

**Alqout, O., & Reynolds, F. (2014). Experiences of obesity among Saudi Arabian women contemplating bariatric surgery: An interpretative phenomenological analysis. *Journal of Health Psychology, 19(5), 664-677.***

### **Abstract**

This study explored experiences of obesity, its perceived causes, and motives for surgery, as described by seven Saudi women contemplating bariatric surgery. The women experienced cultural restrictions on their physical and social activities. Obesity embodied these restrictions, attracting stigma and moral failure. Traditional clothing, foods, hospitality norms, and limited outdoor female activities were regarded as barriers to weight loss. Bariatric surgery was chosen to protect health and to access normative female roles. Some were encouraged by relatives who had undergone surgery. Opting for surgery reflected both participants' sense of powerlessness to self-manage weight and the social acceptability, within their family context, of this biomedical approach.

### **Literature review**

Across the world, obesity affects more women than men (WHO, 2011), and can be a distressing experience (Cooke & Wardle, 2007). For example, obese women experience more stigmatizing social attitudes, may feel less sexually desirable, and low in self-esteem (Puhl & Heuer, 2009). Obesity also poses a challenge to health, increasing the risk of cancers such as breast cancer, and other conditions such as Type II diabetes and coronary heart disease (WHO, 2011). In health psychology, there has been some acknowledgement of the need for culturally sensitive care (Aboud, 2012; MacLachlan, 2000), and yet most relevant research on which to base interventions has been conducted in Western contexts. In the context of obesity research, there is evidence that people from different cultural

backgrounds have somewhat different attitudes to body weight, healthy foods and weight control, and that weight loss interventions should incorporate these understandings (Barroso et al., 2010). MacLachlan (2000; p.380) has argued that health psychologists need "... to incorporate personal meaning because assessments and interventions will be valued and believed to the extent that they take cognisance of a person's own experience of his or her situation".

The study reported here was conducted in Saudi Arabia where obesity rates have significantly increased, being higher than in other Gulf states (Trainer, 2010). Recent data show that 40-50% of Saudi women are obese (BMI >30), compared with about 30% of men (Musaiger, 2011;WHO, 2010). Increasing rates of obesity across the whole of the Arabian Gulf region have been attributed to many factors including increasing socio- economic status, linked with the oil and gas revenues, urbanization, increasing quality and quantity of food choices, and access to more 'fast' foods as well as high-calorie traditional foods (Musaiger, 2011;Trainer, 2010). As in the West, lifestyles in the Arab states have become more sedentary, encouraging weight gain. Married Saudi women in midlife are especially vulnerable to obesity, as are unemployed women (Musaiger, 2011). Authors have put forward a range of contributory factors to explain why women in Saudi Arabia are more affected by obesity than men, and they include limited nutritional knowledge, repeated pregnancies, loose traditional clothing covering the whole body, and socio–environmental barriers such as not having enough space to exercise indoors (Albassam et al., 2007; Musaiger, 2011). Loose female clothing, as culturally required, has been thought to hide body shape, reducing body image concerns and motivation to lose weight (Musaiger & Qashqari, 2005; Al-Tawil et al., 2007). However, these arguments are not supported by a study that found few differences in attitudes towards eating and body weight among Iranian women living in Tehran and Los Angeles, leading the authors to conclude "that having one's body covered the majority of the time [in Iran] is not necessarily protective against body image concerns and eating disorders" (Abdollahi & Mann, 2001; p.266). Evidence for all

these suggested causes of obesity is drawn from statistical associations in quantitative survey data. Obese women's own attributions for the difficulties that they encounter in managing body weight in the Saudi context have been neglected.

Arabic cultural norms regarding body weight appear to have changed, shifting from traditionally associating a heavier body with health and affluence to adopting more Westernised aspirations for thinness (Al-Sabaie, 1989; Rasheed, 1998, Al-Subaie et al., 1996). However, good quality data about current cultural norms in relation to ideal body shape and weight are lacking. Some Arabic studies (e.g. Musaiger et al 2004; Tlili et al., 2008) have relied on participants choosing preferred body silhouettes from a range of drawn outline shapes, which is a procedure that omits the large range of the social cues that influence perceptions of attractiveness and health in face-to-face interaction.

Qualitative research into women's subjective experiences of obesity in the Arab states is very limited. However, a qualitative focus group study with Arab women in the United Arab Emirates explored barriers to losing weight (Ali et al., 2010). Participants identified certain personal characteristics as contributing to their overweight/obesity, such as large appetite and using food as a coping strategy for low mood. They also described pressures associated with the wider culture such as obligations to eat large portions at social gatherings, lack of culturally approved exercise facilities for women, and sedentary lifestyles associated with having maids at home. Similar issues were documented among obese Saudi women by Rasheed (1998), using a quantitative questionnaire.

Although studies of Arabic women's subjective experience of overweight and obesity are extremely limited, research in the West has uncovered high levels of distress, linked to experiences of social stigma and discrimination, for example in employment and social relationships (Brewis et al., 2011; Puhl & Heuer, 2009). Feelings of powerlessness lead some to seek medical solutions such as bariatric surgery to reduce stomach size, and the

body's ability to take in and digest food. An interpretative phenomenological study of women who had undergone bariatric surgery in the UK (Ogden et al., 2006), found that they were motivated by a range of distressing experiences such as the onset of health problems, concerns about dying prematurely, frustration with activity limitations and a desire to become pregnant. Green, Larkin and Sullivan (2009) found nuanced meanings of obesity and diet failure among a largely white British sample of women. Interpretative phenomenological analysis (IPA) uncovered participants' sense that multiple selves were often 'doing battle' in eating contexts, and gender role pressures. This methodology offered a sensitive way of exploring the experience of obesity, justifying its use to explore Saudi women's experiences of obesity for what appears to be the first time.

### **Aims:**

The aims of this phenomenological study were to explore Saudi women's experiences of obesity, their perceptions of the biographical factors that had influenced their body weight, and their reasons for wishing to undergo gastric surgery.

### **Method:**

#### *Design:*

Guidelines for a study using IPA were followed (Smith, Flowers & Larkin, 2009). IPA is a qualitative approach that shares with phenomenology a commitment to understanding personal experience. Nonetheless, verbal accounts are not thought to offer direct glimpses into others' lifeworlds. The researcher is accepted as engaging in analytical meaning-making, co-constructing the understandings that emerge. IPA also has a commitment to idiography, entailing detailed analysis of individual accounts within a sample, to achieve an appreciation both of commonalities and divergences in experiences. Given these underlying values, we understood that obesity is not a single or straightforward phenomenon, and that we needed to contextualise the women's experiences in terms of their local family and wider Saudi culture.

### *Ethics:*

The host university gave ethical permission for the study. Clear written information was provided, followed by signed consent. Confidentiality has been respected; names are pseudonyms. Participants were offered a summary of the findings.

### *Participants*

This study recruited a convenience sample, collaborating with a surgical clinic that was already treating the women. Seven participants who were awaiting surgery provided interview data for this study. It is not possible to determine how many women became aware of the project through being given the information sheet by their physicians. All participants were classified by the clinic as morbidly obese with BMIs > 40 and their ages were 26-43 (median 39). No further details about their weight were collected as this was thought to be potentially too intrusive.

The clinic provided an opportunity to gather the experiences of women with obesity, which would otherwise have been difficult to obtain, as the Saudi culture presents many barriers to accessing females. Open advertising in the community is not permitted, and outside the privacy of the clinic, the woman's family might be reluctant to allow her to be interviewed. We accept that participants would be likely to have a medicalised view of obesity and its treatment, given this recruitment route, but they would also have had a long period of struggle with obesity and hence be able to reveal some of the challenges that women face in relation to body-weight in this culture.

### *Semi-structured interviews*

The method for data collection was face-to-face semi-structured interviews, widely chosen in IPA studies and enabling the in-depth collection of personal, sensitive information. **Table 1** presents the topic guide. Additional probes and requests (such as 'Could you tell me more

about that...?) were asked, as needed, to gain a stronger sense of the lifeworld. Interviews were conducted by the first author, a female health promotion professional, in Arabic, and translated to enable co-analysis by the second author.

### *Data analysis*

The analysis in this study followed principles of IPA (Smith et al., 2009), seeking firstly to describe themes emerging from each interviewee's account, in an idiographic way, and then identifying shared and distinctive experiences across the seven interviewees. A reflexive approach was taken, and the authors brought interpretative resources of health promotion and health psychology to understanding the women's accounts. We sought to increase credibility by analysing some interview transcripts independently and then mutually, not in any sense of quantifying agreement but to enrich the understandings achieved. The themes were tagged with quotations from the interviews to help maintain a phenomenological stance. The first author enjoyed an 'insider' position as a Saudi woman, whilst the second author approached the analysis as an outsider to the culture. These distinctive positions were helpful for sensitising the authors to different emerging issues, such as gender role commitment and the experience of 'resigned restriction' (respectively).

## **Findings**

**Table 2** outlines the themes and sub-themes.

### ***1. "My weight limits my freedom": experiences of extreme restriction***

The participants all described experiences of considerable physical restriction affecting many everyday activities. This had worsened as their weight had increased:

"I used to go to an assembly of Qur'an learning and also to a health club, but

after the increase in weight, I could not because climbing the steps and getting down affected me greatly and tired me a lot. I cannot climb easily as I lose my breath” (Nancy, aged 43).

Walking was often a challenge, as even moderate exercise caused pain.

“I feel difficulty in breathing and pain in my spine ... I stop moving when I feel all of this pain....In addition, I cannot sit for a long time. I prefer to lie down on the ground instead of sitting. That position allows me to rest and I can breathe better” (Rahmah, aged 40).

Many of the participants regretted that their weight prevented them from performing effectively in their roles and responsibilities both at home and at work.

“I feel that my weight affects performance of my duties and my movement is slower and shorter in duration. My weight limits my freedom and my movement from one place to another, as well. When I see my patients I feel my body is very heavy and difficult to move” (Fatima, aged 30, a medical doctor).

Participants who were married all described feeling inadequate in their care of husbands and homes. Some who were mothers did not feel that they were adequately meeting the daily needs of their children, as they were not able to work, care or play as they felt they should with them. The phrase ‘shirking duties’ was used by several participants:

“I feel like I am shirking my duties to my daughters, I cannot put in more effort. My daughter asks me to work ...on her hair...My hands are larger and very full; therefore, I am unable to adjust her hair for her. I cannot complete cleaning of

a room. When I reach the middle of the room while sweeping, I start sweating and I feel strangled and have palpitations in the heart” (Maryam, 39).

“I do feel like I am shirking my duties towards my husband. I do not do the housework. When I am asked to do something, I just tell him “later, later” and in the end, I do not do it at all and I am tired” (Rahmah, 40).

In this context of extreme physical restriction, sedentary pastimes such as watching television and using other forms of digital technology provided the main form of leisure.

“I like to spend my time watching TV and playing PlayStation games, as well as chatting on my Blackberry” (Meshael, 29).

These sedentary activities were valued for being accessible as they require little body movement and can be enjoyed within the home; they also require little face-to-face social interaction (an issue that many participants had particular concerns with, as will be explored in the next section).

## ***2. “It affects my social relationships”: the experience of obesity within social relationships***

Obesity was very much experienced as an inhibiting factor within the women’s social lives, undermining the women’s attitudes to themselves and threatening their relationships. All participants described experiencing stigma in relation to their weight, and some recounted hurtful comments not only from strangers but even from close family members. For example, Meshael, who previously described her liking for solitary pursuits, conveyed feeling embarrassed by her nephew’s reaction to their physically active game:

“At one point, I grabbed my sister’s son [during the game] ... He asked me how I did that and he laughed too much. I was very ashamed of myself” (Meshael, 29).

Social events had triggered humiliating feelings and were therefore avoided as much as possible:

“When my husband asked me to go out, I refused to go with him because I cannot find a [shoe] size appropriate for my feet. In addition, I hear the comments from the people even though they are not aware that I hear them. So, I don’t go out. I just go from work to the house and from the house to work” (Maryam, 39).

There were several examples of internalized stigma, where the women expressed anxieties about others’ likely reactions to their body shape:

“I do not like to go out much and meet people because I am shy and when I join the people, I do not enjoy it. I keep thinking for long periods about what they will say about me. I watch them looking at me and their lips to see what they say even if they don’t talk about me, but I do imagine that they do so. Therefore I don’t like to go out much. I prefer to stay at home rather than going out” (Meshael, 29).

Prejudices were not only conveyed by strangers but from family members, who could be far more hurtful:

“My family does not permit me to go out with them to attend functions and go to public places as they find me a source of shame for them” (Asma, 26).

Some women recounted family members as sabotaging their previous efforts to lose weight, by judging that her efforts were insufficient, and ineffectual:

“I see that my surroundings have a significant impact on weight reduction. When I follow a diet, all the people around me work to shatter me by saying ‘You did not reduce your weight and you have no change in your weight. Oh! Fatty, reduce your weight. The whole world has lost weight except you.’ Then I feel crushed and desperate and alone, and I go to my room” (Meshael, 29).

Some unmarried participants were concerned that their obesity would prevent them from finding a husband:

“My younger sisters are already engaged and I am not because I am fat and my body structure does not qualify me for marriage. I am tired of myself and I wish to marry” (Asma, 26).

Body weight was thought to be judged negatively in Saudi society with many participants believing that men viewed heavier women as unattractive:

“My confidence in myself became shaky and if it [confidence] was not there, then the people will not know me from the beginning except through my outer appearance. It gives the first impression about me. Men today are concerned about appearances very much. Therefore, who would want me with this physique?” (Meshael, 29).

In a society where women are usually introduced to possible husbands through their families, negative family attitudes towards their weight prevented the possibility of marriage, leaving the woman feeling isolated and unable to take on culturally prescribed gender roles.

“It affects my social relationships. ...no bridegroom was introduced to me because I was obese and no one these days wants to marry a woman with that physique” (Fatima, 30).

Several of the married participants expressed concerns about their marital relationships and sexual contact. Husbands were thought to harbour negative feelings towards their body shape and to find them sexually unattractive. Obesity also interfered with intimacy:

“Obesity affected my marital relationship, as I hate him to approach me and I feel suffocation... I create excuses to shirk from it [intercourse]” (Maryam, 39).

Obesity also had another social dimension in that women experienced it as impeding pregnancy. For two of the older participants, the desire to conceive another child had finally motivated the decision to have weight loss surgery:

“With obesity, I now have little possibility of pregnancy because my eggs are very weak. However, if I reduce my weight, it will improve and there will be a greater possibility of pregnancy” (Rahmah, 40).

“I want to feel the experience of motherhood and I would like to have a child. I went to a gynaecologist and my weight was 170 kg and the doctor told me that I must reduce my weight” (Maryam, 39).

The participants' accounts revealed a considerable tension between desiring to fulfil traditional female role obligations and wishing to escape their everyday encounters with social exclusion, and hurtful criticism.

### ***3. “My history of obesity goes far back”: understanding the origins of obesity in participants’ lives***

Most of the participants portrayed their obesity as a long-standing ‘force’ in their lives that they had previously tried to control without success. Most of the participants linked their obesity to their childhood or adolescence period, and some attributed it to their family genetics. Cultural norms of hospitality and traditional patterns of eating were also viewed as encouraging weight gain throughout adolescence and adulthood. Traditional gender roles and difficulties accessing gender-appropriate exercise facilities were experienced as barriers to managing weight successfully.

For participants who had learned their eating patterns in childhood, attempts at food restriction in adulthood were experienced as quite ineffectual.

“The family has very large impact. If you don’t want to eat, they ask, ‘Why don’t you eat? Please eat and it is better for you’” (Maryam, 39).

Although longstanding family eating patterns were thought by most to have encouraged their obesity, further causes were thought by some to reside in their family genetics. The participants portrayed themselves as feeling very much out of control and unable to fight against these inner forces.

“All my family is of the fatty type. We are all huge and full-bodied. Thus, my obesity is no doubt because of some genetic factor” (Salma, 42).

Pregnancy was understood as another risk factor for weight gain. As is common in Saudi society, several participants had given birth to three or more children and asserted that they had gained weight dramatically during each pregnancy and post-partum period. They

attributed gaining weight not only to the bodily changes associated with pregnancy but to the post-partum food culture learned from their mothers and grandmothers:

“Upon every delivery, my weight increased 10 kg and upon each further delivery, the weight increased more and more. With the last child, my weight increased 30 kg and my blood sugar increased; I became broken psychologically” (Nancy, 43).

Maryam described cultural prescriptions for managing the post-partum period including traditional foods, eating patterns and remaining at home for an extended period. All these factors, operating over many years, in relation to several pregnancies, were thought to increase weight:

“When I got married, my weight was 133 kg approximately, but when I carried my first daughter, I miscarried the child. I carried another daughter with my starting weight exceeding 180 kg and thereafter it did not stop increasing. I was forced to think of a surgery. Upon pregnancy and delivery, it was a must to eat every three or four hours. Normally, in our society, they are concerned about the woman after delivery. It is a must to eat well so as to compensate for what was lost. She does not go out for forty days and in those forty days after the delivery, the weight increases by 40 kg. The increase in weight after delivery is from traditional foods that are served to the women who have delivered, and fatty drinks, as every food contains a large percentage of oil and it is a must for women who have delivered to eat it. It goes back to my mother’s culture” (Maryam, 39).

Rahmah had mixed feelings about the foods that she consumed after delivery, being both aware of their calorific nature but also believing in their health benefits:

“My weight increases mostly after pregnancy and birth. It is a must for me to feed well during pregnancy because the foetus needs to be well fed. I liked sweets and french fries. Also, after the delivery, I had a habit of eating traditional foods that contain a lot of oil, especially animal fats. It is our habit to have this cuisine, which consists of wheat and ghee. Also honey helps women as it prevents bone tumours” (Rahmah, 40).

Not all accounts attributed obesity to childhood factors, adolescence or pregnancy. Some placed more emphasis on long-standing sedentary lifestyle patterns at home and at work. Most social activities were associated with eating, with strong traditions of generous hospitality. Participants described difficulties increasing their activity levels as there was a lack of places for women to exercise, apart from certain gender-segregated health clubs. As girls, they had not engaged in physical exercise at school, and one participant thought that she – along with many other Saudi women – suffered from obesity as a result:

“We cannot run and jog because of a lack of any places for women that will enable them to carry out these activities... Saudi culture is the main burden for losing weight with regard to Saudi women. This is because of a non-allocation of time for body fitness for the girls in their schools. This is wrong. The authorities must work to make girls active with body fitness as it is applied in the boys’ schools” (Salma, 42).

Families could also place prohibitions on the women’s participation in exercise:

“My family does not allow me to go out and they did not allow me to complete my university studies. They never allow me to go the sports club” (Asma, 26).

Finally, long-standing habits of using food to manage emotional distress were described by two participants:

“When I feel that I am upset, I discharge my distress by eating. When I feel the sense of emptiness and boredom, I discharge it by eating. When I feel tension by not taking care of my children, the tension does not go until it is discharged by eating. Many stresses lead me to increase my weight” (Nancy, 43).

“But when I feel anger, I eat more food and put all my anger into the food. I eat even though I am not hungry, just so that it fills something in me. It is a must to change the sense of anger with happiness” (Maryam, 39).

Although two participants considered the role of emotional distress, most identified long-standing biological and social forces that governed their eating and exercise habits, impeding their ability to choose a healthier, less obesogenic lifestyle.

#### ***4. “Tight clothing will not cover my feelings”: managing obesity through choice of clothing***

All the participants were veiled and wore the culturally required ‘abaya’ outdoors, a loose-fitting robe covering the body, arms and legs. They also preferred loose indoor clothing. Loose clothing gave a sense of comfort and ease of movement, but was also thought to increase the risk of weight gain as it hides the features and details of the body.

“I cannot wear narrow dresses, as these do not give a feeling of comfort. They do not suit me because they show the defects of my body and I don’t like to wear anything that does not suit me” (Asma, 26).

The abaya was considered to help shield the woman against stigma, making her body less visible in public:

“I used to wear what I liked, but after my body had become abnormal, I began to prefer large clothes and I preferred the ‘abaya’ because it covers all of the defects of my body and nobody observes my body when I wear it” (Nancy, 43).

Maryam also seemed to use loose clothing to limit her self-consciousness about her body shape and to manage the shame that she felt about her body in public. In this quotation, she rehearsed the negative reactions that she felt sure were being expressed by other people in relation to her body shape:

“I feel that tight clothing will not cover my feelings. If I wear it, the public eyes will be on and around me. If I wear a robe, it must be spacious. Even the ‘abaya’ must be vast. I don’t want anyone to look at me this way because many comment and say, ‘Oh, Poor woman! God may help her and relieve her from it’ ... I wear a dress to cover my body and usually I am asked ‘Why are you like this? Your structure has become unkempt. Why are you like this? Try to fight it.’ I do think about reducing my weight. I do hate myself ...The wide clothing helps to increase weight because the body extends and the person does not feel it. On the other hand, if I wear jeans then I will feel increasing weight even if it is one kilo” (Maryam, 39).

Broadly, the loose traditional clothing required of Saudi women was welcomed as reducing both bodily and social discomfort, but it carried risks as increasing weight was easier to overlook.

## **5. “There will be much change in my life”: making the decision to have gastric surgery**

As shown in **Table 2**, the participants represented their decision to have stomach surgery as reflecting a range of considerations, both medical and social. Everyone was aware of having health problems such as pain, breathlessness and in some cases diabetes. Doctors had confirmed the severity of these symptoms:

“The doctors decided to undertake the surgery on the one hand, while on the other hand, my decision resulted from a social factor. I am tired of comments from my family. My small sisters prevented me from riding in a vehicle with them because they feel disturbed by my physique. Another prime reason is that I want to marry and I want a groom to come to me. The last reason is to avoid genetic diseases existing in my family, which are high blood pressure and blood sugar, as well as to avoid many health diseases” (Asma, 26).

The women were motivated not only to rescue their own health but to lose weight so that they could serve their families better, fulfilling expected gender roles:

“The doctors decided that it is a must for me to undergo the surgery soon to prevent a heart attack due to obesity. I am tired a lot. My body is tired, my legs are tired, everything is tired. I want to serve myself and to serve my girls by being in good shape” (Maryam, 39).

“I am considering surgery to lose weight and to do housework properly and to do my husband’s marital duties to the fullest” (Rahmah, 40).

Some expressed a wish to become more attractive, feeling ashamed of their public appearance, as explored previously:

“I wish to do gastric surgery in order to avoid diseases and also to get rid of back pains and to be able to stand properly again. I also followed many diets but without success. Another reason was for the reason of my beauty. I want my body to become slim and beautiful” (Salma, 42).

Those who were single believed that the surgery would lead to weight loss which would open up the possibility of finding a husband, and then starting a family:

“When my weight comes close to an ideal weight, there will be much change in my life. Being a doctor, my movements and activities will increase. Also there is a pressure to marry. I want to have a family... I am aware that if I married I might not carry a child and if I am pregnant the delivery will become difficult... It is a must to reduce the weight to start my life again” (Fatima, 30).

For some of the participants, the decision to have surgery seemed to be facilitated by knowing other family members who had successfully lost weight through this method:

“I decided when I saw the positives of surgery on my husband’s brother and he became half of his weight” (Rahmah, 40).

“I saw results on my sister and my brother’s wife. They underwent the surgery and ... the results were breath-taking and beautiful” (Meshael, 29).

All participants were morbidly obese, according to medical definitions, and their decision to have surgery was shaped by looming physical health problems and medical advice, as well

as psychological and social needs to fulfil gender appropriate roles and to gain social acceptance. In some cases, successful family members who had lost weight through gastric surgery seemed to present encouraging role models.

## **Discussion**

This study has explored how Saudi women, who were contemplating surgery, made sense of their morbid obesity. It should be emphasized that despite living within marked social restrictions, the participants were not critical of Saudi culture, apart from expressing some concern at the lack of exercise facilities for women and girls. Rather, the women expressed 'resigned restriction', seeming to accept lives that appeared highly constrained by socio-cultural factors. Their obesity seemed to be a somatic manifestation of the constraints within which they were living.

The participants were distressed about their body shape, and seemed to have internalized highly negative social attitudes. This resonates with previous questionnaire studies that have reported high levels of depression and social anxiety among obese Arabic women seeking weight loss treatment in Saudi Arabia (Abdel-Fattah et al., 2008; Rabie et al., 2010). Several described receiving very hurtful comments from family members about their weight and body size. Teasing and insults about obesity from relatives have been reported in Western studies (Carr & Friedman, 2006; Puhl & Heuer, 2009). Such responses may be particularly destructive to self-esteem, as family relationships are usually experienced as non-voluntary and inescapable. The accounts gathered here conveyed remarkably overt rejection. Al-Sabaie (1989) has suggested that overt criticism and judgement on the basis of first impressions is a Saudi cultural trait. Nonetheless, it remains uncertain whether such critical judgements about female body shape are indeed culturally sanctioned, linked with marked gender segregation and patriarchal family structures, or whether this group of participants had endured particularly unsupportive family environments. On the other hand, there is

evidence that very obese women assume that family members are more critical than in fact they are (Brewis et al., 2011), through self-stigmatising processes.

Perhaps not surprisingly, the participants experienced considerable physical restriction. Previous research has found that more unemployed women in the Saudi culture are obese, and that weight gain is associated with more hours watching television (Musaiger, 2011). This study has offered more subjective insights into these risk factors. Participating in sedentary activities within the home served to shield the participants from public gaze. The loose outdoor robes expected of Saudi women have previously been presented as increasing risk of weight gain through making body size less salient psychologically and socially (Musaiger, 2011). In this study, participants perceived loose clothing as offering a 'passing' strategy that potentially reduced social rejection by disguising the body's outline.

Previous research in Arabic countries has highlighted the lack of sporting/exercise facilities for women and girls (Badran & Laher 2011; Albassam et al. 2007). Arab-Moghaddam et al. (2007) found that few Iranian women took part in sport or physical activities, because of gender segregation, a lack of infrastructure for women's sports and leisure activities, the need to seek permission from family members, and pressure to fulfill their family role obligations. A perceived lack of exercise opportunities, together with difficulties in managing eating patterns, seemed to encourage the Saudi women in this study into pursuing a medical strategy for losing weight. It is to be noted, though, that weight loss through non-medical strategies is not impossible for Saudi women. Albassam et al. (2007) found that a weight loss intervention for Saudi females encouraged an additional 8.5% of the sample to engage in moderate physical activity (mainly walking), compared with the 25% who reported being active at the start of the programme. It therefore remains uncertain whether the women interviewed in this study were genuinely unable to access exercise opportunities, were living in particularly restricting family circumstances that prevented regular outdoor exercise, or were more incapacitated by obesity.

The Saudi women in this study portrayed considerable commitment to fulfilling traditional gender roles, such as getting married, having children and caring for the family, and they regarded their obesity as a great obstacle to doing so. Failure to fulfil gender-appropriate roles brought considerable shame and distress, managed by social withdrawal and comfort eating. Such role 'failure' has been described as a source of distress by other Arabic women living with long-term health conditions (Aghamohammadi-Kalkhoran et al., 2012; Nizamli et al., 2011). Whilst threats to physical health were acknowledged as a motivation to have surgery, as reported by post-surgical patients in the UK (Ogden et al., 2006), participants dwelled more on their sense of moral failure to live up to their family obligations, and their desire to take up valued gendered roles when they had lost weight post-surgery.

A previous IPA study in London, England, with obese women post-surgery emphasized their powerlessness to control eating and food choices (Ogden, et al., 2006). The women in that study seemed to opt for surgery through "a desire to hand over control to an external force" (p290). Powerlessness was perhaps even more strongly conveyed by the Saudi women. All portrayed their weight problems as longstanding and difficult to control, attributed to genetic and childhood influences, cultural norms of hospitality, repeated pregnancies (among the married women), family criticism and lack of accessible exercise facilities for women. This study has offered more insights into the powerful combination of forces that seemed to exacerbate the isolation, sedentary behaviour and comfort eating of this group of obese Saudi women.

The decision to have surgery was multi-faceted, with similar distal and proximal influences as found by Ogden et al (2006). Increasingly self-evident health problems and doctor's advice motivated the women to act on long-standing needs (for example, to marry or have a child). The Saudi women strongly emphasised their desire to fulfil gender-appropriate roles once weight was lost, especially to find a husband or (for those who were married) to serve the needs of husband and children more adequately. Family members who had previously

lost weight after bariatric surgery acted as role models. This may have been an important source of social encouragement given the apparently limited willingness to suggest surgery for weight loss reported by Arabic physicians (Al-Ghawi & Uauy, 2009). Participants were optimistic about the change that the surgery would bring into their lives. However, a study of Muslim women in Malaysia showed that dietary management was difficult in face of strong family pressures to take part in feasts and other hospitable occasions where traditional foods are served (Sharoni & Wu, 2012). Hence whether the participants would succeed in losing weight post-operatively remains uncertain.

### **Limitations**

Clearly the small sample limits generalisability. The women's very high levels of obesity and motivation to take a medical route to weight loss also mean that this sample is quite specific, again limiting simple generalisation. Some subtle meanings may have been lost in translating interviews into English. The study focuses on women's experiential accounts and does not provide a 'realist' or objective view of Saudi cultural factors implicated in obesity.

### **Conclusions**

The Saudi women in this study described many difficult experiences associated with obesity. In a society which already constrains women from freely participating in activities outside their homes, obesity could be interpreted as an embodied manifestation of these restrictions. High levels of distress were associated with limited mobility, negative body image and failure to fulfil gender roles in culturally prescribed ways. Stigma from wider society, teasing from family members and a lack of social support for dietary change or exercise left the women feeling isolated and embarrassed about themselves and their body shape. Although they understood that exercise contributes to weight management, they described many social barriers to accessing female exercise facilities. Given these social restrictions, it is perhaps

not surprising that all participants described themselves as inactive and as spending much time in relatively isolated sedentary pursuits, such as watching TV with its attendant risks of snacking.

Most attributed their weight problems to long-standing factors, related to biology, family and cultural practices. The Saudi requirement for loose clothing was valued for reducing the visibility of the body and hence its vulnerability to public ridicule. The participants were optimistic that weight loss surgery would change their lives for the better, but whether their dietary and exercise habits could ultimately be changed in the face of so many cultural barriers is open to question. Population figures show that a large proportion of Saudi women are obese (Musaiger, 2011; WHO, 2010 ) and this small-scale qualitative study has shed light on the psychosocial factors that may be contributing to this widespread health problem. Further qualitative research is needed, in particular to elicit the experiences of Saudi women who are taking a non-medical approach to managing their weight, to find out how they are negotiating the cultural restrictions placed on women's physical exercise and eating patterns.

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### **Table 1 Topic guide for semi-structured interviews**

1. Open question to interviewee to introduce herself to the interviewer (such as her interests, work or family roles)
2. Past and current experiences with weight and managing weight; barriers to losing weight (and, if not covered by the participant, additional probes to explore her experiences of traditional foods, options for physical activity)
3. Feelings about self, roles and relationships; whether and how obesity has been experienced as influencing self-image, roles and relationships
4. Previous experiences with losing weight and experiences leading to the decision to opt for bariatric surgery.

## **Table 2: Experiences of obesity: themes and sub-themes**

### *“My weight limits my freedom”: experiences of extreme restriction*

- Difficulties walking and moving
- Difficulties in sleeping
- Difficulties in managing work and household tasks
- Use of television as escape

### *“My weight affects my social relationships”: the experience of obesity within social relationships*

- Shame, stigma and loss of self-confidence
- Difficulties finding a husband
- Concerns about marital relationships and sexual contact
- Fears about fertility

### *“My history of obesity goes far back”: understanding the origins of obesity*

- Parental influence on eating patterns
- Genetic influences
- Pregnancy, birth and culturally prescribed foods
- Lack of female sports facilities

### *“Tight clothing will not cover my feelings”: managing obesity through traditional clothing*

- Reducing self-consciousness about weight and body size
- Limiting stigma and shame
- Limiting physical discomfort

### *“There will be much change in my life”: making the decision to have stomach surgery*

- Doctor’s advice
- Health concerns
- Concerns to improve appearance and reduce stigma
- Desire to marry and/or have a family
- Observing the impact of surgery on others