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Strong, female and Black: Stereotypes of African Caribbean women's body shape and their effects on clinical encounters

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DOI:
10.1177/1363459315595847

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Document Version
Peer reviewed version

Citation for published version (Harvard):
Andrews, N, Greenfield, S, Drever, W & Redwood, S 2015, 'Strong, female and Black: Stereotypes of African Caribbean women's body shape and their effects on clinical encounters', *Health*.
https://doi.org/10.1177/1363459315595847

Link to publication on Research at Birmingham portal

Publisher Rights Statement:
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doi: 10.1177/1363459315595847

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Abstract

The aim of this paper is to explore how tendencies to stereotype minority ethnic groups intersect with lay discourses about them in ways that can reproduce cultural prejudices and reinforce inequalities in access to services and health outcomes. Drawing upon Black feminist and cultural studies literature, we present a theoretical examination the stereotypes of the Black woman as 'mammy' and 'matriarch'. We suggest that the influence of these two images is central to understanding the normalisation of the larger Black female body within African Caribbean communities. This representation of excess weight contradicts mainstream negative discourses of large bodies that view it as a form of moral weakness. Seeking to stimulate reflection on how unacknowledged stereotypes may shape clinical encounters, we propose that for Black women it is the perception of strength, tied into these racial images of 'mammy' and 'matriarch' which may influence when or how health services or advice are both sought by them and offered to them. This has particular significance in relation to how body weight and weight management are/are not talked about in primary care based interactions and what support Black women are/are not offered. We argue that unintentional bias can have tangible impacts and health outcomes for Black women and possibly other minority ethnic groups.

Keywords

Stereotypes

Patient-healthcare professional interaction

Health Inequalities

Overweight and obesity

Ethnicity

Introduction

In this theoretical paper in which we draw on upon Black feminist and cultural studies literature, we explore how tendencies to stereotype minority ethnic groups intersect with lay discourses about them in ways that can reproduce cultural prejudices and reinforce inequalities in health care access and health outcomes (Laird et al., 2007). We focus on stereotypical images of African Caribbean women in relation to body shape and body size, and highlight how unacknowledged bias in clinical interactions may limit the value of discussions about health, especially about weight and weight management support, and prevention of obesity related chronic illness such as type 2 diabetes and cardiovascular disease. Empirical approaches to measuring the body such as the Body Mass Index (BMI) are used to categorise an individual as underweight, healthy, overweight, or obese (Reddy, 2006). The epidemiological literature indicates that there are high rates of overweight and obesity in African Caribbean groups compared to the general population in the United Kingdom (UK) and that excess weight in African Caribbean women is higher than in the general population; 65% of African Caribbean women are classified as having an 'unhealthy' high weight compared to 57% of White British women (Hirani and Stamatakis, 2006).

Exploring the intersection of race, ethnicity and gender in relation to the discourses about the 'fat body' and Black femininity, we consider how these discourses might operate in clinical encounters and interactions about overweight and obesity between healthcare professionals and women from African Caribbean communities. While the influence of stereotypes of Black

women has been explored within the context of mental health (e.g. Edge, 2004), less attention has been paid to how such stereotypes may influence perceptions of weight and weight management. The aim of this paper is to stimulate reflection on how unacknowledged stereotypes may shape clinical encounters at a time when health seems to have become visually accessible by 'being manifest in the parameters of the body' (Grønning et al., 2013:267).

Starting with a brief historical investigation of the image of the Black female body, we address how the larger Black body is 'normalised' within African Caribbean, and indeed, mainstream society. We discuss how this particular view of the body is tightly bound up with the stereotypical imagery of Black women which portrays them as *strong*. This association of larger body size and strength for Black women exists in tension with mainstream views, which link excess weight with poor levels of health and fitness, and with weakness, especially moral weakness. We suggest that this notion of strength influences the health behaviours of African Caribbean women. Consequently, healthcare professionals' prescription to lose weight may be interpreted not as an invitation to increase levels of wellbeing and fitness, but as a demand to *relinquish* their strength.

The theoretical perspectives explored in this paper are rooted in social constructionism and this analysis is part of a wider empirical research investigation that seeks to examine African Caribbean women's discursive and cultural constructions of health with particular focus on body shape and size. The aim of the empirical work is to examine how biomedical knowledge is assimilated, reconstructed and transformed by a number of different discourses including cultural stereotypes, and popular medical science and lifestyle advice disseminated by various

media. Researchers working with a social constructionist framework challenge the humanistic understanding of the individual as stable, rational, independent and autonomous. Rather they see subjectivity as constructed through social processes which include the various discourses, historic and cultural as well as popular scientific, that are operating in a society and thus available to individuals. While we share the critical outlook of the social constructionist project by contesting what might be called the 'conventional wisdom', we do not subscribe to the more radical, nihilistic constructionist idea that it is impossible to produce legitimate knowledge (for a discussion of these issues see for example Bury, 1986). Such a position condemns everything and proposes nothing to advance practice (Bauman, 1992). Instead we draw on Black feminist and cultural studies literature to examine the wider cultural meanings around bodies and how they intersect with social constructions of gender which we posit can be fruitful in highlighting what unacknowledged discourses may be operating during clinical encounters about excess weight.

Recognising that defining and labelling ethnic groups in health research is both complex and problematic, we follow the principles described by Bhopal (2004). The modern utilisation of the concept of race refers to its social source rather than biology and provides a way of defining, for social purposes, populations that look different and have different ancestral roots' (Bhopal, 2004:442). The term 'Black' refers to people of African ancestry; 'White' refers to people of European descent. The use of the term Black is important for this discussion as it draws on the discourses and experiences of people of African descent in Europe and America (Walvin, 2000). We will refer to the body of African American research conducted with Black women which we will draw into the British context. In this paper, the term ethnicity refers to 'the group to which people belong, and/or are perceived to belong, as a result of certain shared

characteristics, including geographical and ancestral origins, but particularly cultural traditions and languages' (Bhopal, 2004: 441). Ethnicity will be denoted by terms such as African American, African Caribbean, and White British.

Understandings of the body

Against a background in many parts of the world of easy access to high calorie/high fat foods and a reduced need to engage in physical activity, excess weight and large body size have become problematic for health. Biomedical evidence suggesting that these present a major threat to health has resulted in discourses about a global 'obesity pandemic' which no public health system in the world has been able to reverse (Swinburn et al., 2011). In an attempt to address the nation's weight problems, the UK National Health Service (NHS) has called on healthcare professionals to 'make every contact count' by encouraging conversations with patients about health and lifestyle based on behaviour change methodologies (NHS Future Forum, 2012). Such techniques and practices reflect what Foucault (1973) termed the 'medical gaze', an orientation on which he saw modern health care practice to be predicated, targeting the body as an object to be presented for scrutiny, classification and treatment. This medical gaze is especially powerful because it shapes and maintains the production of knowledge about the body within biomedical and mainstream societal discourse while marginalising other forms of understanding (Foucault, 1973; Foucault, 1980). To identify patients with an 'unhealthy' weight, healthcare professionals use objective measures, such as the BMI scale. Indeed, it is argued that the adoption of standardised means of assessing overweight in both populations and individuals, has facilitated the development of an 'obesity science' and the reasoning that has led to the claim that current population trends point to an 'obesity epidemic' (Fletcher, 2014). However, the validity of the BMI as a universal measure has been questioned and other

measures such as waist circumference and hip-to-waist ratio may provide more accurate indication of risk to health (Dobbelsteyn et al, 2001).

While the biomedical evidence is unequivocal, pointing to an imbalance between energy intake and energy output, it is far from clear what approach should be taken to assist people to achieve a balanced weight. There is much professional guidance about how issues of weight management may be raised, yet in practice it is often a matter of the relationship between the healthcare professional and the patient which is 'one of the most complex [...] and is therefore emotionally laden and requires close co-operation' (Ong et al., 1995:903). Research suggests that general practitioners and practice nurses are apprehensive about initiating and discussing weight management with patients (Michie, 2007), citing concerns about offending or upsetting patients because of negative societal discourses about fat which constructs the overweight or obese body as deviant (Mold and Forbes, 2011) and the individual as weak and morally flawed. For professionals, these stereotypes, alongside cognitive and emotional consequences for the individual, mediate how and when the topic of overweight is broached with patients for whom the conversation is thought to be appropriate. However, while the powerful influence of the biomedical view of health and weight is evident in mainstream discourse, it is important to recognise that alternative conceptualisations of excess weight and obesity exist and shape ways that patients perceive their own health. In fact, Foucault suggests that alternative views that question the authority of the biomedical view are inevitable as the power to define knowledge about the body and health enables the 'possibility of resistance' (Foucault, 1984/1997:292) where discursive positions can be challenged or resisted.

The contestation of power/knowledge manifests as a 'reverse discourse' (Foucault, 1978/ 1981:101), offering alternative interpretations to expert definitions of health. With regard to understanding body shape and size, alternative perspectives on what constitutes a healthy body are made possible through an 'oppositional gaze' (hooks, 1992), resisting the authority of the medical gaze to define health and normality, enabling other meanings to be ascribed to the body and other stories to be told about health. Similarly, healthcare professionals consulting with individuals and families from diverse communities need an understanding of a range of 'oppositional gazes' on meanings of health, wellbeing and fitness that do not easily align with biomedical discourses and that resist the idea of the risk of ill-health residing silently in their body. For example, a UK study that explored attitudes to weight of both Black and White women, Shoneye et al (2011) found that Black participants had a more favourable opinion of larger body sizes compared to their White counterparts. This finding echoes results of research conducted in African American communities that reports a cultural normalising and acceptance of excess weight and obesity for women (e.g. Gilliard et al., 2007; Schuler et al., 2008). In the following section, we explore the possible genesis of the oppositional gaze on the Black female body.

The making of an image: The mammy and the matriarch

Drawing upon Black feminist and cultural studies literature, we examine the stereotypes of the Black woman as 'mammy' and 'matriarch'. We suggest that the influence of these two socially constructed images is central to understanding the normalisation of the larger Black female body within African Caribbean communities. Furthermore, such stereotypes construct the large body as *strong,* which is an empowering oppositional gaze to the medical gaze and mainstream views of the body.

There is a well-documented history of how Black femininity has been portrayed in the West. One of the earliest stereotypes of the Black woman is that of the Black 'mammy'. It is suggested that this classical, and most famous, representation of Black women image emerged in the Southern states of the US during the civil war, a time when enslavement of Black people was extensive in the US and Caribbean (Collins, 2000). As the mammy, the Black woman is depicted as 'fat and dark, with "nappy" hair and a booming voice. She is ever-nurturing, though virtually sexless' (Williamson, 1998:66). Through this image of Black women, a contrast between Black and White femininity is set up. While White female beauty is defined in terms of slenderness and fragility, producing a body unfit for physical work, the Black female body is depicted as large and strong, yet not in terms of male strength and dominance, but as indicative of its potential for low-status physical work and subservience. Within plantation society, the role of the Black mammy was the enslaved woman who 'became the maid of all work, caring for the children, washing, ironing, cooking, cleaning and helping in the fields as well' (Parkhurst, 1938:351). Portrayal of Black women as mammies in the popular culture of the first half of the 20th century include Hattie McDaniel's character 'Mammy' in the film Gone with the Wind; the recurring housekeeper character 'Mammy Two Shoes' in the MGM Tom and Jerry cartoons; and Aunt Jemima, the trademark logo image featured on Quaker Oats Company food products. The emergence of the 1960s Black power movement in the US critiqued such depictions of Black women as undesirable and made popular the slogan 'Black is beautiful' (Mercer, 1994:98). This challenge to the notion of beauty prompted Black women to celebrate their natural attributes - including a larger body size and shape, and non-European hair texture and facial features - as a challenge to racism.

It is suggested that the mammy has not been relegated to history; rather this image of Black women continues to exist in the form of 'modern mammies' (Collins, 2004:138). Ascribing this label to Winfrey is not to diminish her success as a media personality and entrepreneur, but to critically engage with her image as a cultural icon for the neoliberal era (Peck, 2008). In moving away from a particularly negative view of the Black aesthetic, the modern mammy image of Oprah is one of a strong, hardworking, nurturing confidante who is always receptive to the needs of those she serves, her guests and her audience (Stanley, 2007). In an online magazine article, Oprah describes how after years of struggling with her own weight, she has found her *strength*:

> "I did a head-to-toe assessment, and though there was plenty of room for improvement, I no longer hated any part of myself, including the cellulite. I thought, this is the body you've been given—love what you've got [...] In that moment, as I stood before the mirror, I had my own spiritual transformation […] What I know for sure is that the struggle is over. I've finally made peace with my body" (Winfrey, 2002).

The mammy stereotype in its historical and contemporary forms suggests the notion of *strength* which is linked to a large Black female body. Body size comes to represent the strength to undertake physical manual tasks, to persevere through hardship, to care for the family, to challenge negative representations of Blackness, *and* to be comfortable in one's own skin. Thereby, in the process of accepting or resisting particular stereotypes, the large Black female body is central to this symbolism of Black women and strength (Beauboeuf-Lafontant, 2003). This conceptualisation is in stark contrast to mainstream societal discourse, where individuals who are overweight or obese are conceptualised as lazy, morally weak and out of control

(Meleo-Erwin, 2011). Thus despite images of White female beauty of slenderness and vulnerability, 'the most respected physical shape of Black women, within and outside the community, is that of the large woman' (Gilkes, 2001:183). As if to underline this view, members of Oprah's audience called into question her legitimacy for giving advice and openly criticised her after she had lost a considerable amount of weight (Stanley, 2007).

The second image of the Black woman is that of the matriarch, which also draws on the notion of strength in relation to Black femininity. This image emerged in post slavery US society and depicts Black women as aggressive, emasculating and fiercely autonomous within the family and wider society (Collins, 2000). This image is particularly politically charged as it was used in labelling Black families as 'pathological', with a focus on single mothers who often headed these families. It was in the US during the 1960s that this particular view of the Black matriarch was used to challenge to the negative view of the Black family, in a similar way to the redefinition of beauty discussed earlier. The matriarchal image came to represent Black women's rejection of the placid mammy stereotype. However, the objection to the mammy is based on the image of smiling servitude rather than on physical traits. The maternal features of the mammy are retained, but transformed into a 'more acceptable image of [Black] women as "strong"'(Hill, 2009:738). This construction of strength continues to permeate popular culture where Black women are portrayed as tough, savvy and streetwise (Emerson, 2002). The flipside of this image of the strong Black woman is that she is also seen to be hostile and aggressive. Michelle Obama, for example, responded passionately to claims that she is matriarchal and said that she is tired of the 'angry Black woman' stereotype that influences the lives of many Black women (CBS News, 2011). While this construction of the matriarch is not underpinned by a particular body shape or size, it may influence how Black women address health issues. Women who

internalise this image of Black femininity as being strong and independent are encouraged to adopt the assumption that they can 'go it alone, without others, a notion that fosters silence and social isolation among those who feel they are less than a woman if they show signs of weakness and vulnerability' (Taylor, 1999:40).

Research suggests that there might be a relationship between the stereotypes of Black femininity as strong and the health behaviours African Caribbean women engage in. For instance, while there is an over-diagnosis of psychoses in African Caribbean communities, there is an under-diagnosis of neurotic disorders such as anxiety and depression (Edge and Rogers, 2005) which may be seen as signs of powerlessness and vulnerability. Similarly, findings from population based studies indicate that there are significantly higher rates of undiagnosed depression in this community compared to the White British population, especially for women (Berthoud and Nazroo, 1997; Nazroo, 1997; Shaw et al., 1999). Moreover, research into the low rates of self-reported depression and help seeking behaviour in women from this ethnic group suggests the possibility that the image of the Black woman as the matriarch and historical connections to the mammy role continue to shape understandings and lived experiences of Black femininity. In their study into perinatal depression in African Caribbean women, Edge et al (2004:434) quote a participant who states:

> "I think it all relates to slavery […] We had to be strong for our kids […] we had to protect them, had to be strong for them […] and it's just been instilled into the daughters […] that you need to be strong, to hold your family together. You can't depend on no man […] You need to be a strong [woman]."

This quote alludes to the shared narratives of African American communities in the US and African Caribbean communities in the UK as both emerge from post slavery Black Atlantic communities and how these may influence behaviours, health and wellbeing. This social construction of Black femininity will be explored further in the following sections in relation to perceptions of health, excess weight and obesity, and weight management.

Alternative discourses

In this section, we will explore how alternative views of health that have currency in African Caribbean communities might influence how epidemiological risks associated with factors such as excess weight and obesity are conceptualised. Using the 'prevention paradox' theory (Rose, 1985), the relationship between stereotypical views of the larger Black body and perception of susceptibility for obesity related chronic diseases will be explored, using findings of research conducted with African Caribbean women. We will go on to discuss the implications of this paradox for healthcare professionals when talking about the associated risks of excess weight with African Caribbean women in clinical settings.

In a study that investigated the health beliefs of African Caribbean people, Brown et al (2007) report that the participants were well aware of the link between excess weight and the onset of type 2 diabetes. In fact, Shoneye et al (2011) found that the Black female participants were more likely to identify health as a motivator for weight management than White female participants. However, biomedicine is only one of the lenses through which risks to wellbeing may be perceived. Individuals and communities construct their own knowledge about *who* is at risk of ill health. The concept of 'lay epidemiology' suggests that individuals comprehend and interpret health risks through the everyday observation of health and illness in personal

networks and public discourses, through formal and informal information channels (Frankel et al., 1991). Davison et al (1991) propose that individuals are often aware of health risks as a result of health promotion initiatives, and have an understanding of what defines an individual as a 'candidate' for illness from biomedical perspectives. However, on a personal experiential level health, life and death defy epidemiological risk factors: 'undesirable events happen to some people sometimes, but not everybody always' (Davison et al., 1991:2). This contradiction, termed the prevention paradox, refers to the observed reality that not everyone who engages in risky health behaviour will go on to develop chronic illness, and that some people who live apparently healthy lives will become ill. As health promotion increases awareness in society, it simultaneously encourages attention to be drawn to 'unwarranted survivals and anomalous deaths that run contrary to public health messages' (Allmark and Tod, 2006:461).

For insight into the normalisation of excess weight and obesity in African Caribbean communities, the prevention paradox explains how the stereotype of the big, strong Black woman is reaffirmed. While public health campaigns use population based study results to identify health risks, in reality not every person who is overweight or obese will experience chronic illness (Ortega, 2013). Through the African Caribbean lay epidemiological lens, the larger female body which appears to defy illness through its strength and excess weight is not subject to weakness , therefore 'what is common is right, we presume' (Rose, 1985). Indeed, it is reported that while Black women are more likely to discuss the health implications of excess weight and refer to the health experiences of family members as catalysts for lifestyle change, they also refer to having a larger body as an advantage because it is 'less susceptible to illness' (Shoneye et al., 2011:538). Thus African Caribbean women, in common with many others, will employ a 'repertoire of health beliefs' (Davison et al., 1991:6) that they can draw upon in various

situations to explain health and illness. Perceptions of weakness are also tied to the stereotype of the strong Black woman in relation to seeking help. A UK study into perinatal mental healthcare found that African Caribbean women are less likely to seek help from medical professionals for perinatal depression than other ethnic groups citing the influence of deeply held beliefs of stigma and the importance of self-control and self-reliance (Edge, 2011). As such, the stereotype of the Black woman, her body and strength, result in an ambiguous assemblage when healthcare professionals seek to mediate between lay and biomedical discourses and explore health risks and offer assistance. By implication, healthcare professionals who encourage African Caribbean women to view themselves as candidates for obesity and related chronic illness challenge their lay epidemiological schema (Berthoud and Nazroo, 1997). More interestingly, to be deemed a candidate for illness is to go against perceptions of independence and strength that form part of the construction of Black femininity. Thus within this lay epidemiological framework, a request for weight loss may equate to a challenge to perceptions of independence and strength and is seen to lie outside the realm of the healthcare professional's legitimacy to intervene.

Stereotyping in the clinic

In this section of the paper, we will draw attention to the influences of societal stereotypes of race and ethnicity that are likely to influence the medical gaze. Acknowledging that there may be some biological differences between racial and ethnic groups with regard to what constitutes 'excess weight', the discussion will move on to highlight that the medical gaze assigns specific meanings to body size and weight which may be manifest and explicit, as well as latent and unintended. Healthcare professionals are not immune to cultural biases and negative stereotypes; this has been confirmed by evidence of racism within healthcare services both in

the UK and US (Bowler, 1993; Burr, 2002; Green et al., 2007; Lewis et al., 1990; McNeil and Binder, 1995; Sabin et al., 2008). Less obvious, but possibly also damaging to individuals and groups, are stereotypes of Black women as strong, and possibly aggressive, which may be contributing factors to decisions about how, when and indeed, if conversations about health and weight are initiated.

The BMI continues to be used in measuring and categorising excess weight and has also become a well-established part of lay discourse about overweight and obesity. When relating to healthcare professionals, such understandings can result in well informed challenges levelled at the legitimacy of the health information that is being given in the clinic. Kwan (2012) found that participants were able to critique the dominance of the BMI scale because they saw it as an inaccurate measure of physiological health and fitness in diverse populations and patient groups. The reality of biological differences between patients allows the healthcare professional and the patient to see 'race' without using racist stereotypes, acknowledging that 'racial and ethnic differences can also determine the biological course of certain diseases' (Epstein, 2007:216).

However, there may be instances in the clinic where understandings of difference based on societal stereotypes rather than biomedical knowledge become manifest. In such instances, the objectivity of the medical gaze is compromised by the social meanings ascribed to racial and ethnic difference. Where African Caribbean women may refer to stereotypes of Black femininity to figure out health issues, healthcare professionals may also draw upon stereotypes when working with women from this ethnic group which influence their care. For example, Bleich et al (2012) found that obese African American patients were less likely than obese White patients to

be offered advice on physical activity in primary care consultations. We propose that the stereotypes of strength and matriarchy of Black women may influence both Black and White healthcare professionals when raising the issue of weight management with female patients. While healthcare professionals may have a desire to provide the best care for all patients, it is possible that the influence of stereotypes may inadvertently contribute to health inequalities through non-conscious racial and ethnic bias (Green et al., 2007; Laird et al., 2007; Sabin et al., 2008), which have been shown to become more acute when working under high levels of work pressure (Burgess, 2010; van Ryn and Fu, 2003).

While judgements based on stereotypes made by healthcare professionals may not be conscious, they are apparent to patients who may be aware of bias during consultations. This not only compromises relationships between patients and healthcare professionals, but also affects health outcomes. In their study about self-reported needs of South Asian women experiencing mental health problems, Chew-Graham et al. (2002) report that the women were well aware of racist stereotypes regarding them, expressing concern that healthcare professionals may draw upon these representations during consultations. This concern led them to seek medical attention for mental health issues only at the point of crisis, rather than when symptoms first became apparent. For Black women, we propose, it is the perception of strength, tied into racial images of the Black mammy and the matriarch which may influence when or how health services or advice are both sought by and offered to them. This suggestion is supported by research which indicates that in a sample of African American women, self-esteem was affected by negative and comedic portrayals of larger bodies, both Black and White (Chena, 2012). Lau (2011) found that mainstream pressure of slenderness as the ideal body size and shape juxtaposed with cultural standards of femininity which affirm larger female body

shapes within African American communities made it difficult for Black women confidently to address their weight management issues and seek medical advice. Additionally, this particular construction of Black femininity also silences Black women who are living with disordered eating conditions such as anorexia nervosa and bulimia nervosa (Striegel-Moore et al., 2003; Williamson, 1998), which are rarely discussed.

In the final section of this paper, we will explore how stereotypical imagery has real effects not only on health seeking behaviours by Black women, but also on the interactions in consultations they have with healthcare professionals. Recognising the pressures under which many consultations and healthcare work are undertaken, we offer some suggestions on how the damaging effects of stereotyping in the clinic might be mitigated.

Implications for practice

Evidence about health inequalities and health outcomes is growing and findings point to many adverse health effects of stereotyping at both individual and collective level. At individual level, stereotyping is a strategy for mental shortcuts that guides an observer's behaviour towards the other and shapes how they respond to the other's behaviour (Watson et al, 1984). It is oriented towards the past and is regressive, depriving what is seen as 'the other' of the freedom to be and do otherwise (Kyoo, 2013). In the case of African Caribbean women, stereotypical thinking may involve expecting aggressive or angry responses to the initiation of a dialogue about health and weight and diet; assuming that African Caribbean women are generally content with their bigger size and would resist any attempt to raise the issue; and fearing causing offence or being unable to respond to emotional reactions. If unchallenged, stereotypes become part of all-purpose architecture of preconceptions, assumptions, mental imagery, and generalisations in a

strategic attempt to save time, get things done and mitigate potentially difficult situations. In the primary care clinic, wider societal issues and discourses shape the interactions between patients and healthcare professionals who face increasing pressures to provide services to an aging population with more co-morbidity and complex needs while expectations and numbers of consultations are rising. It is, therefore, understandable that healthcare staff make cognitive economies to simplify the complex work of health care practice. However, it also perpetuates a service in which healthcare professionals often remain ill-equipped to serve the needs of their ethnically diverse patient populations (Mir and Sheikh, 2010).

Aronson et al (2013) explicitly link stereotyping to discrimination, health inequalities and poor health for those who are the targets of stereotypes, often those from minority ethnic groups. They also point to the mounting evidence suggesting its harmful effect at collective level (Karlsen and Nazroo, 2002; Nazroo et al. 2007). Furthermore, there is a tendency to 'pathologise' minority cultures and their social practices, attributing poor health and poor health outcomes to aspects of their culture, rather than to structural inequalities and experiences of discrimination (Ahmad and Bradby, 2007). As Atkin and Chatoo (2007) observe, health inequalities have become enduring, long-term problems that are only partially resolved, often waiting to be rediscovered in different guises. They argue that while the focus of research is only on the presence of inequalities rather than on ways to challenge them, health research may find itself in an analytical cul-de-sac in which the mechanisms and social processes leading to the production of health inequalities remain unaddressed and potential solutions unexplored.

We suggest that health care professionals examine and possibly challenge their own assumptions and stereotypes about patients from an African Caribbean background, especially

in relation to body shape and size. While many curricula of health professionals' pre- and post-qualification educational programmes already address the issue of stigma and stereotypes, giving concrete examples such as the ones we examine in this paper, may serve to deepen an understanding of others' differences and increase a sensitivity to their needs. This involves a respectful enquiry into a person's identity rather than assuming knowledge about the person on the basis of their physical characteristics, i.e. skin colour and size, and signals that the person is seen as an individual in her own right and not as a representative of a group. Such a recognition and acknowledgement of difference makes it less likely that health care staff draw on stereotypes, in turn limiting dialogue and foreclosing possibilities for health promotion that could be explored. Through this lens, the consultation has the potential to become a 'liminal space', a transitional or border zone between biomedical discourses and lay understandings where assumptions and pre-conceptions can be tempered and stereotypes suspended. Instead of obscuring capabilities and strengths through a recourse to stereotypes, such a space enables dialogue and an interpersonal connection that that may be more fruitful in assisting African Caribbean women and health care staff in identifying if and how new decisions about health could be made. Through engaging in such practice, healthcare professionals are more likely to foster an environment that encourages them to perceive healthcare services and advice as accessible and meaningful to them. For African Caribbean women in particular, who are thinking about making lifestyle changes to reduce health risks, the healthcare professional who raises the issue in a non-threatening way may provide a source of support that does not always exist within mainstream social discourse. Rather than challenging notions of Black femininity, such an approach may be helpful in initiating lifestyle changes.

Conclusion

In this paper, we have explored how stereotyping in the clinic can threaten social interaction between patients and professionals and may contribute to health inequalities. While the biomedical discourse of health influences the professional clinical gaze and mainstream understanding of excess weight, oppositional views of the body and other lay discourses also have significant influence on health behaviours. We have shown how the social construction of Black femininity has enabled a cultural normalising of excess weight and obesity in African Caribbean communities. The concept of strength is central to this. It resists biomedical and mainstream construction of fat and links Black femininity with notions of physical and emotional strength which are often depicted through images of the larger Black female body. This representation of excess weight contradicts mainstream negative views of larger female bodies that portray excess weight as a form of weakness. We suggest that this notion of strength influences the health behaviours of African Caribbean women and contributes to shaping interaction with healthcare professionals in the clinic.

We conclude that by having an understanding that for some African Caribbean women body size may be linked to strength, healthcare professionals can become aware that by encouraging weight loss, they may be also posing a challenge to her sense of autonomy and control. As such, consideration must be given to developing alternative strategies to encouraging health promoting behaviours rather than pursuing a narrow focus on weight. A dialogue which starts with identity and cultural resources and not with deficiencies and problems located in particular ethnic groups has a greater chance of preserving the dignity and integrity of the individual and of building trust and confidence. To what extent such an approach is both efficient and effective in producing behaviour change and improved health outcomes is difficult to predict. However, given the importance of the quality of patient-health care professional interactions and the

damaging effects of stereotyping on individuals and groups, a critical examination of the aetiology of stereotypical imagery and the bias it produces in health care staff when interacting with the targets of such imagery is a key starting point.

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