



## Original article

## Weight stigma in physiotherapy practice: Patient perceptions of interactions with physiotherapists

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## ABSTRACT

**Background:** Weight management is increasingly considered part of physiotherapists' scope of practice in order to improve patient outcomes by, for example, reducing load on joints, or improving chronic pain. However, interactions with patients involving weight may result in patient perceptions of negative judgement from health professionals, which can result in poorer health outcomes. How physiotherapist/patient interactions involving weight are perceived by patients has not yet been investigated.

**Objectives:** To explore patients' perceptions of interactions with physiotherapists that involved weight, and investigate how these perceptions may inform physiotherapy practice.

**Design:** Face-to-face interviews with physiotherapy patients, with follow up interviews conducted by telephone. Data were analysed thematically.

**Method:** First interviews were held in a physiotherapy practice with follow up interviews conducted two weeks later. Interviews were audio recorded, transcribed and analysed using an inductive thematic method established by Braun and Clarke.

**Findings:** Thirty interviews with 15 patients were analysed. Four main themes relevant to weight were identified: 1) perceptions of being 'in physiotherapy' including pre-conceptions, the physical environment, and exposing the body, 2) emphasis placed on weight in physiotherapy interactions, 3) communication styles, and 4) judgement perception.

**Conclusion:** Some patients perceived negative weight judgements from elements of physiotherapy interactions and environments. Physiotherapists need to be aware of this perception because it may result in poorer patient outcomes and patients avoiding physiotherapy appointments. The results suggest strategies to counteract weight stigma include: adjusting the physical environment of the clinic, portraying an understanding of complex determinants of weight, and employing collaborative, non-judgemental communication styles.

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## 1. Introduction

Weight management is increasingly considered part of physiotherapists' scope of practice (Rea et al., 2004; Snodgrass et al., 2014). Messages encouraging integration of weight management into physiotherapy have become fairly commonplace from physiotherapy leaders and in popular physiotherapy forums (e.g., Physiopedia, 2011; Dripps, 2014). Furthermore, as the body is the focus of physiotherapy, weight is likely to be salient regardless of whether weight management is a focus. Body weight is, therefore,

likely to be involved in physiotherapy interactions. Whether physiotherapists are helping or harming patients with interactions involving weight has not received much attention. This is important from an ethical standpoint given that physiotherapy codes of conduct include 'do no harm' (Guttman and Salmon, 2004). Physiotherapists likely focus on weight to improve patient outcomes by, for example, reducing the load on joints, or improving chronic pain. However, weight is a sensitive topic and perceptions of weight stigma (negative attitudes towards weight) result in poorer health outcomes (Puhl and King, 2013). Thus, an intervention intended to improve the health of the patient may, if it is perceived as stigmatising, result in harm. Whether patients perceive weight stigma from physiotherapists is, therefore, an important consideration.

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Weight stigma involves negatively stereotyping people perceived to be overweight with characteristics such as laziness, sloppiness, ill-health and lower intelligence (Carr and Friedman, 2005). Weight stigma in the general population has been reported as prevalent (Puhl and Heuer, 2009) and increasing (Andreyeva et al., 2008), and having adverse effects on health (Puhl and King, 2013). A minority view suggests weight stigma or 'fat shaming' may have positive effects on health behaviours (Ogden, 2013), but the contrary has been demonstrated consistently. People who perceive they are recipients of weight stigma avoid health care appointments (Drury and Louis, 2002), exercise less (Vartanian and Shaprow, 2008) and have more disordered eating (Tomiyama, 2014). Weight stigma has been discussed as widespread in society i.e. in media, government policy and within health (Campos et al., 2006; Lupton, 2012). For example, the complex and multifactorial causes of weight are frequently depicted as a simplistic energy imbalance, with causes assigned to individual responsibility (Gard and Wright, 2005; McAllister et al., 2009). This is despite consistent findings, including Cochrane reviews, that dieting is ineffective in reducing weight beyond short-term changes (Norris et al., 2005) and exercise has inconsistent effects on weight (Shaw et al., 2006). A variety of health professionals exhibit weight stigma including doctors (Sabin et al., 2012), nurses (Mulherin et al., 2013), exercise scientists (Chambliss et al., 2004) and dietitians (Stone and Werner, 2012). Sack et al. (2009) reported that physiotherapists had neutral attitudes to people who are obese, despite finding over 50% believed people who are obese were weak-willed, non-compliant and unattractive. These results suggest physiotherapists likewise possess negative stereotypes of overweight people. Setchell et al. (2014) found physiotherapists demonstrated implicit weight stigma in responses to case studies, and explicit (overt) weight stigma in responses to an anti-fat attitudes measure. However, whether weight stigma affects physiotherapist/patient interactions, or is perceived by patients, has not yet been explored.

In other areas of health, weight stigma affects health professional–patient interactions. Overweight male patients perceived poorer quality of care from physicians, including reduced length of consultation (Hebl et al., 2003). Pregnant women with a BMI greater than 30 kg/m<sup>2</sup> reported accusatory responses, a lack of respect and insufficient helpful advice from their general practitioners (Lindhardt et al., 2013). Patients who perceived negative judgement about their weight trusted their health professionals less than those who did not (Gudzune et al., 2014). Moreover, a survey of public opinion regarding language used to discuss weight by doctors found that more negative language resulted in lower patient motivation levels and participants expressing a greater likelihood of changing health care providers (Puhl et al., 2012b). In a study of obese women's experiences of healthcare, Buxton and Snethen (2013) highlighted the importance of respect and communication styles in weight loss discussions.

To date, no studies have investigated how physiotherapy patients perceive weight related interactions. To address this deficit, this study explored the following research questions: How do patients perceive interactions with physiotherapists involving weight? What elements (if any) of physiotherapy interactions do patients perceive as weight stigmatising?

## 2. Methods and materials

### 2.1. Design

Physiotherapy patients' experiences were explored using a qualitative semi-structured interview design. Two in-depth, semi-structured interviews were conducted with each participant. A second interview is thought to provoke a reflective or analytical

perspective from the participant, while the first focuses more on experiences (Flowers, 2008). Participants responded to open-ended questions about their experience of interactions with physiotherapists involving body weight (Appendix 1). Questions were developed from the findings of Setchell et al.'s (2014) study on weight stigma in physiotherapists and from available literature on weight stigma. However, the presence of weight stigma was not assumed. Interviews were piloted on two participants resulting in minor alterations to the question guide. Two experts in the field of weight, whose professional roles include investigating implications of negative judgements about weight from health professionals, were engaged as consultants. They provided feedback on design and analysis from the perspective of those who have been stigmatised for their weight (Louis and Bartunek, 1992). *A priori* rigour and quality procedures were established based on consolidated criteria for reporting qualitative research (COREQ: Tong et al., 2007). Ethics approval was obtained from the institutional ethics committee and all participants provided informed consent.

### 2.2. Participants

Participants were current Brisbane, Australia residents who had been patients of physiotherapists. Recruitment was via posting on 'community noticeboards', including Facebook and Twitter, and notices at shopping areas or workplaces within a 10 km radius of the first interview location. Although the sampling strategy was a convenience sample, the researchers intentionally recruited in environments with potential participants who varied in socioeconomic status, ethnicity, gender and age. The number of participants was determined as the study progressed, when saturation was reached (i.e., when few new topics were being discussed, and themes had sufficient data for analysis). Data were analysed following each interview in an iterative process during recruitment.

Data saturation was reached with 15 participants (30 interviews). Forty-one people responded to broad recruitment strategies inviting participants to discuss their experiences as a physiotherapy patient. All were contacted by telephone and asked whether they had experienced interactions involving weight in a physiotherapy context. The researcher clarified, if needed, that weight experiences could be neutral, positive or negative, could be about being any body size, and about the patient's body, the physiotherapist's body or someone else's. There was no restriction on when this experience occurred as patient perceptions, rather than actual experiences, were the research focus. For ethical reasons persons were not considered if they had been a patient of the first author or had attended the physiotherapy practice used to conduct interviews. Twenty six people were excluded because they had either not had experiences involving weight in a physiotherapy context (19), attended the practice where the interviews were being conducted (2), were unable to attend interviews (1), had never attended physiotherapy (2), or did not respond to follow up contact (2).

### 2.3. Procedure

The first author who conducted the interviews was trained in qualitative interviewing. The first interview was face-to-face and 'situated' in a private physiotherapy clinic. A 'situated' interview (conducted in an environment that is similar to where the experiences being discussed had occurred) was chosen to facilitate access to memories of previous physiotherapy experiences (Carpiano, 2009). Demographic information was gathered and a debrief sheet provided after the first interview. The interviewer took field notes in a reflexive diary following each interview. Participants received a diary after the first interview to facilitate reflection on the topics

discussed (Appendix 1). The diary was designed for participants' personal reflection and was not used directly in the analysis.

The second interviews were conducted two weeks after the first, by telephone. Second interviews provided opportunity for participants to discuss new ideas arising after the first interview, and for the interviewer to ask further questions. Transcripts were not returned directly to participants for verification, but preliminary analysis from the first interview was presented to participants for feedback in their second interview. Interview length was not pre-determined and was concluded when both participant and interviewer agreed they had exhausted discussion of the topic. All 15 participants completed both interviews approximately two weeks apart, as intended, although one initial interview was conducted by telephone, as the participant was unwell. This interview was shorter and less in-depth. There were no refusals to participate or answer any questions.

#### 2.4. Data management

All interviews were audio recorded and transcribed for analysis. Transcripts were de-identified and pseudonyms used. The first author coded the transcripts and organised these codes into thematic groups derived from the data in data management software. Themes were clarified and analysed using inductive thematic analysis as developed by Braun and Clarke (2013). Thematic analysis is 'a method for identifying themes and patterns of meaning across a dataset in relation to a research question' (Braun and Clarke, 2013, p175). Inductive thematic analysis aims to generate analysis from data, rather than being driven by existing theory. Analysis followed an iterative process of review, clarification and revision (Braun and Clarke, 2013). To minimise the effect of the researchers' views on the results, the research was considered reflexively at all stages including design (minimising leading questions), data collection (neutral tone, non leading questions), and analysis (exclusion of answers to inadvertent leading questions). The other authors, and the consultants read the transcripts. They confirmed analysis was credible and grounded in the data.

Results and discussion are presented in synchrony and quotes use participants' pseudonyms.

### 3. Results and discussion

#### 3.1. Demographics

Participants' (n = 15) age range was 27–68 years, with 10 identifying as female, four as male and one as male transgendered. The group was generally highly educated despite attempts to recruit a diverse socio-economic spectrum. Race/ethnicity was mostly white-Australian, except for three participants (Anglo-Irish (1), black-British (1) and mixed including indigenous-Australian (1)). Participants' body weight was intentionally neither measured as part of the research, nor directly mentioned by the interviewer, yet most (13 of 15) participants discussed experiences that were about being seen as 'overweight', while two discussed experiences of being seen as 'underweight'. There were no discussions about being seen as 'normal weight'.

#### 3.2. Physiotherapy experiences

Participants recalled experiencing treatment by 54 different physiotherapists, primarily in South-East Queensland, with a minority of experiences elsewhere (Sydney and London). These physiotherapy experiences were mostly musculoskeletal, although some were in other settings (orthopaedic, women's health, neurology and respiratory). Participants identified weight

interactions with 35 of their physiotherapists, of these 33 were during musculoskeletal consultations, most often in private practice settings.

#### 3.3. Themes

In-depth analysis of the 30 interviews identified four major themes, five sub-themes and three to five codes for each sub-theme (Table 1).

##### 3.3.1. Theme 1. Being 'in physiotherapy'

Participants identified a number of elements of the physiotherapy environment as making weight salient. These comprised three subthemes: 'situating physiotherapy', which refers to the patient's pre-existing ideas about physiotherapy, 'physical environment', which refers to the physical physiotherapy environment (usually a 'clinic' or similar) and 'exposed body', which refers to being exposed visually, or to touch, in a physiotherapy context.

**3.3.1.1. Situating physiotherapy.** Participants saw physiotherapy as similar to, or part of, both the health and sports/fitness industries. This meant physiotherapy was commonly perceived as having similar attitudes towards weight (i.e., often negative) as these industries. Participants often indicated that they arrived at physiotherapy with the preconception that they would be judged negatively for being overweight. Ellie, for example, described how other health care and sporting interactions "have very much informed ... how I feel when I go into a physio setting". Russell and Carryer (2013) noted a similar effect in physicians' patients, where they 'entered into the general practice domain with a heightened sensitivity to stigmatization ...'. As Hetti stated, patients expect that weight will be mentioned in physiotherapy: "It's just my assumption that at some point in the conversation there's going to be a comment about me being a bit overweight". Thus, before patients enter the clinic, they are influenced by their pre-existing ideas of physiotherapy's attitudes towards weight. Patients may perceive different clinical settings differently. For example, Lena reported feeling uncomfortable about her weight in sports physiotherapy environments yet perceived more positive experiences in less sports-focussed clinics. She said: "it was all very relaxed and a very different experience".

**3.3.1.2. Physical environment.** Participants discussed a number of elements in the physical physiotherapy environment that increased patient discomfort, often precipitating negative body image evaluation and fear of being judged. These included prominent presence of mirrors (see Martin-Ginis et al., (2003) for more on how people feel worse after exercising in front of mirrors), use of images privileging thin bodies (in advertising, websites, health promotion materials and charts displayed in clinics), furniture that was poorly designed for a range of body sizes, and visible displays of exercise equipment. Nico described his reaction to the Pilates equipment visible in the clinic where the interview was conducted: "when I was really struggling with my weight I think I [seeing the gym-like environment] .... I probably would have felt a bit guilty." A number of participants also mentioned the body of the physiotherapist. As Jaya explained "having your weight mentioned by someone who is ... obviously very fit and healthy made it sort of feel more uncomfortable".

**3.3.1.3. Exposed body.** Participants frequently mentioned that seeing a physiotherapist was confronting in relationship to body weight, as their bodies would be exposed visually or to touch. This included the lack of privacy in open treatment area layouts, being partially undressed, being watched while moving/exercising and

**Table 1**  
Outline of themes, sub-themes and codes from interview data investigating patient experiences of physiotherapy interactions involving weight. NB: physiotherapy or physiotherapist is abbreviated as 'PT'.

| Themes                            | Sub-themes  | Codes  | PT as sport/fitness<br>Images displayed   | Expecting weight to be mentioned<br>Furniture, equipment  | The body<br>of the PT                                   |
|-----------------------------------|---|--|---|---|---|
| 1. Being 'in physiotherapy (PT)'  | a) Situating PT<br>b) Physical environment<br>c) Exposed body | PT as health<br>Prominent mirrors<br>Openness of treatment area<br>Emphasis on weight<br>Level of collaboration<br>Empathy and rapport<br>Feeling not good (fit/thin) enough | Disrobing, being<br>partially undressed<br>Weight causes<br>PT conditions?<br>Timing matters<br>Level of collaboration<br>Negative thoughts<br>about own weight | Being observed or touched<br>Weight as complex<br>Silences speaking volumes<br>Being seen as person, holistic care<br>Does the PT see weight like this or do I? | Attention<br>quality<br>Attitude,<br>level of judgement |
| 2. Is weight relevant?            |   |  |   |   |   |
| 3. Communication                  | a) Weight talk<br>b) Communication styles                     |  |   |   |   |
| 4. Judgement (perceived and self) |   |  |   |   |   |

having 'hands-on' treatment. Eimer described discomfort regarding the openness of the exercise area in a university clinic: "*an open environment particularly where there's other people around brings up lots of issues for me*". Ellie explained that being undressed in front of someone is "*confronting*" and "*makes me think more about my weight*" and Nina stated that exercising in an environment where "*everyone can see you*" is also "*confronting for someone who is overweight*".

### 3.3.2. Theme 2. Is weight relevant?

This theme had no sub-themes. Rather, there were three codes for the relevance of weight to physiotherapy: too much emphasis placed on weight by physiotherapists; the plausibility of the relationship of weight to conditions treated by physiotherapists; and the causes of body weight. Hetti questioned the emphasis on weight in a women's health physiotherapy appointment: "*it was just like: 'oh for God's sake, I've just had all this happen to my body and now you're telling me that I should think about weight!'*". Jaya questioned the plausibility of her weight's relevance to her back pain: "*It keeps getting blamed on my weight. I think that made me a bit defensive about going [to physiotherapy] .... I have a bad back and I'm fat. And that might make it worse but it certainly isn't the cause or the root of my back pain*".

Physiotherapists tend to focus on simplistic, individually controllable causes of weight (Setchell et al., 2014). However, all participants, regardless of body size, reported that the causes of their body weight were more complicated than individually controllable factors such as diet and exercise. Reported causes included: thyroid cancer, side effects of medication (anti-depressants, steroids for respiratory conditions and HIV medications), inactivity due to injury (both overweight and underweight), social circumstances and substance addiction. No participant said that weight was simple to control or change with diet or exercise. Interestingly, while the interviewer never directly asked what might be the cause of each participant's body weight, all participants discussed this. Perhaps, like other patients, they wanted to pre-empt the usual ideas about the simplicity of the determinants of weight (Puhl et al., 2008), which blames individuals (Tischner and Malson, 2011).

A minority of participants described positive experiences of negotiating weight with physiotherapists. Darren related what he perceived as a positive interaction with his physiotherapist in which he felt the emphasis on weight was appropriate. He described that she explained that to "*lose weight would help but the main thing was to strengthen the quadricep muscle*".

### 3.3.3. Theme 3. Communication

This theme had two inter-related sub themes: communication about weight or 'weight talk' and more generally 'communication styles'.

**3.3.3.1. Weight talk.** Participants discussed a number of ways in which physiotherapists talked about weight – some perceived as more positive than others. Salient factors as to how positively conversations about weight were perceived were: levels of collaboration, timing and silence (non-responding). Collaborative communication involved two-way conversation involving both the physiotherapist and the patient's knowledge and opinions. Conversely, educative communication involved only the physiotherapist's knowledge being shared by 'telling' the patient information. Participants reported both of these types of communication, although educative interactions more frequently. Participants overwhelmingly perceived collaborative interactions more positively. Positive collaborative discussions about weight included the physiotherapist acknowledging the patient would



already know they were 'overweight' and the physiotherapist not assuming that the patient was overweight due to 'easily controllable' factors such as exercise and diet. Jaya described an interaction she viewed negatively: *"it wasn't news to me ... having somebody state the obvious in a statement way is never nice"*. Darren had a more collaborative interaction: *"she wasn't necessarily informing me but she was just kind of, you know, assuming prior knowledge"*.

The timing of weight related discussions was seen as more appropriate when the patient was clothed, and when rapport had already been established. Ellie described her discomfort at being undressed when her physiotherapist mentioned she thought Ellie had lost weight: *"you're already in an uncomfortable situation where you're semi-naked so maybe it's not the best time to think about what you look like"*. While there were difficulties discussing weight, not talking about weight, if mentioned by patients, was also problematic. For example, Ellie assumed when her physiotherapist said nothing that meant something negative about her weight: *"I do assume that, yeah, there's some level of unhappiness with my weight and it would help the cause if I was not as overweight as I am"* and Radwa wanted more information than the (perceived as dismissive) change of topic she received when she asked if weight was contributing to her knee problem.

**3.3.3.2. Communication styles.** Physiotherapists' communication styles in interactions not associated with weight influenced how well communications about weight were perceived. Participants perceived general interactions as more positive when physiotherapists expressed empathy during treatment sessions, and used a collaborative rather than an educative communication approach. Participants also viewed a person centred approach more positively, where participants felt they were considered as individuals. The quality of the physiotherapists' attention was also important as Eimer described: *"it wasn't that he wasn't confident - it was just that he wasn't as involved"*. Participants perceived good attention (appearing interested) and non-judgemental/positive attitude as positive and likely to preface good interactions about weight when it occurred. Kyle gives his perspective on this: *"it's about interpersonal communication. So some physios might not be able to pick up what you're putting down. Others would and then it just depends on whether that relationship blossoms into something that creates healing and creates a positive situation."*

#### 3.3.4. Theme 4. Judgement (perceived and self)

Participants who considered themselves to be overweight frequently felt that they would be (or have been) judged as not thin/active/good enough in a physiotherapy environment. Before going to her first physiotherapy appointment Nina said: *"I felt people were going to judge me and wonder why I've got to the way I've got and how come I've let it (sic) and blame me"*. Participants also frequently described negative self-evaluations about their weight in response to physiotherapy environments. Eimer said: *"there's so much talk at the moment about health and obesity that ... if you're not really slim and really fit then you feel like there's something wrong with you"*. Emotions commonly included: guilt, shame, embarrassment, self-consciousness and a sense of being a failure. Participants frequently questioned whether these negative self-evaluations were due to the physiotherapy environment or to projections of their own self-image, and commonly blamed themselves for these perceptions, a form of self-stigmatisation. Nina said: *"Nothing was done to me that made me feel like that. It was my own head."* This sense of shame, self-blame and fear of receiving weight stigma is considered one of the reasons people are likely to avoid healthcare appointments (Pausé, 2014).

#### 3.4. Summary and inter-relationship of themes

In summary, participants generally recounted negative (or stigmatising) experiences of interactions involving weight in physiotherapy settings, although positive interactions were sometimes described. The findings of this study suggested a number of factors in physiotherapy interactions that participants perceived as being relevant to weight. These included: elements of being 'in physiotherapy'; physiotherapists' attitudes to, and knowledge of, weight; and physiotherapists' communication styles. The four themes outlined above were inter-related. Generally, if elements of one theme were present they amplified effects of other experiences. For example, participants reported that if a physiotherapy environment had a thin physiotherapist or a was sporty looking clinic this could increase negative self-evaluations and fear of judgement, which in turn could negatively affect perceptions of communication. Participants also discussed that the converse situation occurred. For example, good communication helped to mitigate the effects of the environment or self-stigmatisation.

### 4. Conclusions

#### 4.1. Implications

The findings of this study indicate that physiotherapy encounters have many elements that relate to weight. Further, although some patients had positive perceptions of weight interactions with physiotherapists, many patients may expect and perceive that physiotherapists have negative attitudes towards 'overweight bodies' (weight stigma). In some cases these perceived attitudes may be because physiotherapists do stereotype (Sack et al., 2009) or stigmatise (Setchell et al., 2014) people who are overweight. Alternatively, but still important, it may be a matter of patients' perceptions or stereotypes of physiotherapists. While physiotherapists may not be able to change patient perceptions, they can use this knowledge to be more sensitive. Whether due to physiotherapist attitudes or patient perceptions, this expectation of negative attitudes towards weight is problematic, as patients who perceive weight stigma trust their health care professional less (Gudzune et al., 2014) and may change health providers (Puhl et al., 2012a). Further, this stigma may have a negative effect on patients, including poorer psychological and physical health outcomes (Bacon and Aphramor, 2011; Schvey et al., 2014). Findings from this study highlight a number of topics worthy of inquiry that are beyond what can reasonably be interpreted from these data. To address this, further research investigating in a clinical setting is warranted.

Because this research was conducted in one geographical location some aspects of physiotherapy interactions about weight may not have been covered. Therefore, there may be limits to the generalisability of findings to different socio-cultural physiotherapy environments. However, the findings do describe many aspects of the physiotherapy experience and are likely to have applications to broader physiotherapy contexts. Despite participants recalling a variety of physiotherapy experiences, most weight salient or stigmatising experiences were recollected to be during musculoskeletal and private practice physiotherapy interactions. This focus, however, may have been over-demonstrated due to the initial interview being situated in a musculoskeletal setting, despite the interviewer encouraging reflection on a variety of physiotherapy experiences.

A number of factors may have influenced the results of this study. Recollections of older interactions may be subject to recall bias. However, all recollections are what the patients believe and so are valid and relevant. The interviewer's views may have influenced

the data. Attempts were made to minimise this throughout data collection where the interviewer was careful not to provide her own views. However, the interviewer's status as thin and a physiotherapist could position her as an 'outsider' with overweight participants and thus potentially elicit a more cautious response, whereby participants would be less explicit (Hayfield and Huxley, 2014) about weight stigmatising experiences. The rapport developed over the two interviews likely mitigated this.

#### 4.2. Suggestions for clinical practice

Patients' perspectives reported in this study suggest physiotherapists may not adequately understand, sufficiently consider or be educated about the discomfort interactions involving weight may precipitate. To address this, physiotherapists do not necessarily need to dramatically change practice, but could consider implementing a number of practical strategies based on the findings from this study and other related research. Organisations representing the profession, as well as individual physiotherapy clinics, could consider using a range of body sizes when creating visual material such as advertising, websites, charts or health promotion materials (Pausé, 2014). When creating or adapting physiotherapy environments, prominence of mirrors (Martin-Ginis et al., 2003) could be considered, as well the suitability of equipment/furniture for a range of body sizes. Further, the privacy of the physical layout of the clinic, both in terms of treatment rooms and exercise/movement analysis areas, is another area for consideration. It is also important to be aware of the sensitivity of exposing the body and the negative self-judgements this may precipitate. Thus, when the patient is disrobing or disrobed physiotherapists should be particularly careful about what is being discussed. When weight is considered relevant to discuss, collaborative styles of communication (Trede, 2012) are more helpful, without assumptions about patient knowledge levels or weight's causes. The topic of weight should neither be ignored nor overemphasized, and should be handled with empathy (Watson and Gallois, 1998) and a non-judgemental tone. Patient centred general communication styles and rapport building (Street Jr. et al., 2009) are likely to enhance specific communication about weight.

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#### Appendix 1

##### Interview Guide

##### 1st interview (situated in a private health clinic)

1. Can you describe on what occasions you have seen a physiotherapist?
2. Did you have any thoughts or feelings that related to your body weight in any way as you were deciding to whether to attend a physiotherapy session?
3. Can you describe an interaction you have had with a physiotherapist that involved something to do with your body size?  
Possible follow up questions:
  - Could you expand on ... .. please?
  - Do you remember any words or phrases or how things were 'put'?
  - Is there anything about the physical environment (eg equipment/furniture) in this clinic (or others like it that you have

been in) that you have noticed has any relevance to your body size? For example makes you feel comfortable or uncomfortable?

- Did you have any sense that the physiotherapist found the interaction with you satisfying or unsatisfying?
  - Did you feel that the reason you went to see the physiotherapist in the first place was adequately addressed?
4. Do you have any suggestions about how this experience could have been made more positive for you as a patient?  
Possible follow up questions:
    - Can you expand on ... .. please?

I think that's basically everything I wanted to ask. Do you have anything else you would like to raise or final thoughts you have had? Anything you think that might be relevant that I haven't asked?

##### Diary

On reflection, if you have any more thoughts about the topics discussed in the interview or anything related you can use this 'diary' to note your ideas so that we can speak about them when we have the second interview in two weeks.

1. Have you had any other thoughts about the experience(s) that related to your body weight in a physiotherapy environment?
2. Have you had any other ideas that you would like to share about how to make these (or other similar) experiences more positive for you/other physiotherapy patients?

##### 2nd interview (telephone)

1. On reflection, and using your diary to prompt you as needed, do you have any more thoughts about the experience of weight related interactions with physiotherapists which you described in the first interview?  
Possible follow up questions:
  - Can you expand on ... .. please?

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