These men did not sense they were exposed to significant societal pressure to conform to an idealised body shape, compared to their female counterparts. There was an increasing awareness, however, that societal expectations were changing.

> *I wouldn't have thought there was the same degree of um, pressure, social pressure. However I think that is becoming a bit more prevalent now than it would've been, say five or ten years ago. (Participant 7)*

Theme 2: experience of weight management in general practice

This theme comprised three sub-themes, with the dominate theme being communication.

Sub-theme communication. This sub-theme includes the categories 'raising the topic'; 'terminology'; 'advice given' and 'style of communication'

Participants had a fairly uniform experience of having the topic of their weight raised during a consultation, as this man described,

> *Every time I go in the nurse will always mention, about diet and talk about diet, and watch what I eat. (Participant 14)*

Participants, anticipating their weight was going to be discussed developed coping strategies.

> Yeah they've talked about the weight, blood pressure, I always get in first. . .. . .[laugh], so that's the way that I always tackle it, I always get in first.(So why do you get in first?) *Because I guess, I try to relax that way, 'cause . . .I know that's gonna come. (Participant 6)*

All men unanimously agreed that both GPs and PNs, had a responsibility to discuss a patient's weight. They cautioned, however, that this needed to be done in a respectful manner, with certain words being considered disrespectful.

Terms such as 'morbidly obese', 'obese' and 'fat', were generally deemed unacceptable as illustrated by the following quote.

> *I don't know they call it, the b****y term they use is that, a, a, morbidly obese. . .it drives me nuts. It's a terrible term. (Participant 6)*

> *Overweight certainly find it would be quite acceptable. . .. (Participant 11)*

Men found there was a lack of tailored advice, with inconsistent advice causing frustration. This man echoed many of the participants' comments when he said,

> *They don't come up with any b****y great ideas with what I can do about it, they, you know they have a bit of a moan and away you go. Mmm. (Participant 9)*

Men spoke about knowing what changes were needed but the advice given to them did not address how to make the changes.

> *We know what needs to be done we just don't know how it's going to be done.* (Participant 7)

Men spoke of wanting clear, straight forward information from their doctors and nurses in relation to support for weight management and in regard to their health status.

> *Well with my GP I know him now, he knows who I am and, and he uses a lot of layman terms to explain stuff. He well ah, he will be factual and honest about it all. Well I think, for me I want to have it in simple terms. And like, what is wrong I want to have reality. ({Participant 14)*

Sub-theme: GPs and PNs as role models. The desirability for a GP or PN not to be overweight or obese if providing weight loss advice triggered a mixed response. For some, it did not appear to matter.

> *Role models, oh not too worried about what they look like or anything. All I expect from the GP is, just get it right and tell me what, what's my problem. (Participant 6)*

Others admitted this would affect the credibility of any advice given,

> *I would be a little more sceptical I guess if I had an obese GP. (Participants 13)*

Other aspects of the relationship between a patient and health professional were felt to take precedence.

> *If they are dedicated to the conversation, if that happens I think that overrides gender, overrides, weight, overrides other things. (Participant 11)*

Theme 3: Stigma

This key theme emerged during the process of detailed data analysis. The talk of nearly all participants contained reference (sometimes extensive) to unprompted instances of experiencing shame, discrimination and consequent embarrassment as a result on their large size.

Table 1
Types and impact of stigma experienced by study participants.

Enacted Stigma	Felt Stigma	Impact of Stigma
*The service industry thing really. . .Well they got, they got enough money don't they (larger people), see they're spending the money as well, just because they're big. . .don't treat them like they're b****y pariahs, so you treat, treat them with respect . . .whereas oh yeah, don't, don't treat them like big fatties, they're already conscious, we belong sort of thing. (Participant 11)*	*I guess in some, in some respects I think people do that, 'cause it's easy to, it's a good. . .bit of an ice breaker and it's a funny thing. . .in the end of the day how people will approach it, but they do look, they, they you know they do say, it's the big fella here or you know and you, and, and it doesn't really hurt but you don't really want to be the, the big fella. (Participant 6)*	*You question yourself and you are conscious of your weight, if you don't fit within right in, considered the normal weight range, you're automatically quite often down, and even after your, almost like you're a diseased person and, this I get to, play on your confidence some days (Participant 12)*
Ah certainly my mother has been critical of my weight at times, yeah but humiliated not really. She has just sort of said you are putting on too much weight, or what is that belly you have got there. (Participant 13)	*You know that makes me angry, they will say to me, oh, they will say something nasty. Yeah bottom line, if I put on a heavy shirt like a hanging shirt and what not and go out and have a few games of pool, it is good, but if you happen to wear one of my corny t-shirts I got that is a bit tight, you get people poke you in the belly and say oh, what is this. . . (Participant 9)*	*I am getting to a point now that I am starting to avoid trip, you know we are thinking of going to Samoa sometime for a visit and maybe up to Auckland, and I am trying to avoid it because I just don't want to receive comments from relatives and my wife family, man you are too big, man you are overweight you know. (Participant 14)*

It became clear that all these men experienced enacted stigma (unfair treatment by others — discrimination) on account of their size and were aware of felt stigma (internal feelings of shame and the expectation of discrimination) in their everyday lives {Scrambler, 2009 #1431}. They also described the impact stigma had on their lives.

The stigma experienced originated from a variety of sources. Although discriminatory experiences while attending primary care services were mentioned, they were not as pervasive as discrimination from family, friends and work colleagues.

Quotes illustrating the type, source and impact of stigma experienced by participants are presented in Table 1.

Discussion

This is one of the first studies in New Zealand to focus on the experiences of large men in primary care and one of the few within the medical and health services literature to do so. Conspicuously, all participants spoke of gaining weight at a time of social transition. These social transitions were all linked to changes in obligations in their life; a life they considered difficult, with multiple challenges to navigate. The findings make it clear that while New Zealand men experienced their weight being discussed in primary care, the encounter was not always respectful, with the associated advice generally considered unsatisfactory. Importantly, the men in this study all described ongoing stigmatising experiences in their lives, causing them to feel embarrassed, offended and angry. Stigmatising experiences were more evident in workplaces, and among family and friends, rather than when attending primary care. Nevertheless, stigma was pervasive and a cause for considerable concern.

A striking finding to emerge from the conversations with these men and one rarely reported in the literature [25] was their ability to pin point the time in their lives when they really noticed they gained weight. For all it was a point of social transition (starting employment; marriage; change of job; having a family or retirement) and potentially a time of vulnerability. This finding in conjunction with the importance these men and others have allocated to the need for their bodies to be fit for purpose [26], suggest times of social transition may be opportune occasions for primary care health professionals or occupational health professionals to raise the topic of weight. These occasions may be times men feel it is legitimate to 'do health' and make a weight loss attempt, particularly as legitimating healthy behaviour is recognised as important for men [27].

Communication quality emerged as the key feature of the weight management consultation for these men. Despite varying experiences this group of men were unanimous in their view that primary health care professionals had a responsibility to discuss an individual's weight, a view contrasting with the known reluctance of GPs and PNs to raise the topic of weight [15,16,28]. If men are not engaged in a weight loss conversation, they may become complacent about their weight. Prompting by a health professional may act as a motivator [29].

The term obesity was considered unacceptable by most in this study, yet other studies have found that it seems to act as a stimulus for men [30]; potentially by creating cognitive tension, generating a discordant thought. This may then generate a need to resolve the contradiction between the descriptor used by the health professional and the body they feel a responsibility for, by making a weight loss attempt.

The lack of tailored information provided in primary care frustrated the men in this study. They had a very clear understanding of factors that influenced their weight related behaviour, as have men in other studies [8,25], and were aware of strategies to lose weight. Their missing link appeared to be the provision of tailored weight management support strategies. The need for gender tailored approaches to weight management is recognised [29], yet such information is sadly lacking. Gender-sensitised weight loss programmes have shown success overseas [31] but to date no NZ study has replicated these results.

Weight-based stigma in men is understudied [32]. The men in this study discussed the different types of obesity stigma they faced in their lives, the sources and location of the discrimination and the impact it had. Family, friends and work colleagues were instrumental in subjecting these men to stigmatising experiences, a finding mirrored in studies by Vartanian and colleagues and that by Lozano-Sufrategui et al. [32,33]. Discriminatory comments were not always considered inappropriate, with some men viewing them as justified and deserving. Monaghan and Malson [34], suggest how this could be a way of showing masculine emotional resilience, distinguishing the male response from that of the 'sensitive woman'.

Their experiences of primary care does not appear to reflect the more negative experiences of large women in NZ [7]. The relationship between obesity stereotypes and gender, however, is not clear. Research suggests men experience stigma at a higher BMI than women: BMI 35 kg/m^2 or above, compared to BMI 27 kg/m^2 in women [35].

Strengths and limitations

This study adds to the limited literature related to men who live with obesity and the beliefs, values and experiences that they may bring to primary care consultations which may impact their health care experience. As a qualitative study, there is no attempt to suggest these findings are generalizable as such. Rather, the study seeks to better understand the experiences of a selected group of

men who were diverse in terms of their age ranges, their scholastic achievements and where they lived. Although two of the main ethnic groups in the country, Pacifica and NZ European participated, no Māori men were interviewed. Notwithstanding, the themes that emerged from this study, may well be helpful in promoting further discussion in primary care settings, and link to other studies which have explored one or other dimension examined within this study. Further studies may find other NZ men hold similar views and have comparable experiences.

Conclusion

This study, the first of its kind in NZ, provided an in-depth understanding of the weight management experience of NZ primary care for men who live with obesity, as well as their lived experiences more generally. These findings are particularly relevant as the male perspective is barely visible in obesity and weight management discourses contained in the health services literature. Further research is required regarding the role of social transitions for men and weight gain and there is a need to trial the effectiveness of gendered-sensitised weight management support for NZ men. This study does support the limited literature on the experiences of large men with weight based stigma and as one participant said, "you don't wanna be the big fella".

Ethical statement

This study was approved by the Multi Region Ethics Committee (MEC/12/EXP/041). All participants were provided with an information sheet and all participants were consented.

Declarations of interest

None.

CRediT authorship contribution statement

Fiona Doolan-Noble: Conceptualization, Investigation, Data curation, Formal analysis, Methodology, Project administration, Writing original draft. **Tony Dowell:** Supervision, Validation, Writing-review and editing. **Sue Pullon:** Supervision, Validation, Writing-review and editing. **Dane Fuller:** Investigation, Validation, Writing - review and editing. **Tom Love:** Supervision, Validation, Writing-review and editing.

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To the study participants for taking the time to share their stories.

Appendix. : Interview Schedule

	Questions	Prompts	Observations/ Reflections
1	Can you tell me what is positive about being a "big" man in New Zealand today?	Sports Employment	
2	So if those are the good things, are there aspects that are not so good?	Health Appearance Clothing (added following piloting of interview schedule)	
3	How satisfied are you with your current size and body shape?	Do you like your size but wish you how your body was put together (composition) was different?	
4	Has your general practitioner or practice nurse ever discussed your weight with you?	How was that for you? Did they raise the topic of your weight in relation to other health care interventions such as a cardiovascular risk assessment, was it raised in relation to why you were having a consultation or was it just brought up in the conversation? Did they take any measurements? For example your height/weight/waist circumference? How was that for you? Do you think it is appropriate for your general practitioner or practice nurse to discuss your weight with you? How did they refer to your weight? (Weight, excess weight, fat, obesity) Did they offer you any advice and if yes what was it and was it useful? Did they offer you any support and if yes what was it?	
5	Views regarding GPs and PNs	Do you think your GP and practice nurse should be good role models by maintaining a healthy weight and exercising regularly? If an overweight GP or PN gave you advice to lose weight would you trust that advice?	
6	Has you general practice got the equipment/furniture of the right size to meet your needs?	BP cuffs Scales Examination tables Chairs without arms (Note this question may not be relevant dependent on the size of men interviewed)	
7	Have you ever had an experience when someone has made you feel humiliated because of your weight?	Can you tell me about that experience? Have you ever experienced a humiliating situation within a health care setting? If yes can you tell us about that, for example how did it leave you feeling/has it put you off seeking health care?	
8	Can you tell me at what stage in your life did you first notice you were gaining weight?	Try to establish if weight gain happened at a point of social transition – leaving home; first full time job; getting married; starting a family.	

9	At that time what do you think caused your weight gain?	Eating too much Lack of opportunity to exercise Eating the wrong foods Too much alcohol Lack of understanding around what you were eating Lack of ability to afford healthy kai The environment not being conducive to maintaining a healthy weight – too many fast food outlets or lack of opportunities to be physically active Personal factors – lack of motivation, will power
10	Do you think carrying excess weight has any negative consequences on your health?	Physically Mentally Socially
11	Since gaining weight have you ever tried to lose weight?	What motivated you to try? Explore desire to be more athletic, look good, health concern or other. How did you try to lose weight? Explore whether they joined a commercial weight loss programme, (& if not why not; is it perceived as a women's thing) did they join a gym; did they do it alone or did they enlist support and if so from whom? What strategies were involved – increased physical activity, restrictive eating, reducing fat and or alcohol intake? What were your goals in relation to addressing your weight? (Improved body image; to generally improve lifestyle; to get weight to a normal BMI; to improve a health problem or to stop gaining weight)
12	If you haven't tried to lose weight is it because you are happy with your size and shape or are their barriers that seem difficult to overcome?	Could you tell me about the barriers?
13	What features would a weight loss programme have to offer to attract you to consider taking part?	If unsure provide examples from programmes that have targeted men and explore.
14	What are the current recommendations regarding a healthy diet and the frequency and length of time you should be physically active for each day?	Do these messages connect with you or not?
15	Overall who do you think is responsible for your health and well-being?	Explore response.

Is there any other aspect of your life as a big man that you think is pertinent to this research and we have not discussed?

Thank you for your time.

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