



# A systemic stigmatization of fat people

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Susanne Brandheim

Faculty of Arts and Social Sciences

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Social Work

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## Preface

This dissertation was completed at the vivid department of social and psychological studies at Karlstad University. Making the decision to anchor the research questions in my own life experience of being fat in a thin-embracing culture was rewarding yet at the same time challenging. Embodying the very stigmatized trait I was aiming to make sense of, collapsed the convenient border that separates the ‘researcher’ from the ‘researched’ in ways that had to be continuously scrutinized—foremost by myself. Adding to this challenge were the passionate responses I received from students when the subject of my dissertation became known. I listened to many, sometimes unbearable, stories of how fat individuals are treated – especially by doctors and other caring professionals. Certainly these stories had an emotional impact on me, but they also kept me on track, offering me a way to disconnect from my own experiences and hold theirs in mind instead. Thank you everyone who shared their stories with me. Your voices will be heard in upcoming projects.

A number of scholars have read and commented on this work. First of all, I would like to thank my supervisors Clary Krekula, Arja Tyrkkö and Lars-Gunnar Engström. Thankyou for for your patient readings, guidance and corrections during this process. Thankyou also Bengt Starrin and Ulla Rantakeisu for supervising at an earlier stage of this work. Others who have made more temporary readings and contributed with valuable feedback include Liselotte Jakobsen, Magnus Nilsson, Ulla-Carin Hedin, Magnus Åberg, Anna-Lena Haraldsson, Lis-Bodil Karlsson and Björn Blom.

To my friends and colleagues at the department: We have shared a lot during my doctoral studies. It has been like wine like water, but you were all always available and encouraging, and often, to speak in social work terms, even empowering. A special troupe that kept me going was Karin Lundkvist, Andreas Henriksson, Mona Lindqvist and Therese Karlsson. Your uplifting conversations have meant everything to me – you are so clever, kind and fun!

Felix, when I started working on this project, you were 12 years old, and due to unforeseen life events it was literally you and me against the world. The days when you needed me at home, you still convinced me to keep going because, like noone else, you believed I would someday make a difference. You are so independently reflective in your reasoning– so far from prejudice yet always questioning, always ready to beat me down in any argumentation. Thanks for your laughs, your support and your integrity. This work is dedicated to you.

*Susanne*

Karlstad, September, 2017.

## Abstract

The aim of this work was to develop knowledge about and awareness of fatness stigmatization from a systemic perspective. By a mixed methods approach, fatness stigmatization was located as a social problem in a second-order reality in which human fatness is observed and responded to, in turn providing it with negative meaning. Four separate studies of processes involved in systemic fatness stigmatization were performed.

In the first study, the association between a person's body mass index and psychological distress was investigated. When controlling for an age-gender variable, this association was almost erased, questioning the certainty by which a higher weight in general is approached as a medical issue. In study 2, we focused on the process of stigma internalization by examining how a mix of negative and positive interpersonal responses connects to fat individuals' distress. Findings showed that negative as well as positive responses seemed to have a larger impact on fat individuals. A suggestion was that fat individuals, under pressure from a cultural and historical aversion toward fatness, have developed a higher sensitivity to responses in general. In the third study, the justification of explicit bullying of a fat partner in a loving relationship was explored with help of a directed content analysis of a reality TV weight-loss show. The analysis illustrated how explicit bullying of a fat partner could be justified by animating the thin Self as violated by the fat Other, thus highlighting core ideological values while downplaying the evils of the bullying act.

From a systemic perspective, the implications of these studies were related to each other, seated in a context comprising a historical aversion toward the fat body, a declared global obesity epidemic, the rise of a new public health ideology, a documented failure to reverse or even put a halt to this so called obesity epidemic, and a market of weight-loss stakeholders who thrive on keeping the negative meanings of being fat alive.

A pervasive stigmatization of fat people was made intelligible from a systemic perspective, where processes of structural ignorance, internalized self-discrimination, and applied prejudice bind to and reinforce each other to form a larger stigmatizing process. In the fourth paper, a theoretical argumentation suggested that viewing fatness stigmatization as a systemic oppression rather than a social-psychological misrecognition, could hold transformative keys to social change.

*Keywords: obesity, fatness, systemic, stigmatization, medicalization, transformative, second-order reality*

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## References

### Included studies

- I—Brandheim S, Rantakeisu U and Starrin B (2013) BMI and Psychological Distress in 68, 000 Swedish adults: A weak association when controlling for an age-gender combination. *BMC Public Health* 13 (68).
- II—Brandheim S and Engström LG (submitted) Psychological distress in people labeled with obesity: The relative role of negative and positive response.
- III—Brandheim S (accepted for publication) Justifying Fatness Stigmatization by Animating a Self in Crisis. *Critical Social Work*.
- IV—Brandheim S (2012) The Misrecognition Mind-set: a Trap in the Transformative Responsibility of Critical Weight Studies. *Distinktion: Scandinavian Journal of Social Theory* 13 (1): 93-108.

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# 1. Introduction

When we meet obese people, should we cast them a knowing glance of concern and ask how they are doing? Should we send flowers and “get well soon” cards to obese family members and friends?

(Gunderman 2013, the Atlantic Online)

Fat people are endowed with negative meanings. Unlike conditions where the manifestations are either invisible or indistinct, people with obesity (the medical term for fatness) wear theirs (Brewis 2014), making them extra vulnerable to judgments and categorizations. Moreover, they are judged and categorized, forcefully responded to at several communicative levels. Backed up by medical claims, fat people are located as members of a diseased group, in fact even as embodied carriers of an epidemic (see: Oliver 2006; Peretti 2013; WHO 2014). Meanwhile, a growing number of scholars such as Richard Gunderman are skeptical of the labeling of fatness as a disease. Gunderman’s irony in the quote above strikes a point. Get-well-soon cards are not sent to fat people—at least not because of their fatness. The fatness disease is not shown the same caring concerns as are shown to other diseases. At the same time, there *are* concerns. Fatness has become an issue for the medical profession to treat, cure, and reverse at an individual as well as a collective level. The magnitude of this attention to a fattening population is, in fact, according to the World Health Organization, of catastrophic proportions (WHO 2017). Ever since the onset of an emerging obesity epidemic was first declared in 1997 (Oliver 2006; Campos 2004), the risk of becoming fat or not being able to lose weight worries more individuals than ever (Fayet et al. 2012; Mann et al. 2007). The proclaimed risk of entire populations becoming fatter has gone far beyond worrying. In fact, the so-called obesity epidemic has become one of the most dominant public health concerns of the day (Guthman 2016). The World Health Organization has concluded that the development of obesity depends on genetic, environmental, lifestyle, social, behavioral, nutritional, cultural, and community factors (WHO 2014) and thus has managed to include almost everything that has to do with being human in society as a possible cause of fatness.

When questioning the knowledge accumulation regarding causes, solutions, and associations related to fatness and fat people, critical scholars have discovered deeply inaccurate knowledge of fatness among physicians, nurses, and nutritionists (Fabricatore et al. 2005). Examples included overestimations of the actual caloric intake of most fat people (Robinson & Bacon 1996) and a severe lack of knowledge of metabolic and other biological functions which predispose people to and perpetuate fatness (Vadiya 2006). Deeply seated in this accumulated knowledge, researchers also found the assumption that weight is easily controlled through decisions at the individual level to exercise more and eat less, despite findings that reveal little long-term success for any such treatment approaches (Bogart 2013; Friedman 2004; Szwarc 2004–2005). In this way, critical scholars contend, professional practices tend to put citizens in situations of incompetence, even when such practices are supposed to serve them (Ulrich 2000).

At the same time that fatness is declared to be one of today’s most urgent public health problems (WHO 2014), being fat is a human variation that is believed by many scholars to have become a more stigmatized experience than any other bodily stigma in the world right now

(Ebnetter et al. 2011; Lawrence et al. 2012; Sikorski et al. 2011). In many parts of the world, it is still possible to speak to and about fat people in ways that mock that person, making fatness one of the last standing stigmatized handicaps (Liebman 2001). With a few national exceptions, there are no laws against the discrimination of fat people (see: Puhl et al. 2015), a fact that signals they are not yet considered a fragile group in need of protection. Meanwhile, according to reviews, the prevalence of weight discrimination is now comparable to rates of race and sexual discrimination, particularly among women (Andreyeva et al. 2008; Puhl et al. 2008).

With 2 billion people worldwide considered overweight or obese (WHO 2017), some normalization effect could have been expected by now. Instead, the stigmatizing of fat people shows no signs of recession. Numerous studies that are critical of the viewing of fatness as a disease in need of a cure show how fat individuals in this labeling process are depicted as lazy, gluttonous, unmotivated, unattractive, undesirable, and unhealthy (Boero 2013; Edwards & Roberts 2009; Puhl & Heuer 2010, 2009). Also, since the stigmatizing processes incorporate several other elements, such as stereotyping, the stigma concept is even broader than discrimination (Phelan et al. 2008). Fat individuals' frequent experiences of weight stigmatization are associated with psychological distress, difficulties that lead to a negative self-perception, physical stress symptoms (Friedman et al. 2008; Hatzenbuehler et al. 2009; Rathcliff & Ellison 2013) as well as devastating psychological and physical health consequences such as depression and disturbed eating behaviors (Puhl et al. 2014; Puhl 2011; Puhl & Heuer 2010, 2009; Puhl & Brownell 2006).

Despite both formal and informal ethical rules, efforts to introduce anti-stigmatizing methods have failed (Forhan & Ramos 2013; Himes & Thompson 2007; Paluck & Green 2009; Puhl et al. 2013), and in the midst of a presumably enlightened public in welfare societies that condemn any bullying of the Other, the ridiculing of and contempt for fat people prevail. Reflecting on this paradox, critical researchers are increasingly starting to acknowledge that excess body weight is more harmful because of the stress associated with enduring an unfavorable social trait than because of anything stemming from the fat cells themselves (Beausoleil & Ward 2009; Boero 2012; Campos 2004; Muennig 2008).

The social sciences have described processes of so-called medicalization since the 1970s, and Peter Conrad argues that the power of medicine to intervene in human variations has widened for each decade. Examples are studies of the medicalization of hyperactivity, post-traumatic stress, child abuse, menopause, and alcoholism (Conrad 2005). In a delicate manner, medical values also reflect societal values (Canguilhem 1989; Quiroga 2007). Medicalization is, therefore, a reflection of surrounding social factors (Bell 2016) residing within human interactions, structures, and ideologies, reinforced in turn by medical applications (Clarke et al. 2003). Traditionally, there has been a reward for human conditions that become medicalized, and that reward is the "sick role," allowing for the "sick" to release guilt and enjoy some societal care (Parsons 1951). This reward also offers release to strained social relations as the "sick role" tells significant others that their close ones cannot be fully blamed for their condition (Conrad 1992). This sick role, though, does not yet exist for individuals medicalized as fat. Rather, the stigmatization of fat people has continued to increase (Boero 2012).

An increasing notion of the fact that stigmatization often emerges from the campaigns themselves has raised questions among health scholars on how to construct anti-stigmatizing campaigns that deal with fatness (Bacon & Aphramor 2011; Maclean et al. 2009; Puhl & Heuer 2010; Syme 2004; Thomas et al. 2008). In a meta-analytical review of the negative side effects of medicalization, Kvaale et al. (2013) found evidence that not only is medicalization no cure for

stigma, but may rather create barriers to recovery. Individuals diagnosed as fat report that they sense a lack of respect in the applications which discourages them from being active in seeking preventative care (Brewis 2014). Moreover, in the face of a consensus that the stigmatization of fat people undermines public health efforts to curb the obesity epidemic (Puhl & Heuer 2010), there is a growing interest among public health politicians in shame-based tactics as a part of weight-loss interventions (Forhan & Ramos 2013; Lewis et al. 2010; Miller et al. 2013). There is, however, no sign to show that such tactics would be effective or for that matter even humane (Herman & Polivy 2011; Thomas et al. 2010). In fact, a governmental focus on shame seems to have rather ensured that individuals remain in a state of anxiety about the possibility of their bodies being revealed to be abnormal (Cobb 2007).

According to Jackie Leach Scully, a disease label is deeply connected to society's power to act, and medicine, she says, has an unprecedented ability to do things. At the heart of contemporary biomedicine, there are tricky areas of ambiguity in which choices of disease models embody profound ethical debates about identity, human rights, and the tolerance of difference, which demand that proper distinctions be made between real diseases and human characteristics that we just happen to find disturbing (Leach Scully 2004). Thus, it is of the greatest importance that the medical institution has sufficient and applicable knowledge of the conditions for which it is held responsible.

Little attention has been paid to how institutional practices or policies may disadvantage individuals from stigmatized groups (Hatzenbuehler et al. 2013), and "the underrepresentation of this aspect is a dramatic shortcoming in the literature on stigma, as the processes involved are likely major contributors to unequal outcomes" (Link et al. 2004: 515). This is where a constructivist perspective lends itself well to an understanding of how practiced knowledge of fatness connects to the stigmatization of fat people.

Julie Guthman uses the term "artifactual constructivism" when claiming that it is not the fat itself but "how we know the obesity epidemic" that is socially constructed (Guthman 2013). Understanding a social problem as an artifactual construction in a second-order reality is an understanding of what is communicated about a specific phenomenon. If "how we know the obesity epidemic," that is, if how human fatness is responded to in terms of scientific knowledge development, governmental interventions, and attitudes somehow maintains an unethical stigmatization of people who are fat, these responses should be framed as a social problem of historic proportions.

That no-one would commend themselves to be the one who stigmatizes others shows that somewhere there is a lack of awareness of how fatness stigmatization is kept alive. According to the developer of the systemic racism theory, Joe Feagin, working on individual concepts such as "bias" or "prejudice" is too weak to make sense of a society's racist reality. A stronger, systemic theory includes normalized notions of the culturally distinct group, such as stereotypes, images, and ideologies with links to institutionalized discriminatory and self-discriminatory practices (Feagin & Bennefield 2014). In line with Feagin's theory, understanding the stigmatization of fat people as a systemic social problem requires going beyond a conceptualization of individual prejudice disconnected from structural power inequalities.

System scientist Gregory Bateson claimed that somehow there is a "pattern that connects" when he pointed out how visible paradoxes from which extrication is so difficult almost always lead back to systemic binds (Bateson 1972). By investigating fatness stigmatization from a systemic perspective, as a social problem seated in a second-order reality where fatness is responded to within a medicalization frame, awareness can be raised on how targeted actions can

produce unexpected negative results via larger processes beyond the practice level. Such awareness would benefit stigmatized individuals in general and fat individuals in particular by refocusing accountability from the inter-individual level to systemic processes that fuel this stigmatization. It would also be beneficial to the social work profession or any governmental welfare organization that responds to human conditions under the pretense that their methods are including while the subjects of their attention feel otherwise.

## 1.1 Aim and objectives

The aim of this work was to advance knowledge and awareness about the stigmatization of fat people by viewing it as a systemic construction in a second-order reality. Four systemic processes were discussed: structural, in terms of knowledge regarding the fatness/ill health association; internalized, in terms of how fat individuals take up the messages about themselves; applied, in terms of how negative treatments of fat people can be justified; and finally, transformation-wise, in terms of possibilities of a destigmatization of fat people. These studies addressed the following questions:

- What is the shape of the association between weight and psychological distress when accounting for an age/gender variable?
- What is the relative role of negative and positive response to fat people's psychological distress?
- How can stigmatization of fat individuals be justified?
- How could a change from a misrecognition mind-set to a perspective of systemic oppression hold more destigmatizing possibilities for fat people?

In the first study (*BMI and Psychological Distress in 68,311 Swedish adults: A weak association when controlling for an age-gender combination*), the specific aim was to describe the shape of the association between BMI and psychological distress when controlling for an age-gender variable. In the second study (*Psychological Distress in people labeled with Obesity: The relative role of negative and positive response*), the aim was to investigate what role negative and positive responses played in the association between obesity (BMI>35) and psychological distress. The intent was to get a deeper understanding of the stigma internalization process in fat individuals. The specific aim of the third study (*Justifying fatness stigmatization by animating a self in crisis*) was to study how explicit bullying of a fat individual could be justified. The intent was to reveal how stigma can be applied unconsciously by passing as something else.

The argumentation of the fourth theoretical paper (*The misrecognition mind-set: A trap in the transformative responsibility of critical weight studies*) was that a re-focusing from feeling misrecognized in one's fatness to view fatness stigmatization instead as a systemic oppression could carry more profound possibilities for a destigmatization of fat individuals. The results from the studies were interpreted and discussed from a systemic constructivist perspective and an application of an outlined theory of systemic stigmatization.

## 1.2 Important concepts

### *Fatness or obesity*

This work refers to the stigmatized subject as fat, fat people, or people with obesity. Obesity is the medical term for fatness, a term that will be used in the text when this is the choice of others or when the biomedical view of a higher weight is discussed. In two of the studies, we use this term ourselves because, among many publishers, this is still the only legitimized way of referring to this human variation. While obesity is a pathological label (Cooper 2009) signaling a diseased body (Monaghan et al. 2013), fatness describes the stigma mark. A brief ethical discussion about using the term fatness will be revisited in the methodology chapter.

### *A systemic perspective*

While structural explanations of inequalities accent differentials in resources, they do not offer a sufficient explanation for persisting differentials (Daniel & Schultz 2006). A systemic perspective offers such an explanation with its focus on processes instead of structures. Many scholars present theories of social systems, each with somewhat different architectures. According to scholars who deal specifically with socio-cybernetic systems theory, social systems are systems of communication (Bateson 1972; Beer 1981; Luhmann 1995). From this perspective, a social system consists of communicating processes such as actions, rules, decisions, specific codes, attitudes, and information. All these processes refer to each other and thereby enable larger processes to form; that is, the processes are systemically bound to each other. Compared to the concept “systematic” that typically describes planned processes that unfold gradually (Grammarist 2015), the term “systemic” means that the processes themselves that are altogether creators of the system’s existence (Luhmann 1995). While systematic processes can be traced to an initiator, systemic processes are difficult to reverse because they are built into the system. In systemic racism theory, the term systemic refers to acts that are less overt or “less identifiable in terms of specific individuals committing the acts, but no less destructive of human life” (Ture & Hamilton 1967). There can be no claims of causality with the systemic perspective. We should rather speak of synergistic processes where the systemic parts bind to each other to form new meanings.

### *Systemic stigmatization—not stigma*

Erving Goffman defined stigma as an abnormality recognized by everyone. While the concept of marginality, for instance, describes a different *position* in relation to the “normal position,” stigma describes a different *identity* in terms of physical, psychological, or social deviancy in relation to the “normal identity.” Goffman built his theory on how the ancient Greeks used to “mark,” often by burning or carving, individuals who were considered deserving of a visible devaluation of their moral status (Goffman 1963). The stigma, or the mark, is thus carried by the individual herself. Stigmatization, on the other hand, refers to the devaluing actions. David Farrugia criticized Goffman’s “naturalized” view on how a stigma is constructed and claimed stigmatizing processes to be produced actively by a political structure that, by practice, devalues *some* differences (Farrugia 2009). This important distinction between stigma and stigmatization appeals to the aim of this work where fatness stigmatization is viewed as a systemic construction in a second-order reality. It is not the stigma of being fat that is scrutinized, but rather the active processes directed toward fatness and fat people that uphold the negative meanings of being fat.

### *Psychological distress, health, and ill health*

Psychological distress was the dependent variable in studies 1 and 2. It describes a range of symptoms of a person's internal life, such as anxiety, confused emotions, depression, or meaninglessness. It was a conscious choice to focus on perceived psychological health rather than physical symptoms, especially in relation to the research subject of this work—the *stigmatization* of fat people, which is foremost a psychosocial inflicted harm. While health is one of the fundamental rights of every human being (WHO 1999), it is defined differently depending on ontological statements.

From a humanistic viewpoint, health can be viewed as a resource, experience, and a process (Medin & Alexanderson 2000). In her phenomenological study, Margareta Strandmark specifically outlined a theory of health as lived experience. Regardless of physical symptoms, Strandmark defined health as the vital force that enters when the individual has self-respect, can manage the situation, and experiences well-being as well as seeing a meaning in life. The interviewed individuals described this vital force as the necessary strength for experiencing and improving health in the first place (Strandmark 2006). In line with these findings, the report *No Health Without Mental Health*, a conjoint of UK health governments recognized psychological distress as the leading cause of morbidity and disability (HM Government 2011). In line with these ontological notions of health, psychological distress was used as the dependent variable *because* of its preconditioning status before other types of ill health.

## 1.3 Disposition

Following the first introductory chapter, Chapter 2 contains a presentation of the social, ideological and historical context in which fatness stigmatization occurs. In Chapter 3, a review of critical research on fatness stigmatization is presented, where an increasing amount of research is scrutinizing the stigmatizing effects that have followed a three-decade long medicalization of fatness. Chapter 4 presents a general theoretical development of systemic stigmatization, put forward as a phenomenon in which societal response processes directed toward specific human differences form a larger stigmatizing system invisible to a non-analytical eye. In Chapter 5, the methods of the four studies as well as the overall design will be described and evaluated. The specific challenge of my own “situated knowledge” (Haraway 1988)—that is, my life experience as a fat person—will also be discussed.

The results will be presented in Chapter 6. First, the separate results of the studies will be presented. After this, these results are interrelated and viewed from the perspective of a systemic stigmatization theory outlined in Chapter 4. In the final chapter, Chapter 7, the results will be discussed and possible contributions to stigma research in general and fatness stigma research in particular, are outlined. Critical reflections will be made, and pathways for future research will be suggested before the closure.

## 2. Contextualizing the stigmatization of fat people

The purpose of this chapter is to draw the contours of the social, ideological, and historical Western world context in which fatness stigmatization has emerged. Arjan Bos with colleagues describes how social structures behind stigmatization vary culturally, implying that attention needs to be paid to both its social context and the current local knowledge systems (Bos et al. 2013). In line with the overall aim of this work to develop knowledge about fatness stigmatization as a systemic construction, contextualization is key.

The first part of this chapter provides a brief account of a fatness aversion with historical roots. In the following part, a new public health management is presented as the ideological relief against which the declaration of a threatening obesity epidemic could be made. In the next step, the failures of a governmentally induced medicalization of human fatness are presented, both in terms of non-existing weight loss results at both the structural and individual level and in terms of the negative psychosocial consequences that the blaming of these failures on the individuals themselves has fostered. Finally, in addition to this context of events, the involvement of a more materialistic force is considered. Tightly entwined with the historical, ideological, and social responses to human fatness is a weight-loss market where our longings and fears are commodified by so-called “obesity entrepreneurs” (Monaghan et al. 2010) all of whom have a stake in that the meaning of fatness is continuously constructed in a negative manner.

### 2.1 A history of fatness aversion

Viewing excess human fat as something negative is not a new discovery. Human fatness sparked interest long before today’s public health declaration of a global obesity epidemic. Louise Foxcroft claims that fatness as a problem has been present throughout human history (Foxcroft 2012). John Coveney points out three emerging periods of fatness management. First was a classical period in which moderation and self-mastery in relation to food revolved around timeliness and need (fourth century BC). This was followed by an early Christian period in which food was associated with carnality and the pure Christian self-imposed fasting and denial of pleasure (second century AD). Finally, there was a modern period that privileged rationality over pleasure in the interests of creating self-regulating citizens (Early to High Middle Ages) (Coveney 2000). This latter period is described in Weberian terms as “the rationalization of diet” that concerns itself with “the health of the body, the elimination of disease and the purity of the soul” (Coveney 2000: 67). In 17th-century Europe, the idea was conceived that “exotic people,” such as Spaniards, Indians, Africans, and Tahitians, could not be fat. Their opposite, the learned and civilized, had more plastic bodies, which could be fixed and above all improved with different nutritional regimes (Gilman 2008).

Ken Albala demonstrates a growing sensitivity to class distinctions in Renaissance dietetic literature. During this time (High Middle Ages to 18th century), texts articulated a two-tiered system that distinguished laboring from leisured classes, a division based mainly on a

physiological logic that recognized how digestive power is enhanced in individuals engaged in manual labor and diminished among more sedentary types (thus dictating different diets for each) (Albala 2002). Later in time (17th century), “the social connotations of food increasingly overshadowed basic humoral physiology” (Albala 2002: 195). Albala explains this by the widening gulf between rich and poor and a growing need for the “middling sorts” to distinguish themselves from courtly excess and “rustic” coarseness.

During the 20th century, there was a shift of ideas from being well-fed and taught to being fat and immoral in the approach to fatness, probably in response to the fact that even the poor now had enough food to become fat. These poor were considered immoral savages to start with, and now they suddenly had unlimited access to food to revel in. Dieting became linked to various techniques for creating a better self (Coveney 2000). Fatness could then be linked to immorality, ignorance, and emotional, headless, gluttony. Today, Michael Schoenfeldt follows Michel Foucault’s emphasis on dietetics as a mode of self-discipline that “not only entails the forced assimilation of corporeal urges to societal pressure but also produces the parameters of individual subjectivity.” The inability to regulate one’s passions represents a kind of enslavement, not fitting to political participation: “The individual who cannot govern the self is unfit for other forms of citizenship” (Schoenfeldt 1999: 15, 163).

This history of the meanings of the fat body tells a narrative where people have long considered fat bodies to represent deeper aspects of themselves in relation to others. Not being fat has expressed moderation, self-mastery, purity, and rationality. Not being fat has also—from the moment it was realized that the poor could also become fat—distinguished a better self from the other, an able citizen from the other and, above all, a higher class of self-regulating subjects compared to the Other. Foucault spoke of bio-power to explain what happens when the subject, in response to the processes through which “the basic biological features of the human species became the object of a political strategy,” started working on the self to express a heightened morality and discipline (Foucault 2007: 1).

There are historical narratives that deviate from this one. For example, the scarcity of food throughout most of human history did, to certain degrees, attach cultural significance to the fat male body, signaling that it belonged to a person of health, prosperity, and strength (Eknoyan 2006). Regarding the female body, compared to today’s slim ideal, a certain chubbiness was aesthetically favored well into the first decades of the 20th century (Eknoyan 2006). Meanwhile, stigmatization, which is the subject of this work, always occurs in contexts with a social power differential (Link & Phelan 2001), carefully suggesting that positive image of fat men in power may have had more to do with the meanings of power than those of fatness. In the case of female chubbiness as favorable, this may well have been a matter of how bodily norms connected to beauty have shifted. While social norms are a form of structural prescriptions, a systemic stigmatization of fat people implies a directed framing and devaluation of those who fall outside the norm, hence reaching far beyond ideas of which bodily composition is more or less desired.

## 2.2 The rise of an obesity epidemic and a new public health

The human body’s ability to store fat is an undeniable biological fact. However, the construction of fatness as an epidemical threat is a rather new phenomenon. The idea of a devastating obesity epidemic emerged from one PowerPoint presentation (Oliver 2006). The year was 1997, and the man behind the presentation was William Dietz, then a new employee at the Centers for Disease

Control and Prevention (Oliver 2006: 39). The fact that parts of the Western population had become fatter had been known for decades. Meanwhile, Dietz believed fatness to pose a larger threat to humanity than what the media and research had previously noted. His PowerPoint presentation showed how fatness had spread from state to state, like a metaphorical infection that in 15 years had managed to invade the entire USA. The epidemiological graphics were overwhelming, and the visual impact when Dietz moved from slides of “healthy” white states to more and more “infected” red states laid the foundation for the epidemic mind-set. Obesity researchers all over the world downloaded these graphs, distributed them through their research, while news media launched the headlines about a new life-threatening obesity epidemic (Oliver 2006).

The World Health Organization listened to these epidemiological findings, leading to a definition of fatness not merely as an epidemic but an upcoming social catastrophe, a “Globesity” pandemic that was sweeping across the world (Peretti 2013). In 2013, the American Medical Association (AMA) voted to classify fatness as a disease, at one stroke making one third of the American population diseased (BBC News 2013). This was, in fact, the second stroke, the first being when the BMI for overweight was lowered from 30 to 25, a move that practically overnight made 30 million Americans overweight (Boero 2012; Kuczmarski & Flegal 2000).

Long before 1997, however, when the obesity epidemic was constructed, fatness had already been associated with personal disorder. Fat people had for some time been recognized as unable to cope. Institutions dealing with fatness knowledge existed, and within those institutions, the presumptions of this condition had been continuously disseminated and refined (Hacking 2006). What was new in the 1990s was the rise of a new kind of health expertise, which—by way of mass media—extended fat concerns outside of these pre-existing institutions, turning to nations, governments, and every citizen in the Western world. Practically overnight, the world population was plagued by a new danger that was earlier considered an individual problem and, therefore, globally, left aside.

Results from numerous studies agree that fatness stigmatization cannot be divorced from the power relations within whom this phenomenon emerges (Gracia-Arnaiz 2010; McPhail 2009; Monaghan 2007; Townsend 2009). Power and knowledge are deeply intertwined when institutionalized seats of power use knowledge to guide political interventions, public health policies, and health care. Since the declaration of a global obesity epidemic, the prevention of fatness, as well as its possible solutions, is of paramount importance to governments and policymakers and has become the focus of initiatives that promote healthy eating, physical activity, and weight reduction (Beausoleil 2009; Cawley 2011). In *The Oxford Handbook of the Social Science of Obesity* (Cawley 2011), these themes are dealt with under “the imperatives of changing policies” (Roberto & Brownell 2011: 599), “lessons to learn from tobacco policies” (Chaloupka 2011: 634), “food taxes” (Powell & Chriqui 2011: 660), “school- (Brown 2011: 677), workplace- (Goetzel et al. 2011: 701), and community interventions” (Economus and Sliwa 2011: 732), and discussions of “regulations on food advertising” (Ippolito 2011: 750). Interestingly, these studies do not afford any trust in medicine to come up with effective preventive solutions. Instead, it is the public-policy arena that is presented as holding the most promising response (Cawley 2011). Here, the emphasis is recommended to be placed on policies that “modify social norms and create optimal defaults where the default option is the healthy choice, thus facilitating and reinforcing individual behavior change” (McKinnon et al. 2009). What this new, massive interest in fatness shows, and what breaks with other historical conceptions and managements of fatness, is how the construction of a structural epidemic

catastrophe managed to, instead of leading to structural changes, justify a “governmental right” to intrude and interfere at the individual level.

A new public health settled; one that did not seek to cure disease but to teach people how to avoid it—to be as healthy as possible (Dew 2012). Healthism, as a new concept, became an ideologically insidious force consisting of the beliefs, behavior, and expectations of the articulate, health-aware and information-rich middle classes (Greenhalgh & Wessely 2004). It was partly equated with a form of consumerism in the meaning of being an ideology of conspicuous consumption. Just like ordinary consumption is said to mark class distinctions, the specific healthism-oriented construction of thinness as a health as well as a sociocultural ideal reinforced the historical artifact where the slender body represents not only a state of good health, but also reflects control, virtue, and good citizenship (Burrows 2009; Chong & Druckman 2007; Evans 2006; Gard & Wright 2005; Jutel 2001; Rich et al. 2004; Thomson 2007; Warin 2011). In general terms, connected to power and subordinations, this is how thin folks were put to discipline fat folks.

This new health ideology is not as much about what health “is” as about how a new rationality shapes the way health is promoted. In this new ideology, health is choice, activity, and consumption. It is a pursuit of healthiness (Ayo 2012)—the efforts humans make to “transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault 1988: 18). With this new understanding of health, it is the individuals themselves that are seen as both the cause and the solution to potential health problems. The current cultural interest in a healthy lifestyle can be viewed as a moralistic one whereby values such as prudence, hard work, responsibility, and asceticism are expressed through a range of technologies of the self (Ayo 2012) where dieting and toning your body is one of them. Today, this historical moralistic desire for producing a worthy Self has become institutionalized at the core of our political welfare model, where psychologists, nutritionists, dieticians, pediatricians, medical specialists, and primary health care practitioners are professionals that all have become involved in weight loss practices (Ogden & Flanagan 2008).

Here, says Nicholas Rose, in the absence of immediate signs of illness, fatness is treated more as a precautionary principle—a condition that is said to predict a possible sick role. The fat patients or clients are accordingly encouraged to manage their bodies not to end up in this possible future sick role (Rose 2009). Gastric bypass surgeons are explicit in this. They want to do surgery on people who are healthy, those with the best chance to survive a serious intervention. This is also why surgeons, in addition to referring to possible future co-morbidities in their fat patients, often cite stigmatization itself as the most compelling reasons for surgery (Boero 2012). In this massive response to body composition, several of the tools used to describe and represent the obesity epidemic have confused the relationship between size and illness so to “co-produce” fatness as a health problem (Jasanoff 2004).

### 2.3 The failed management of fatness

Although the controlling of body weight has become one of the highest priorities for health practitioners in advanced countries, the main combined result of the responses to fatness is that the management of fatness, both structurally and individually, has failed (Walls et al. 2011). Medical and public health professionals have engaged in trying to uncover not only the causes of obesity, but also the reasons why efforts at curbing it have proven unsuccessful (Office of the

Surgeon General 2001). The Swedish government stresses that all health policies integrate an obesity preventive perspective in their daily work with patients. Guidelines proclaimed to build on scientific evidence are given by the National Board of Health and Welfare. The main measure for such prevention is primary-care counseling. Short counseling consists of 10 minutes of advising the patient to move more and eat less. The next level of counseling lasts up to 30 minutes and is said to be more of a dialogue. Here, the advice is said to be more tailored to the individual's personal conditions. For example, the patient can receive a list of nearby gym facilities or a folder with healthy food recipes. This advice can also be reinforced by mail, phone, or additional counseling, and this counseling is proposed to begin when the patient is approximately 15 pounds overweight. Meanwhile, the same report that presents these guidelines concludes that this counseling so far has had no effect on changing fat people's so-called lifestyle (NBHW 2010).

Scholars who are critical of how governments approach human fatness claim that fatness is simply not a disease (Gard & Wright 2005). Others refuse to label fatness a disease because such a label risks creating irresponsible people who will stay fat because their lifestyle is justified as impossible to manage (Stoner & Cornwall 2014). Regardless of how it is defined, fatness has become a disease-oriented task to solve for governments, medical science and health agencies such as the National Health Service in UK, the Division of Nutrition and Physical Activity at the Centers for Disease Control and Prevention in the US (CDC 2014), the National Board of Health and Welfare in Sweden (NBHW 2010), and the World Health Organization (WHO.INT).

At a global level, WHO (2010) recommends a variety of control methods to curtail the "obesity problem," including instruction, surveillance, and evaluation, thereby playing a key role in alerting individuals and governments to different risks associated with fatness and the urgent need for self-regulation (Lewis et al. 2010). This neo-liberal form of citizenship is also evident in the UK white paper on the nation's health entitled *Choosing Health*, a title obviously created to shift focus from ideas of structural interventions toward concepts of individual responsibility (Warin 2011). In the US, the rational goal *Healthy People 2010*<sup>1</sup> was set up with the goal to reduce the amount of fat Americans to 15% before 2010. According to data from the Behavioral Risk Factor Surveillance System (BRFSS), no state accomplished this goal. Instead, 30 states ended up with 25% of the population labeled with obesity.

A recent example of a failed fatness intervention is the caloric labeling campaign in the US, where the idea was to warn restaurant customers of the caloric burden of many menu items, so the customer would choose more wisely or more expertly informed (Herman & Polivy 2011). This intervention made no difference in what the customers—fat or not fat—ordered (Elbel et al. 2011, 2009; Urban et al. 2010). This failure was explained as due exclusively to character flaws of the lay persons rather than any possible flaw in the caloric labeling concept itself. At the Netherlands Center for Ethics and Health (CEG), Marieke ten Have and colleagues investigated 60 obesity interventions and policy proposals by evaluating their ethically relevant aspects, and they found several problems. Among the more severe problems, from a stigmatization perspective, was that the psychosocial consequences of the interventions were negative, involving feelings of uncertainty, blame, fear, unjust self-discrimination, and disrespect (ten Have et al. 2011).

Studies conclude that billions of dollars are spent on preventive implementations and interventions against fatness, so far without results (Boero 2012; Merry & Voigt 2014; Parham

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<sup>1</sup>The Obesity Society: [http://www.obesity.org/statistics/\[2009-05-18\]](http://www.obesity.org/statistics/[2009-05-18])

2013; Sobal and Maurer 2013). One recent example was the \$500 million fund that was meant to reverse childhood obesity by 2015 but failed (Roberto & Brownell 2011). Critical scholars who are trying to find reasons for this lack of results point to a lack of knowledge at the professional and political levels together with a too narrow focus on individual responsibility (Forhan & Ramos 2013) to deal with this insufficient knowledge (Thomas et al. 2008).

Some studies have concluded that many people have, in fact, become even fatter *because* of these policy efforts. A review of the long-term outcomes of calorie-restricting diets revealed that one to two thirds of dieters regained more weight than they lost on their diets (Mann et al. 2007). A study of the consequences of taxing sugar-sweetened beverages found increased consumption of beer among some households (Wansink et al. 2013). Another study concluded that alerting patients to their heavy weight status made some feel stigmatized, become depressed, and eat more (Allison 2011). Efforts to encourage people to consume more fruits and vegetables have also had the unintended consequences of an increased selection of unhealthy snacks (Werle & Cuny 2012) and an overall increase in eating than before the intervention (Folkvord et al. 2012). Describing certain restaurants and foods as more “healthful” and “low-calorie” ended up in consumers consuming more calories in side dishes and beverages when choosing these “healthy” restaurants (Chandon & Wansink 2007). In a study of two care centers in Sweden, 90% of the nurses expressed how their overweight patients stayed overweight and many of them became even bigger than before (Arborelius 2001). According to Dennis Raphael and Toba Bryant, what these approaches fail to address are issues of social justice, health inequalities, and the lived experiences of people within the larger social context (Raphael & Bryant 2002).

In addition to the failures, there is the argument that stigmatization can be used as a tool in campaigns, policies, and interventions to affect fat people to take on the responsibility of becoming thin (Betts 2010; Callahan 2013; Puhl & Heuer 2010; Trigg 2010; Vartanian & Smyth 2013). This approach seems based on the assumptions that obesity is largely under an individual’s control and that stigmatizing obese individuals will motivate them to change their behavior (Vartanian & Smyth 2013). One such shame-based tactic is when researchers routinely report the “direct” cost of fatness to the system which is often relayed using the term burden (Starky 2005). Those who are considered to contribute to this burden also become what many consider a social burden. Government health documents have drawn on the burden concept to highlight the individual responsibility of good citizens to eat right, exercise, and fit the prescribed desirable norm (Beausoleil & Ward 2009). These tactics have proven to be neither effective nor ethical in health promotion initiatives seeking to improve the health and well-being of fat individuals (Lewis et al. 2010; MacLean et al. 2009; Thomas et al. 2010; Vartanian & Smyth 2013). Rather, as affirmed failure is condescending, many fat individuals have internalized these failures into a deeply flawed self-image (Tsenkova et al. 2011). Therefore, side by side with the extensive epidemiological research striving to get a hold of this epidemic, critical researchers question not only the usefulness of this approach but also its moral overtones and unethical consequences.

It should be recognized that not all governmental efforts to help people lose weight have failed. Gastric surgery in different forms, making eating anything but extremely small portions of food impossible, is declared to so far be the only method that has evidently worked. Large people have lost enormous amounts of weight, due to the starvation process surgically forced on them. However, from interviews with people who underwent these invasive interventions (upcoming research), the results are far more complex than to speak of success stories. Weight has been lost, but there are complications that need a thesis of their own if we are to evaluate these bodily

interferences in terms of life quality, self-perceptions, nutritional problems, weight regain, the need for more surgery, and more. Nevertheless, it is important to show awareness of the fact that today the medical establishment considers this surgery a successful weight-loss method.

## 2.4 Stakeholders and claims-makers in a weight-loss market

A Western world consensus emerged around the lean body due to the convergence of medicine, class, and industrial interests when particular markets began to promote this body as the ideal body shape (Gracia-Arnaiz 2010). The very idea of success connected to the transformation of a fat body to a thin one has laid the foundation for a weight-loss industry that, with the daily aid of mass media, has managed to reinforce the confusion over fatness being a severe danger or a minor obstacle to self-health-realization. In the meantime, policymakers' decisions are not always based directly upon research. In responding to the demands of different stakeholder groups, policy makers may quickly develop visible policies that best satisfy the demands of the various groups (Daigneault 2013). It must once again be recognized that the research, the policy planning, and its implementation are all occurring within the context of the current fatness panic (Choi et al. 2005). The medical, aesthetic, social, and economic fatness discourses are today hard to separate (Leppänen & Linné 2007). Many stakeholders thrive on the moral panic created by the new public health ideology. In parallel with the medicalized discourse, the threads of cultural discourses are intertwined in ways that have opened a completely new market in which different entrepreneurs may profit.

With the aid of mass media, different stakeholders and claims makers seated in between the declared obesity epidemic and the emerging healthism have fostered an unlimited marketplace where they can stake their claims, sell their products, and compete with their weight-loss services. A study by Lee Monaghan and colleagues draws on body sociology, critical weight studies, and moral panic theory when presenting a typology of those who actively make and remake fatness into a correctable health problem and whom they describe as obesity epidemic entrepreneurs (Monaghan et al. 2010). Table I presents a shortened version of this typology.

*Table I. Obesity entrepreneurs behind the current fatness paradigm*

Type	Example	Interest
<b>Creator</b>	<i>Science</i>	Delivering facts, humanitarian/ paternalism, professionalism/funding
<b>Amplifier/ Moralizer</b>	<i>Media</i>	Reporting facts, commercialization, air moral issues
<b>Legitimator</b>	<i>Government</i>	Address problem, adjudicate, create policies
<b>Supporter</b>	<i>Campaigners/ Opportunists</i>	Educate, make profits
<b>Enforcer/ Administrator</b>	<i>Health professionals</i>	Reputation, needs of organization and client
<b>Entrepreneurial Self</b>	<i>Slimmers/Dieters</i>	Display moral worth, manage discrimination, improve health and well-being

*Source: Monaghan et al. (2010), shortened version.*

Starting from the top of the table, science as the creator of knowledge will be more thoroughly elaborated further on—connected to medicalization. Media as a moralizing amplifier is a well-known fact, also noticed in this work (see: Boero 2013). The new public health has become an authorized legitimator in this market. Pharmaceutical companies, one example of supporter entrepreneurs, actively seek to develop the “magic bullet” against fatness and its supposed precursors. No one has yet come up with any weight-loss medication that works, and this high failure rate is what makes the diet industry so profitable. “Repeat failures make for repeat customers” (Boero 2012: 5). Enforcers such as health professionals ranging from doctors, via nurses, dieticians, and psychologists all the way to gym instructors and life coaches are all claiming to be in possession of the knowledge needed to turn the unhealthy fat person into a healthy thin person. Finally, the entrepreneurial selves are highly active stakeholders in this weight-loss market, especially in their active efforts to become a more worthy self by losing weight. Stakeholder competition shapes the definition of fatness as a public issue as well as the arenas within which solutions to this problem are crafted (Hilgartner & Bosk 1988; Smith 2009). According to Lily O’Hara and Jane Gregg, this stakeholder competition forcefully complicates the tension between policies and oppression (O’Hara & Gregg 2012).

Partly due to this stakeholder competition, the stigmatization of fat people has emerged as a new social problem (Boero 2013; Domoff et al. 2012; Merry & Voigt 2014). What was earlier, in pre-industrial society, defined as a social problem was about neediness. Today, it is more about social exclusion where fragile groups are put in the position of not being able to establish as full citizens. What was earlier an expression of conditions such as starvation or child mortality is today more about segregation. What was earlier a passive approach by the state, followed by more active reforms and later social politics/welfare services have today been replaced by a state that increasingly relies on highly active market processes and civil society to deal with social

problems (Meeuwisse & Swärd 2013). In this process, market forces are also engaged in the construction of new social problems such as fatness stigmatization.

## 2.5 Positional reflections

The subject of this thesis was the contemporary stigmatization of fat people where the aim was to advance knowledge and awareness of its systemic construction. This chapter had the purpose of drawing the context in which this stigmatization pervades—the web of affiliations that provide the responses to fatness with meaning. As one would expect, there are many other constructions, social facts, developments through time, and different cultural forces that could have been considered. There were, however, specific reasons for the choices made that reflect how I would position my systemic knowledge contribution.

Tracing the historical roots of fatness aversion was deemed important because the stigmatization of fat people lands in a context with a power differential where negative images of fatness are somehow justified. An essential theme showed across the Western world epochs, a theme that could be described as a distinction between an able Self-regulating citizen and a marked immoral Other. Understanding the Self/Other dilemma is an essential question in social work. Thinking about the Other has frequently been accompanied by attempts at moral reform, and Nanna Mik-Meyer suggests that we need several different research traditions to analyze discursive processes of Othering more fully (Mik-Meyer 2016). The systemic perspective is one such tradition.

By turning to how the obesity epidemic was declared in relation to a new public health ideology, the stepwise development of this “disease” was revealed, where some decisions taken by health authorities, in fact, severed the obesity epidemic overnight merely by manipulating figures and measurements. When claiming that the stigmatization of fat people has become an important social problem, it was crucial to point to how problems can be constructed even with the best of intentions—such as when governments discover what they believe to be a new dangerous epidemic and try to reverse it. From a systemic perspective, unintended negative effects of targeting human differences need to be highlighted, at least if we want to develop a deeper self-awareness of welfare power relations.

When efforts to reverse this declared epidemic fail, accompanied by an increasing stigmatization of fat people, a deeper self-awareness on behalf of those to whom it falls to manage this category of people becomes even more important. Both the medical and social work professions take pride in basing their practices on evidence, and whenever evidence speaks against the chosen interventions, ethical considerations should be made regarding the continuance of those interventions. Guthman turns to the relationship between scientific knowledge and power in the construction of the obesity epidemic and suggests that the assumptions that are built into epidemiological measurements and conventions convey information that over-dramatizes some elements while under-specifying others (Guthman 2013). A systemic perspective can uncover the importance of always scrutinizing those in power over the knowledge production regarding human differences, to make sure that they do not just do things to people because they can.

Finally, the market of obesity entrepreneurs (Monaghan et al. 2010) was deemed to play a key role in the understanding of how knowledge about fatness and attitudes toward fat people form. By commodifying aversion toward a specific trait, a compact reinforcement of the “problem” is

established, thus the market takes part in the construction of social problems. The influence of, for example, mass media and social media in providing us with images of difference is morally profound, and needs to be highlighted in the systemic perspective of stigmatization.

### 3. Critical research on fatness stigma

The systemic perspective of fatness stigmatization is conceptually and theoretically developmental. Thus, critical research reviewed here belongs to several disciplines such as sociology, public health, fat studies, and critical weight studies. Without explicating it, this research is focused mainly on the second-order reality where fatness is responded to, and where the governmental medicalization of fatness is the common theme. This review reveals two missing pieces in fatness stigmatization research. The first is that while many of the processes involved in fatness stigmatization have been explored, they have not yet been assembled as systemically bound to each other. The second is that this research is not represented in any information flows such as the news or governmental incentives; thus, it rarely reaches the public, the practitioners, or the fat individuals themselves. In contrast to epidemiological accounts of human fatness that currently monopolize media reports, this critical research questions this approach in its very presumptions and is therefore crucial for this work's transformative aspirations.

Research on children was left out. The studies will be presented in four themes: a conflicting knowledge, the internalization of fatness stigma, the application of fatness stigma, and finally, fatness and stigma in social work research. In this last part, social work research is specifically focused, both regarding where it stands now on the fatness/stigma issue and also how it could develop an increased awareness of systemic stigmatization in vulnerable profession/client relations.

#### 3.1 A conflicting knowledge

Medicalization describes the process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders.

(Conrad 1992: 209)

Professional and governmental health establishments such as the American Medical Association (AMA), the Swedish County Council, and others have recently declared fatness to be a disease (BBC News 2013; Socialstyrelsen 2014). Other sources are more cautious, saying obesity has *some* features that *could* fit into the disease category (Perspectives in Public Health 2014), or that the disease label is based on the “presence of associated complications or their likely occurrence” (Takahashi & Mori 2013). Worthy also of mention is how the WHO changed its descriptions of the fat individual during the decades. From having described fatness (obesity in their terms) as a *disease* and a *cause* of many other illnesses, they today describe it as “an abnormal or excessive fat accumulation that may impair health” (WHO 2017). At the same time, they do not provide any reference to what exactly is “abnormal,” “excessive,” or “impaired” (Guthman 2013), leaving open for the receivers of this message to simply assume a sort of natural bond between fatness of any kind and impaired health. Sander Gilman disregards the disease concept altogether

and sees this move as the culmination of an obsession with body control and a hope for a universal health that has shaped our culture for a long time (Gilman 2008).

Studies have unveiled that general practitioners tend to believe that fatness does not belong within the medical domain (Ogden & Flanagan 2008). Such convictions help to create faulty counseling in which the professional's focus becomes to inform fat patients to make self-interested choices not only to advance their well-being but also, due to the epidemiological status of fatness, that of society (Guthman 2009; Lewis et al. 2011; Thompson & Kumar 2011). In response, other medical experts are calling for caution, suggesting that the oversimplification of obesity as a behavioral disorder ignores the complex etiology of obesity and the myriad of factors that create barriers to achieving significant and sustainable weight loss (Forhan & Ramos 2013; Sharma 2009).

Epidemiological obesity research studies the patterns, causes, and effects of fatness in defined populations (Porta 2008). The system for classifying individuals as obese was designed as an epidemiological tool to be used to monitor developments at the population level (Nicholls 2013). Epidemiology-based studies are constantly referred to by the media, making it an important engine behind the medicalization of fatness. Also, epidemiology-based obesity studies have been a constant part of state science and public health institutions while presented as both apolitical and non-ideological (Rail et al. 2010). Claiming otherwise, epidemiologist Katherine Flegal is critical of how knowledge of fatness has been constructed in the most sweeping manners. While powerful institutions such as the World Health Organization constantly conflate all degrees of overweight when assessing the dangers of being fat, she and her co-workers found that people who are labeled overweight (BMI 25–29.9) experienced significantly lower all-cause mortality than those in the normal category. First, at a BMI > 35, mortality increased compared to the normal category (Flegal et al. 2013). An earlier study showed that the stated epidemiological increase of BMI is not uniform. Instead, they claim, it is already large people who have become larger and therefore pull up the mean global BMI while the weight gain for a majority of the population is quite moderate (Flegal et al. 2002). Considering this, even if state science and public health organizations are said to be apolitical and non-ideological, the choice not to present findings from Flegal and colleagues to the public is political and ideological in a wider—more deceptive—sense.

Mass media have introduced an appearance discourse with judgments of fat people—or people “letting themselves go” (Berreby 2013; Shugart 2011; Throsby 2007). Unfortunately, critical researchers say that science and the media are having an affair—even a cumulative marriage, if you want. Media is framing and constructing fatness as a health–beauty–social problem (Boero 2013, 2012; Rail et al. 2010). Cultural explanations for this problem encompass individual, moral, medical, genetic, biological, evolutionary, socioeconomic, as well as emotional causes (Monaghan et al. 2013; Shugart 2011). Natalie Boero holds that these contradictions exist because so much of what is thought to be known about fat people is taken for granted. In this way, mass media are fueling the disease claim by extending the meanings of fatness to other human “flaws.” This cumulative affair between the media and science also ensures that critical research that challenges the knowledge of this declared disease is missing in the public debate (Boero 2013; Campos 2004).

Critical scholars assert that by focusing on lifestyle, epidemiological researchers are shifting the responsibility of providing supportive and healthy environments away from governments to the individuals themselves (Campos 2004; Crawford 2006; Raphael 2004). The biomedical focus on lifestyle also excludes fundamental cultural and socio-political productions of the body and

health (Campos 2004; Rich & Evans 2005). Other studies question the general conflation of thinness with good health and fatness with bad health (Beausoleil & Ward 2009). Sander Gilman is critical of the sweeping statements from obesity experts: “It may be the danger of fast food, too much sugar or fat, too little exercise, a damaged psyche or weak will, too large portions, genetic predisposition or hormonal balance or [...] being the result of an infectious agency” (Gilman 2010: 116). Boero identifies the obesity epidemic as a postmodern epidemic (Boero 2012). In a postmodern epidemic, she says, no discrete disease entity is required for a phenomenon to be identified as an epidemic. Instead, they rely on the application of medical frameworks to phenomena that are not inherently medical in nature. Other features of postmodern epidemics are that they are driven by media, pharmaceutical companies, and the entrepreneurial self who, together, push to define more and more of social life in medical terms (Conrad 2007) and that no medically designed interventions have resulted in any viable solutions (Boero 2012).

### 3.2 The internalization of fatness stigma

To handle one’s fatness has today become much about how to respond to prejudiced judgments of human character. In a recent study where 40 fat women were interviewed about why they wanted to undergo gastric bypass surgery, none of them spoke of better health—they all just wanted to feel normal for once (Boero 2012). Other studies concluded that experiences of being stigmatized associate with a willingness to select more invasive weight-loss strategies, regardless of high risks (Forhan & Ramos 2013; Sharma et al. 2011).

The difficulties of living with the stigma of being fat encompass from not being able to handle one’s self-image to not being able to get a job in the labor market or a partner in the dating market (Carr & Friedman 2006; Eisenberg et al. 2003; Townend 2009; Webb 2009; Whitehead & Kurz 2008). Fatness stigmatization has many devastating socio-mental implications for the targeted (Hebl et al. 2003; Puhl & Latner 2007) such as disordered eating and binge eating (Puhl & Brownell 2006; Schvey et al. 2011), less liking of and participating in physical activities (Faith et al. 2002; Puhl et al. 2013), as well as poorer body image, depression (Chen 2007; Friedman et al. 2008, 2005; Gee et al. 2008; Hatzenbuehler et al. 2009; Muennig 2008), and suicide ideation (Eisenberg et al. 2006, 2003; Hayden-Wade et al. 2005; O’Hara & Gregg 2012). Findings that stigma-induced stress exacerbates and triggers ill health is also frequently discussed in the literature on the health effects of racial prejudice and discrimination (Borrell et al. 2007; Gee et al. 2008; Puhl & Heuer 2010).

Denise Rathcliff and Nell Ellison have created a model that addresses the maintenance of internalized weight stigma. This model demonstrates how maintenance factors include negative self-judgments, attentional and mood shifts, and avoidance and safety behaviors. In this ongoing maintenance, the researchers disclose that eating and weight management behaviors are deregulated. This is followed by an increase in fatness which in turn increases stigmatization and psychological distress (Rathcliff & Ellison 2013).

Many girls in Western countries have started seriously dieting by the age of 14 years (Ikeda et al. 2004). Almost all (90-95%) diet attempts fail (Arborelius 2001; Mann et al. 2007). Weight-based discrimination is even worse for those at higher weights, with 40% of those with a body mass index (BMI) above 35 reporting daily discrimination based on their body weight (Carr et al. 2008). Studies also demonstrate that fatness stigmatization increases fat individuals’ non-

compliance with health advice and also their willingness to withdraw themselves from all arenas where these recommendations circulate (Ashmore et al. 2008; Puhl & Heuer 2010; Walls et al. 2011). Fat individuals seem to find it impossible to respond to the deviant label and instead avoid interacting in situations where they must be reminded of them. When failing to live up to the right options, fat individuals start to disengage because they perceive that their group is falling short of a standard that is devaluing their self-worth (Hebl et al. 2009). Accumulating evidence shows that stigmatizing fat individuals, in fact, decreases their motivation to diet, exercise, and lose weight (Vartanian & Smyth 2013). In a study in which more than 2,000 overweight or obese women were asked how they coped with the stigmatization that followed on weight loss interventions, 79% revealed that they coped by eating more food (Puhl & Brownell 2006).

This internalized stigma has also provoked resistance. A great amount of research has revealed that fat individuals are dissatisfied with health care professionals. They are critical not only of the simplistic framing of the issue and the ignorance of the facts behind these health campaigns but also of the attitudes with which the message is delivered (Carr et al. 2008; Carr & Friedman 2006). Sophie Lewis and colleagues discovered a perceived mismatch between public health messages from the expertise and the experiences of fat individuals (see also Solheim 2013). The individuals felt that the policy messages were too simplistic and stereotyping. The individuals understood the basic health risk message behind the fatness campaigns while they strongly disagreed with how messages were framed, communicated, and delivered. Between the lines, overweight individuals read the message that they were not taking personal responsibility, that they were morally lazy, and that the problem could be fixed by merely eating less and moving more (Lewis et al. 2010).

There are also examples of when the internalization of stigma is *not* the logical response to what fat individuals perceive as deep professional flaws. In her dissertation on identity, body, and everyday life, Inger Helene Solheim problematizes the single-minded tendency to present fatness as something negative. She shows how, in what has been described as “the fattest village in Norway,” a group of people responding to public health guidelines for reducing obesity had a parallel understanding of eating and health. Instead of thinking of health as an epidemiology-oriented work on the body, they endorsed a more “folksy” attitude where both eating and walking with others were considered health promoting because of their socially bonding effects. Solheim suggests that professionals have failed to take these understandings of health into consideration before creating interventions against overweight and obesity (Solheim 2013).

### 3.3 The application of fatness stigma

The application of stigma is visible already in political obesity rhetoric. Fueling medical-epidemiological research is the idea that human fatness should be targeted under the pretense of carrying a public health “time bomb” (Barry et al. 2009) or a “terror within” (Monaghan 2008) with possible negative effects only to be “surpassed by those of environmental destruction and war” (Oliver 2006)—an “obesity epidemic in need of combat” (Komesaroff & Thomas 2007). Considering this heightened rhetoric, it is logical that not only do fat individuals experience stigmatization from their peers and family members (Gracia-Arnaiz 2010; Puhl & Heuer 2009; Truong & Sturm 2011), but so too do individuals who have a relationship with or are near someone who is at risk of becoming a victim of obesity stigmatization (Hebl & Mannix 2003; Penny & Haddock 2007).

The extent of fatness stigmatization is hard to overestimate. Studies have found that 40-55% of young, so-called overweight and obese individuals report being stigmatized on a daily basis by their peers and family members (Warschburger 2005). Others have unveiled how the treatment of fat individuals is deeply intertwined with ideas about morality and citizenship (Farrell 2011; LeBesco 2010; Merry & Voigt 2014). Aimée Ekman takes such an approach in her dissertation and shows how obesity is largely a problem, not because of the weight itself, but because of others' discriminatory practices and self-discriminatory practices. She adheres to the social problem-hypothesis by claiming body weight to be an actor in the maintenance of a unique ordering system where a higher weight represents disorder (Ekman 2012). The stigmatization of fat people is, according to this, an active condescending process in which we are all obliged to engage, including the fat individuals themselves.

One study concluded that victimization among obese youth was twice as high as among their non-obese peers (Hayden-Wade et al. 2005) and the contempt for fat people continues without being punished (Merry & Voigt 2014; Puhl & Heuer 2010; ten Have et al. 2010). In the media, fat people are consistently disdained, depicted as unattractive, and lacking self-control (Danielsdottir et al. 2010; Hilbert & Ried 2009; Merry & Voigt 2014), and this ability of the media to mold reality has a direct effect on people's mind. To a great degree, the individual of today interprets his or her socio-cultural context and live their experiences through representations in the media, and they even develop and put into practice such media representations (Sandberg 2004).

Fatness has come to symbolize a different devalued identity (Rice 2007) where governmental approaches to health promotion have played a significant role in the social construction of the thin ideal (Hacking 2006; Halse 2009; Wright & Dean 2007; Wright 2000). In America, weight-based discrimination has increased by 66% over the past decade (Danielsdottir et al. 2010; Latner & Stunkard 2003) with prevalence rates now comparable to race-based prejudice (Andreyeva et al. 2008; Carr & Friedman 2005; Puhl et al. 2008) as well as mistreatment of Muslims and the HBTQ community (Latner et al. 2008; Lawrence et al. 2012). Discrimination against fat people occurs in all aspects of employment, and fat people are also less likely to attend university, irrespective of their level of competence (Fikkan & Rothblum 2005). In addition, as noticed earlier, few jurisdictions in the world have anti-discrimination laws covering fat people. Exceptions are the cities of San Francisco, Santa Cruz, Madison, Washington, and the state of Michigan in the United States, the state of Victoria in Australia (O'Hara & Gregg 2012) and, recently, Iceland. Julie Guthman claims that ever since the term "epidemic" started circulating, fatness as human difference was categorized and pathologized in the same ways as the term "homosexual" sexualizes difference and the term "Negro" racializes difference (Guthman 2007).

Health care settings established explicitly to care for diseased groups are a significant source of weight stigmatization (Forhan & Ramos 2013; Lawrence et al. 2012; Tsenkova et al. 2011). In one study, 52% of overweight or obese women reported that doctors had stigmatized them on more than one occasion (Puhl & Brownell 2006). When Judy Swift and colleagues investigated attitudes toward overweight patients among UK health care trainees, they found "unacceptable levels of fat phobia among those training to become nurses, doctors, nutritionists, and dieticians." Of the 1,130 participants, 98.6% expressed negative attitudes toward overweight patients (Swift et al. 2013). In a similar American study of 310 medical students, the results showed that more than half of the students had a significant weight bias (Miller et al. 2013).

Efforts to reduce anti-fat prejudice have not been successful (Forhan & Ramos 2013; Himes & Thompson 2007; Paluck & Green 2009; Puhl et al. 2013). In a review of interventions specifically designed to reduce anti-fat prejudice, Sigrun Danielsdottir found them to be both rare and ineffective (Danielsdottir et al. 2010). The researchers scanned the four largest databases (ISI Web of Knowledge, PsychInfo, PubMed, and Scopus) and found only 16 published studies in the area of prejudice. While most of these interventions were able to produce changes in the beliefs and knowledge about the uncontrollable causes of obesity, expressions of anti-fat sentiment remained (Danielsdottir et al. 2010).

The failures to deal with prejudice are not unique for fatness. A recent review of nearly 1,000 failed interventions aimed at reducing prejudice toward gays, blacks, and religious groups shows that this is a built-in difficulty in social prejudice regardless of the target group (Paluck & Green 2009). Several scholars adhere to the idea of fatness oppression, yet instead of being oppressed by a legal system, fat people are oppressed in the medical and the moral systems (Lawrence et al. 2012; Parker & Aggleton 2003; Scambler 2004). Adding to the idea of a medical and moral oppression is the disturbing scholarly discussion in the US that implies that the ongoing discrimination and stigmatization of fat people could be associated with the governmental tendency not to approve of the use of anti-obesity drugs that are not accompanied by necessary changes in lifestyle or behavior (Forhan & Ramos 2013).

### 3.4 Fatness and stigma in social work research

Connected to one of the core values of the social work profession regarding obesity and public health, there is an urgent need to marry science with advocacy (Wang & Brownell 2005). Despite its unique responsibility as an advocate of vulnerable groups, its interest in providing these groups with a voice as well as its close bonds with the development of human rights and emancipatory and empowerment struggles, social work as an academic discipline has not yet fully entered the field of fatness stigmatization. What Solheim partly shows in her dissertation is a dissonance between professional interventions and “folksy” attitudes—a dissonance of crucial importance to the social work profession in general. Fatness has come to symbolize a different devalued identity—a known possible side effect in any client categorization. Fat people hear that they are not taking personal responsibility and that they are morally lazy (Boero 2013). These messages increase their non-compliance with professional advice and many of them withdraw from arenas where these recommendations circulate (Hebl et al. 2009).

Health care settings are significant sources of weight stigmatization (Forhan & Ramos 2013; Lawrence et al. 2012), and Solheim shows that fat people are often exposed to governmental stigma based on knowledge to which they do not adhere (Solheim 2013). This is a crucial example of when client categorization somehow makes things worse, and where developing knowledge aimed at harm reduction would be an important task for professionals who deliver such messages. For the social work profession, Sheila Fish and Mark Hardy suggest the application of new developments in complexity theory to reduce the potential for harm—especially for “exploring how uncertainty and ambiguity might be managed, responded to, and engaged with” (Fish & Hardy 2015). The constructivism paradigm allows for such an approach. Viewing the stigmatization of fat people as a construction in a second-order reality is not to deny the existence of fatness as a first-order material entity, but to view fatness as a disease that comes to life in how we respond to this material entity.

“It is the system that creates the client,” says Margaretha Järvinen (2013: 294). Drawing on Foucault’s notion of pastoral power (Foucault 2007), she shows how such power in modern welfare society is connected to welfare regimes of truth that define who is the expert in relations where help to self-help is delivered (Järvinen 2013). Professionals such as doctors, psychologists, and social workers all have access to different means to construct and categorize the client, or the “person with the problem” and these constructs must be continually evaluated to secure the quality of any caring labor. Marcus Hertz (2016) suggests that, for social work to be “alive,” we need a theoretical framework that ensures that we do not reproduce negative conceptions of the people we strive to support. To the public, doctors, nurses, and social workers do not appear to be persons with power. To the categorized client on the other hand, they often represent the incarnation of power, embodying the normality claims and demands of the established society (Håkanson & Stavne in Börjeson 2008).

Social work once developed through identification with—and was generated by—social turbulence, inequality, and conflicting interests in modern industrial society. Since then, “the *meaning* of social work has been internally divided” (Júlíusdóttir 2006: 41). This divide is, according to Sigrun Júlíusdóttir, often expressed in a dichotomous thinking where conflicts between research and practice, as well as between ideological commitment and theoretical involvement need to be worked through to clarify the meaning behind social work as a profession (Júlíusdóttir 2006). Stanley Witkin, who calls for a necessary change of the social work profession, claims that, if we wish social workers to be agents of societal transformation, we need to challenge the oppressive discourses that threaten both the profession and the people that we serve (Witkin 2014). If we unfold a theory where stigmatization is approached as a manifestation of systemic response processes, this dichotomous thinking can be bridged through a deeper awareness of why stigmatizing patterns cannot be changed at the practice or organizational level alone.

## 4. A theory of systemic stigmatization

John Shotter describes a new kind of difficulty in social theory with the emergence of social problems that cannot be solved by the application of rational thought because they are not intellectual difficulties. They are orientational or relational difficulties, difficulties of a kind that can be overcome only by relating ourselves to our surroundings differently (Shotter 2009). As Meeuwisse and Swärd acknowledge, social problems today are about social exclusion where fragile groups are put in the position of not being able to establish as full citizens (Meeuwisse & Swärd 2013). Both these perspectives on the new challenges of handling social problems adhere to the aim of this work. The social problem of active stigmatization cannot be solved by first-order anti-stigmatizing efforts because stigmatization does not represent a lack or misuse of resources that could be provided by rational thought. In a society of higher complexity than ever before (Luhmann 1995), stigmatized individuals are put in precarious positions without any traceable initiator. It is in line with this that a theory of systemic stigmatization could be developed—to raise awareness of how harm can be not only unintentional but constructed in practices of good intentions themselves.

To different degrees, stigmatization accompanies all forms of social problems. Stigmatization can manifest as aversion, avoidance, reduction, discounting, discrediting, dehumanization, and depersonalization of others into stereotypical caricatures (David et al. 2000)—always occurring, however, in a context with a social power differential (Link & Phelan 2001). While groups and individuals that belong to a “social problem” category are often considered stigmatized as a consequence of their precarious situation, a systemic stigmatization formed in a second-order reality is something else.

Whenever systems theory is developed within the social work discipline, it often applies to dysfunctional and causal networks such as families, groups, organizations, or different types of interrelations—from parent/child relations to relations between professional and clients (see: Teater 2014). Even Erving Goffman developed his notion of stigma at an inter-individual level (see: Goffman 1963). David Farrugia criticizes Goffman for his single focus on the stigmatized individual whom he claims becomes viewed as a powerless subordinate victim to some kind of “natural” order. Farrugia argues for a broader, more politically induced understanding of a stigma’s placement within current power structures. While Goffman described stigma as an almost immediate (naturalized) interpersonal reaction to differences, Farrugia advises us to consider stigmatizing processes to be actively produced by a political structure that, by practice, devalues *some* differences (Farrugia 2009). From a systemic perspective, the devaluation of certain human differences is to be viewed as a manifestation of processes that daily uphold, communicate, and reconstruct this devalued trait. Moreover, these are processes that extend the political structure to also encompass the entrepreneurial self (Monaghan et al. 2010)—the stigmatized individual who in his or her actions contributes to his or her devaluation.

### 4.1 Modeling a systemic stigmatization

For many people, the trajectories of stigmatization remain an enigma, perhaps due to the complexity of individual and public processes involved (Corrigan 2014). In their research on

HIV-related stigma, John Pryor and Glenn Reeder created a model in an attempt to sort out the complex relations between four different stigma manifestations. In their model, structural stigma represents the legitimization of a stigmatized status by society's institutions and ideological systems. Self-stigma reflects all the impacts of possessing a stigma—from the sense of being exposed to the internalization of negative beliefs into the person's self-image. Stigma by association entails reactions to people associated with a stigmatized person as well as reactions of being this person associated with a stigmatized person. Finally, public stigma represents the shared conviction that a specific attribute is devalued. This manifestation is considered to be at the core of the other three stigma manifestations (Pryor & Reeder 2011). While their stigma model *does* locate the stigma outside of the stigmatized condition, it is not really a model of the “stigmatizers” who by responding to the condition add meanings to it—meanings that were not there before these responses.

To elaborate with a model of the very acts of stigmatization, Pryor and Reeder's model needed some modification. Graham Thornicroft and colleagues developed a sort of systemic “think” regarding the stigmatization of individuals who suffer from mental illness. These researchers suggested that a stigma problem should be seen as an overarching term that, in fact, contains *three* problems: the problem of knowledge—or as they say, ignorance, the problem of negative attitudes—or as they say, prejudice, and the problem of rejecting and avoidant behavior—or as they say, discrimination (Thornicroft et al. 2007). This theory of stigma as a three-element problem gets closer to the stigmatizing processes by its attempt to push the notion of stigma beyond what the authors explain as shortcomings in earlier stigma research; namely the mainly descriptive character (of attitudes) and the de-emphasizing of cultural factors, issues related to human rights, and social structures (Thornicroft et al. 2007).

While Pryor and Reeder (2011) spoke of *stigma manifestations*, and while Thornicroft et al. (2007) uses the concept of an *overarching stigma problem*, I suggest a model where a set of response processes relates back to each other to form a larger *systemic stigmatization process*. Here, response processes are actively and constantly injecting and enhancing each other to form a system that is more than the sum of these processes.

In line with the empirical studies in this work, this systemic stigmatization model focuses on three response processes—structural, internalized, and applied. By structural response, I refer to the process whereby knowledge about the specific condition is produced. By internalized response, I refer to the process where the individuals who embody the condition actively incorporate stigmatizing actions into their self-image. By applied response, I refer to processes of discriminatory practice in face-to-face interactions. These three processes involved in the systemic stigmatization will now first be elaborated as independent phenomena with their own separate stigmatizing logics. These processes are then referred to each other, reinforcing each other, so that a larger systemic stigmatizing process forms.

#### 4.1.1 Structural stigmatizing response

Structural response to a condition considered to be problematic occurs at the level where the legitimizing power is seated, where the perpetuation of a stigmatized status is done by society's institutions and ideological systems (Corrigan & Lam 2007; Link & Phelan 2001). In the case of fatness, responded to as a medical problem, the legitimizing power of interest is medicine. In this case, it is the medical profession that is supposed to produce knowledge that is applicable to the

fatness condition. As noted earlier, medicalization has been studied extensively in the social science as a process whereby natural life events or deviant behaviors are defined and treated as medical problems. By medicalizing a human condition, a distinction is made between folks who have the disease and folks who do not. Rooted in medicine, an institution assumed to be an objective, neutral observer, the effects and context of medicalization often go unnoticed (Conrad 2007). While the extensive literature on medicalization highlights numerous effects of the process, it is just beginning to explore the medicalization's complexity (Ballard & Elston 2005; Bell 2016).

Once a behavior or trait has been medicalized, not only the professional but also the public and private understandings of this condition will be filtered through a medical lens (Adlin Bosk 2013). Thereby, acts of stigmatization can become legitimized by the hierarchical structure built on the status, resources, and power of medicine. George Canguilhem said the dominant ideas about the social context determine what is called a disease and that this disease is, at the same time, a general concept of non-value (Canguilhem 1989). Emily Adlin Bosk concludes how discourses of sickness are deeply intertwined with discourses of badness with implications for the way we conceptualize individuals, for the treatment we prescribe, and for how these individuals understand themselves. She adheres to the idea of the power of medicalization by claiming that the meaning of the unwanted behavior or trait is defined by those in charge of responding to upcoming pointed-out problems (Adlin Bosk 2013).

The essence of medicalization, says Peter Conrad, is this very definitional issue: defining a problem in medical terms, usually as an illness or disorder or using a medical intervention to treat it (Conrad 2005). Peter Conrad and Joseph Schneider describe that medicalization, from the beginning, was meant to remove individual intent and blame from a person's actions (also Corrigan et al. 2000). Instead of punitive responses, the treatment of sickness requires medication or other interventions which can offer relief from discomfort and pain (Conrad & Schneider 1992). Thus, medicalization has advantages for some groups. Medical treatment for infertility, for example, has allowed millions of individuals to attain parenthood (Bell 2016). There are many examples of human affairs that have become medicalized, such as childbirth, pregnancy, and alcoholism. Other examples are the "medicalization of underperformance" diagnosed as ADHD (Conrad & Potter 2000) and the "medicalization of unhappiness" connected to the current era of anti-depressant prescriptions (Shaw & Woodward 2004).

At this point, it would be rewarding to return to Leach Scully who points out the importance of an ethical knowledge production whenever the power to label others is involved (2004). Medicine has the power to affect people's identity and the power to trespass borders of human rights and tolerance, placing great demands on knowledge that is not only applicable to the problem but, more so, sufficient enough to be clear about what is a real disease and what is only a disturbing difference. Perhaps this dilemma is connected to the fact that medicalization seems to have advantages for some but not others. There is perhaps one more essence of medicalization—its distinguishing character. Perhaps this distinguishing character plays a wider role in cases that still have not benefitted from being medicalized. This role will be returned to in chapter 4.1.4.

#### 4.1.2 Internalized stigmatizing response

Stigma leads to suffering only when the person takes up a subject position where the messages about ugliness, failure, irresponsibility, and blame become incorporated in self.

(Malterud & Ulriksen 2010: 51)

Internalized response reflects all the impacts of possessing a condition viewed as a problem—from the sense of being exposed, to the internalization of negative beliefs into the person's self-image. It shows an "awareness of public stigma, the acceptance of the stereotype's legitimacy, and the self-application of the stereotype" (Corrigan & Watson 2002). According to Gregory Herek, experiencing stigmatization is *felt stigma* while a deeper self-worth reduction is an example of *internalized stigma* (Herek 2007). In mental health research, the impact of perceiving discriminatory behavior has been clear for many years in terms of the personal experiences of service users (Thornicroft 2006) where the rejecting behavior of others may often bring greater disadvantage than the primary condition itself (Thornicroft et al. 2007).

Theo Jansen and colleagues elaborated on the term "biographical competence" when referring to the process through which an individual generates a sense of self in relation to wider societal narratives (Jansen et al. 2006). This biographical competence is what makes individuals internalize the negative significance of their marker so that they "come to accept and even collaborate in maintaining oppressive aspects of the system" (Cannella & Lincoln 2009: 55). It equals the part that Ibrahim Kira and coworkers describe as the "already existing trauma" in the form of the chronic stress of being culturally devalued (Kira et al. 2014). It also resembles what Goffman explained as the moral career that the "abnormal" learns where he or she internalizes the collective attitude toward this marker and thereafter tries to adjust to this new self-image (Goffman 1963). Failures to live up to those moral and normal expectations have profound effects on any deviant's psychological integrity (Goffman 1963) where the sense of being different and defective can be internalized in ways that undermine emotional well-being, self-esteem, and even hope (Livingstone & Boyd 2010).

Lawrence Yang and coworkers further developed the concept of stigmatization being a moral-systemic issue and provided keys to an understanding of why it gets so deeply connected to the self; that is, how the transition from the moral system to personal shame works. To start with, the researchers follow Farrugia's main criticism of Goffman and claim that the decision to stigmatize does not take place at the interpersonal level but via broader systemic processes. Stigmatization, they claim, is a moral communication that is threatening the loss of *what is most at stake*—our social relations (Yang et al. 2007). A moral system like this, explains Vessela Misheva, is an absolute condition of social life itself (Misheva 2000). The moral processes "do their work" by evoking a sense of guilt, in the "abnormal." Also, the profound cause of internalized guilt is "the individual's consciousness about herself as a social member, a user of the common good, for example, her social awareness" (Misheva 2000: 89).

Socially, responding to negative attitudes by internalizing them makes sense. Connected to the new public health ideology, Nikolas Rose (1999) explains its hegemonic character; the citizens *want* to be healthy because our society profoundly marginalizes those who "opt out" of health. This hegemonic character of the process of medicalization ensures that socially aware citizens who are labeled as diseased also pick up this subject position and internalize it without

questioning it. In fact, in a study of criminality and shame, John Braithwaite discovered how “the need to reintegrate with others by means of assuming the role of the regretful can become so powerful that individuals often plead guilty to crimes they never committed” (Braithwaite 1989: 162). Ironically, one way out of the negative social consequences of stigmatization is to internalize its applications.

#### 4.1.3 Applied stigmatizing response

Goffman described a stigma as an abnormality forcing the stigmatized individual to adapt to “normal” individuals in specific ways. Meanwhile, the term stigma dates to the ancient Greeks, who cut or burned marks into the skin of criminals, slaves, and traitors to identify them as immoral people who should be avoided. By connecting all social forms of deviancy, Goffman managed to isolate stigmatization as the political act underlying them all. This stigmatization is, according to Goffman, not based on the individual’s unwanted trait itself, but rather describes a specific relation between this trait and a pattern of what is desired. In fact, he even asserts that for stigmatization to work we must not only strive for certain norms but also *apply* them in social life (Goffman 1963).

Some studies on mental illness define applied stigmatization as the negative attitudes, beliefs, and behaviors that care providers possess and enact toward their clients (Charles 2013). Without a notion of this difference between perceived and applied stigma, the medical sociologist Graham Scambler claims, all the stigmatized individuals can do is to *handle* the perceived stigmatization. To *resist* stigmatizing forces, the stigmatized themselves have to gain knowledge of the applied stigmatization (Scambler 2004). From the Greeks, via Goffman and forward, the stigmatization of individuals or groups of individuals has always been connected to moral convictions about right and wrong, desirability and aversion, worthiness and devaluation. Thus, applied stigmatization communicates what is desirable and what is not, and with deviancy being understood in such moral terms, punitive treatment will likely ensue (Kvaale et al. 2013).

Jo Phelan and colleagues identify three possible functions of applied stigmatization: *keeping people down* (exploitation and domination), *keeping people in* (social norm enforcement), and *keeping people away* (disease avoidance) (Phelan et al. 2008). Regardless of function, stigmatization contains a mix of concrete actions of exclusion and silent aversion by the masses, visible as practices such as staring, admonitory advice, or subtle actions of withdrawal (Scambler 2004). These applications refer to a global devaluation of certain individuals on the basis of some characteristic they possess, related to membership in a group that is disfavored, or disgraced by the general society (Hinshaw 2010). Many of these actions need to be justified one way or another to pass without being judged as directed violence. For example, in connection with medicalization, health as moralism is protected from critical claims despite the fact that the health concept is often applied about a person’s appearance (Metzl 2006). As noted earlier, Julie Guthman expresses this in more radical terms as she argues that morality regarding self-production can hide behind concepts such as nutrition and health where the gloss of health provides a sort of protective veneer from moral and intellectual scrutiny (Guthman 2007). Not to forget, to stigmatize the Other, Hinshaw suggests, bears with it several rewards for the identity of the “in-group.” The evidence is clear that putting down others bolsters self-esteem (Hinshaw 2010), where all involved actors are enmeshed in culture-specific ideologies and power relations.

#### 4.1.4 Systemic stigmatization—a set of stigmatizing response processes

By stigma we refer to a badge of shame, an identity marker imposed by others and for which strong disapproval is both expressed and believed to be justified. Stigmas lend themselves to public attitudes of disgust, ridicule and social exclusion. It captures something important about the way persons are treated by members of the majority or dominant groups because of some marker or attribute they have, though it is the significance others ascribe to those markers that produces the stigma in the first place.

(Merry & Voigt 2014: 6)

Michael Merry and Kristin Voigt (quoted above) are both engaged in stigma research, with a focus on the ethics of policies and interventions directed at targeted groups. Drawing on a growing public concern and pressure to intervene in the life cycles of targeted groups, they examine “the perhaps unintended stigmatizing effects that labeling and [state] intervention can have” (Merry & Voigt 2014). In fact, we still know relatively little about how structural processes of medicalization play out at the micro level (Adlin Bosk 2013). The point of outlining a systemic stigmatization theory is to try to understand how processes of response to difference bind to each other in ways that extend the negative meaning—or the ascribed significance—of this difference.

A systemic stigmatization is an orientational, social problem that can be overcome only by responding to the already stigmatized trait differently. Structurally, powerful institutions have the legitimized right to define difference and produce knowledge of this difference. This is a right that also evokes a moral system by categorizing groups of individuals as in need of measures, corrections, or help. This legitimized distinguishing knowledge production is also applied directly to the targeted group. These are the settings where licensed experts are placed to communicate directly to the individual that his or her condition is highly undesirable, by offering the remedy for it. For these actions to pass as nonviolent or nondiscriminatory, they must be firmly justified to provide protection from moral and intellectual scrutiny. When these actions are justified properly, the targeted individual internalizes the image of him or her as undesirable, and a correctional adaptation is likely to ensue from this consciousness about him- or herself as a user of the common good.

By assigning the stigmatization of a difference to the responses to this difference, systemic stigmatization belongs to a second-order reality. Stigmatization is not only *seated* in these responses but emanates from them. When knowledge, the applications of this knowledge, and the receipt of this knowledge connect, the full systemic function manifests itself. The declared intentions of our welfare systems are to include, reintegrate, and normalize targeted groups by way of ethical, evidence-based, and non-ideological practices. This including function of a systemic response works when the knowledge is assured, the applications are ethical, and the recipients of this ethically applied, assured knowledge internalize just enough guilt to put this knowledge into practice. If anyone of these response processes is corrupt; if there is structural ignorance instead of assuring knowledge, applied prejudice instead of ethical correctional tools, or a sense of discrimination rather than consent in the targeted group, the systemic function will change its character and be stigmatizing instead.

## 5. A critical research methodology

In this chapter, I will first provide an account of my research position. Next is a description of the research process. After this, I will present the framework of my mixed methods approach, which comprises both this work's knowledge claim and the methods employed within this framework. Then I will reflect on the methodological choices taken throughout this work. The chapter ends with some ethical considerations.

### 5.1 A situated knowledge

I am by all standards a fat woman and have experienced condescending response in a range of social situations. Meanwhile, lacking the tools for making this negative experience intelligible during the time before my university studies, I had no knowledge of the stigma concept. All I knew was that my body, wherever I turned, seemed to be an open invitation for people to respond to and comment on in an exclusively negative manner. It may sound naive in hindsight, but this negative social experience was not merely surprising. The force by which it changed my self-conception was socially overwhelming. Eventually, though, when the media started to report on an emerging obesity epidemic, breaking loose a bodily anxiety in the early days of the social media revolution, this paralysis turned into a curiosity that ended up in this dissertation work.

Today, an open acknowledgment of the researcher's presence in the research process is encouraged (Creswell 2007) since researchers are considered to influence every phase of the research process from design, to data collection, to data analysis, and through interpretation. This is not a value-neutral study, but should rather be viewed as belonging to the standpoint research tradition. Standpoint theorists make three principal claims: (1) Knowledge is socially situated, (2) marginalized groups are socially situated in ways that make it more possible for them to be aware of things and ask questions than it is for the non-marginalized, and (3) research, particularly that which focuses on power relations, should begin with the lives of the marginalized (Bowell 2015). At the same time, this type of research has, beginning with the standpoint of women, over three decades ago, been criticized on several accounts.

Firstly, standpoint theorists are questioned in their claim for some sort of epistemic advantage; that marginalized groups would produce better knowledge than non-specifically located researchers. Perhaps the best answer to this critique was given by black feminist bell hooks in her description of the advantage of double vision: "Living as we did—on the edge—we developed a particular way of seeing reality. We looked both from the outside in and from the inside out...we understood both" (hooks 1984: vii). Tracy Bowell claims that being marginalized can provide the epistemic advantage of insights into social relations that are unavailable from the vantage point of the non-marginalized (Bowell 2015). A great example is sociologist Tom Shakespeare, born with achondroplasia, a form of dwarfism, who for long has conceptualized disability within a frame of human rights, ethics, and a critique of the medical model of disability (see: Shakespeare et al. 2016). Furthermore, Donna Haraway (1988) criticized the exclusive "gaze" where researchers traditionally have been able to step out of their own bodies to investigate the Other from a position in nowhere, fully armored with so-called objectivity. In this work, I attached this "gaze" to myself to objectify the environment from the "fat position,"

claiming that it is, in fact, the “socially problematic” that take notice of the existing frames of power in the first place because they are the ones bumping into them by their deviation from the norm.

Secondly, some critics suggest that standpoint theorists engage themselves in a false universalism. The categories upon which the theories depend are, in fact, fluid, they say, in a state of continuous contestation (Bowell 2015). Meanwhile, this critique is problematic because it suggests that knowledge claims can be made only from the idea of some sort of “true” universalism. Haraway dubbed such an epistemic standard “the God Trick,” the view that knowledge is achieved only by adopting a disinterested, impartial view from nowhere, while in reality, Haraway says, knowledge is always from somewhere (Haraway 1988). In fact, Yvonna Lincoln and Gaile Cannella (2004) suggest that many forms of alternative research may be more rigorous because they make values and potential biases explicit, whereas values are not required to be stated in more traditional research projects. In this work, I take a stand against the stigmatization of fat people—especially when welfare institutions seem to play a role in this.

A third critique, related to the above, concerns the risk of turning to epistemic relativism when claiming that all knowledge is socially situated and that some social values enhance the process of inquiry and the acquisition of knowledge (Bowell 2015). Answering to this, Harding explains that standpoint theory imposes a strong demand for ongoing reflection and self-critique, enabling the justification of socially-situated knowledge claims (Harding 2004). Claims for a value-neutral approach to inquiry may be able to hide any underlying interests behind an objective facade. Not to forget, standpoint theory research also involves a transformative agenda, often questioning prevailing power relations in which this very idea of value-neutral research is embedded. This work has the explicitly transformative agenda to find keys for a destigmatization of fat people.

## 5.2 Knowledge claim

Social work can and should adopt a value-based approach to research that challenges and confronts the current networks of political and public power that control what knowledge is sought and who is entitled to produce and receive this knowledge.

(Shannon 2013: 112)

Patricia Shannon makes explicit the distinction between pure and applied research in social work, where the intent of the former is to develop and modify theory to contribute to the social work knowledge base, whereas the purpose of the latter is to generate solutions in more direct ways for the social work practice (Shannon 2013). Using this distinction, this work should be considered as pure transformative research. According to scholars in favor of this tradition, the researcher is responsible for creating knowledge that does not just add to existing diagnoses of social problems, but also aims at reversing these problems (Sorde Marti & Mertens 2014). The possibilities of a power shift that benefits the disadvantaged group in question are, therefore, profound in this type of research. Jerry Finn (1994: 25) suggests that “social work must develop change-oriented, value-based models of knowledge development that address people, power, and praxis”. Such value-based models of knowledge are crucial since our knowledge of reality is itself a construction created in the process of making sense of things (Knorr-Cetina 1981).

In relation to the idea of value-based models addressed to people and power, this work also makes an advocacy knowledge claim guided by a social justice ethos. According to John Creswell, advocacy researchers begin with issues such as empowerment, inequality, oppression, domination, suppression, or alienation as their focal point of research (Creswell 2003). To me, the advocacy part of my research means that I have a goal to provide a new perspective on fatness stigmatization that raises awareness among both the stigmatized and those who uphold the systemic stigmatization of fat people and that advances an agenda for change regarding the importance of proper knowledge and ethical applications in the management of difference.

### 5.3 A critical systems theory perspective

If we do not try to explain things, we are not doing science at all. To reason—to infer, to argue—is not simply to describe or report observations made of the world. Reasoning concerns the relations between the objects we observe.

(C.S. Peirce, in Carleheden 2014: 4)

Since the essential knowledge claim of this thesis is change-oriented, a critical systems theory perspective was integrated with the assumption that it is in the relations between the examined response processes that transformative keys are to be found. There is no clear distinction between theory and method in systems research. It is a circular conduct where the problem is detectable only together with its possible solutions (Geyer 2002).

A systemic investigation needs to be firmly contextualized. Processes must be linked to the environment from and to which they flow. While the natural sciences' concept is to de-contextualize, reduce, and refine the results—in fact, this de-contextualization is what makes their results valid—the social sciences cannot handle their research subjects this way. Quite the opposite, the explanatory power resides almost exclusively in the social context. From a critical systems theory perspective, to show how resistance can be framed against discriminatory structures, we must identify the historical, cultural, and social contexts where stigmatization occurs (Dominelli 2002; Eliassi 2006; Fook 2002). This context is drawn in Chapter 2.

What separates this critical systemic perspective from, for example, critical realism is the causality of involved mechanisms that is central to the latter (Bhaskar 2008). A systemic perspective does not involve a search for causality. Instead, the interest lies in the interrelatedness of involved processes, where every part of the system refers to the other parts to form a larger manifested process.

By taking a critical systems perspective, this work has transformative aspirations inspired by Lee Harvey's definition of transformational research as attempts to shed light on how particular knowledges reproduce relations of inequality and oppression (Harvey 1990). The intended outcome is not only an improved understanding of fatness stigmatization but is meant to develop a critical consciousness (see: Freire 1973) about how the ways in which things are responded to affects individuals as well as fosters harmful systemic patterns. This also leads logically to the constructionist distinction between two kinds of realities: first-order realities and second-order realities (Watzlawick et al. 1974). First-order realities comprise uninterpreted facts and data that are accessible, measurable, and empirically verifiable. Second-order realities are created

whenever we attribute, attach, or give meaning, significance, or value to a first-order reality (Watzlawick 1990: 313). It is important to distinguish between these realities so that harmful un-reflexive measurements of human differences will not pass unnoticed.

## 5.4 A mixed methods approach

A critical systems theory perspective implies a pluralism of methods and specific theoretical choices where a pattern of components rather than the components themselves is focused (Leydesdorff 2011). An additional compelling reason for using a mix of methods is that scholars believe it to have the potential to contribute to social change (Sorde Marti & Mertens 2014). Donna Mertens describes how the tenets of the transformative paradigm provide a framework for addressing social justice issues within the context of mixed methods research (Mertens 2011). Shannon agrees, claiming that research that seeks to uncover structures that oppress individuals so that these structures can be changed implies mixed methods research that can capture the scope, depth, and essence of an issue (Shannon 2013). Moreover, the overall aim as well as the research questions in this work, each demanded a specific method to be answered, the assumption being that neither method used in isolation is enough to make sense of the complexity of the research problem (Mayoh & Onwuegbuzie 2015).

The mix of methods used in this work consists of:

- a) A quantitative data analysis of the association between body mass index and psychological distress (study I),
- b) A quantitative data analysis of how interpersonal response may affect the odds for reporting psychological distress in fat people (study II),
- c) A directed qualitative content analysis exemplifying how explicit bullying of a fat individual can be justified (study III),
- d) A theoretical elaboration of misrecognition as a transformative trap and of replacing this misrecognition mind-set with a systemic mind-set on the way to a destigmatization of fat individuals (study IV).

### *Study I—A quantitative method*

A quantitative method emphasizes objective measurements and, as in this case, the numerical analysis of data collected through a survey. This approach allows for a broader study able to enhance the generalization of the results. The established standards of such quantitative research also make these studies comparable with similar studies. The goal of this study was to determine the association between BMI and psychological distress. Data came from surveys carried out in 2000, 2004, and 2008 in a mid-Swedish region.<sup>2</sup> Individuals with BMI values below 18.5 and above 60 were considered extreme values and were excluded. The General Health Questionnaire 12 (GHQ 12) was used as an instrument for measuring psychological distress (Goldberg 1972).

We took our point of departure in research critical of the assumption that fatness exposes people to the risk of becoming sick (Cobb 2007; Evans & Colls 2009; Oliver 2006; Rail et al.

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<sup>2</sup> Liv och Hälsa 2008, 2004, 2000.

2010). This first study needed to be placed in parity with other quantitative studies on the subject—especially since epidemiological statistics are what the declaration of an obesity epidemic builds on. The data consisted of 68,311 individuals between 18 and 74 years. Conventional logistic regression analysis was used to analyze data. To control for the most essential social factors, an age-gender variable was created as a control variable. The style of reasoning was deductive; we started with ideas of possible associations and then analyzed data in search of these associations (Blaikie 2007: 80).

#### *Study II—A quantitative method*

The aim of this second study was to investigate whether interpersonal responses in terms of negative and positive responses were factors that could change the association between fatness and psychological distress. Data came from a survey carried out in 2008 in a mid-Swedish region.<sup>3</sup> Individuals with a BMI below 18.5 and above 60 were considered extreme values and were excluded. The General Health Questionnaire 12 (GHQ 12) was used as an instrument to measure psychological distress (Goldberg 1972). We had 26,287 respondents between 18 and 65 years old. An interpersonal response model was created in which perceived appreciative and condescending responses were taken into account. Conventional logistic regression was used to analyze data. Controls were implemented for age, gender, and current employment situation.

We created an interpersonal model in which appreciative and condescending response in combination was tested against reported psychological distress in a large data consisting of 26,287 respondents. Besides highlighting the rather un-investigated role of perceived appreciation in a highly stigmatized group, we also wanted to test whether this was a viable model for future investigations of interpersonal response in different types of stigmatizing power relations.

#### *Study III—A directed content analysis*

In study 3, a directed content analysis was performed of the reality TV show *Darling You've Become a Fatty* (*orig. Älskling, du har blivit en tjockis!*) The aim was to gain a new understanding of how the bullying of a fat individual can be justified. A qualitative content analysis goes beyond merely counting words to examining language to classify it into categories that represent similar meanings (Weber 1990). The classic steps of content analysis were followed: a formulation of the research question, selecting the sample to be analyzed, defining the categories to be applied, outlining the coding process, implementing the coding process, discussing trustworthiness, and analyzing the results of the coding process (Hsieh & Shannon 2005). This being a *directed* content analysis, a more structured process guided it than in a conventional approach. It was deductive because it began with a theory of affective economies from which key concepts and variables were identified as initial coding categories.

To examine underlying assumptions, each episode was transcribed with a focus on signs as propositional units that work by breaking down the text (Krippendorff 1980). The signs of interest were those that circulated negative or positive capital to the two parts of a loving relationship. Signs included appealing and non-appealing images, implicit meanings, narrated sequences, metaphors, parables, and also explicit statements. The main task was to identify the communicative *circulation* of signs rather than the nodal points (the subjects or images) where this circulation temporarily showed itself. In 10 episodes of this TV show, this approach ended up with 30 units of speaker's voice segments, 64 visual units, 21 verbal units from the trainer, 44

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<sup>3</sup> Liv och Hälsa 2008.

verbal units from the coach (the not-fat partner) and 25 verbal units from the fatty (the fat partner). These units—or signs—were then analyzed according to Sara Ahmed’s model of affective economies (Ahmed 2004).

#### *Study IV—A theoretical development*

The fourth study in this work concerned theoretical development, also a theorizing process. While theory is usually an end product or a point of departure, thus belonging to the context of justification, theorizing, says Richard Swedberg, is a process of discovery (Swedberg 2012). The focus was a transformative development of a new mindset for the emancipation of fat individuals from an oppressive system. I argued for the necessity for fat individuals to turn away from the idea of them being misrecognized in need of realization and instead focus on criticizing the systemic binds that allow for stigmatization to occur in the first place. In a comparison between mainly two scholars—Axel Honneth (recognition) and Gregory Bateson (ecology of mind)—I followed Bateson and suggested that anything that tells us we are not worthy is a disturbance in a greater pattern, and how we understand this disturbance is *the* phenomenon on which to focus. In conclusion, the claim was made that if we continue to understand our sense of vulnerability as a dualistic misrecognition of ourselves, we narrow our focus and become rational enhancers of ourselves instead of transformative agents for social change.

## 5.5 Methodological reflections

In this section, the methodological choices that may have affected the outcomes of this work in terms of trustworthiness or credibility will be discussed. This is done in three parts; self-critical reflections, the mixed methods, and ethical considerations. Issues of validity and reliability will run as themes through all these parts.

### 5.5.1 Self-critical reflections

In this type of work, where, to paraphrase Gayatri Spivak, the subaltern not only “speaks” (Spivak 1988) but even observes and produces knowledge, transparency is an important factor of credibility. Although much has been said about the importance of emancipatory research that includes clients or “the subaltern” to help shape, guide, conduct, and even control some of the design, (Shannon 2013), to fully embody both parts of a subaltern research is to take things a step further.

Adapting an inner drive to uncover an experienced social injustice to the idea that a researcher should start with a rigorous, objective “first look” at a field was not easy. It was like asking me to reset an entire life of collecting data and pretend to start from zero. This was unachievable; thus, the position from which the phenomenon of fatness stigmatization was observed has influenced every choice made during the process. Some possible weaknesses due to these choices are up for reflection. These reflections are ordered under the sections *Pre-understanding and intellectual rigor* and *Role duality and a possible misinterpretation of the findings*. The reader will find these themes to overlap.

### *Pre-understanding and intellectual rigor*

My lived experience has created a personal stake in, as well as relational bonds with, the studied field. Not only have I developed a heightened sensitivity to discriminatory actions; I have also grown into a strong subject position as a visible carrier of what is stated to be an epidemic. My pre-understanding was indeed that fat people are harmed, and that this harm could be made intelligible as part of a systemic construction. Because of the risk of falling into victim talk among “peers,” an active choice was made in this work not to interview fat individuals.

Because of my pre-understandings, this work is best explained as a *directed* searching process rather than an open one. A big struggle was having constantly, at every notion of a pattern, to reflect on whether the findings were due to my lived experience or the result of scientific discovery. I did have internal conflicts during this process, and perhaps sometimes throughout the text or even between the lines these conflicts can be traced. Meanwhile, once again, self-vindication of any kind was never an option. In fact, such an approach to changing the world was put forward as the main transformative trap in article 4 where the main argument was that social change starts with acknowledging the logics of a stigmatizing system.

### *Role duality and a possible misinterpretation of findings*

There is a potential for both role and value conflict when studying a familiar setting. This study had a partly theoretical perspective, and all theorizing is, according to Swedberg, a deeply personal endeavor in that you must do it yourself and build on your own experiences and resources (Swedberg 2012). When the “client” or the negatively categorized “subaltern” not only shape and control the design but also theorize on what is “done” to his or her “group,” the border between roles is almost erased.

The motivation to change the state of affairs risks being judged as stemming from a search for self-vindication rather than an academic interest in social justice. One of the cores of positivistic research is that the researcher is expected to distance him- or herself from the setting, and the means for showing this distancing is via methodological principles of objectivity and replicability. Meanwhile, pure objectivity is impossible. A choice is always done by someone regarding what research questions to pose, what settings to investigate, or what answers to pursue. It is sometimes built on political interests, economic interests, and even career investments. These subjectivities are often invisible. Reflecting on this, this work, with a declared standpoint and an intake of a value position and where I am both a subaltern voice and an academic scholar, has done away with such possibly hidden subjectivities.

Also, the notion of misinterpreted findings refers to the positivist school of thought and does not apply to a constructivist knowledge claim like this. The “mis” prefix demonstrates a belief quite the opposite of constructivism—the belief that empirical findings would have an essence of their own. However, I do admit to the risk of over-interpretations when energy is invested in finding power relations where injustice is produced. I *have* become excited whenever the findings have met the assumptions I had from the beginning, and perhaps I *have* deemed findings that counter these assumptions as more irrelevant than they are. Such decisions have, in any case, passed unnoticed.

## 5.5.2 The mixed methods

### *Study I*

There are some matters to reflect upon in studies 1 and 2. Both these studies used the variable psychological distress as representing ill health. While the medical discourse often associates fatness with physical conditions such as diabetes, high blood pressure, and heart disease, there are several reasons to instead turn to the *sense* of health that psychological distress represents. Firstly, health is a broad and debated concept that is meanwhile deeply connected to quality of life. While a high quality of life is fully achievable for a person with a physical illness, psychological distress is close to its opposite. Secondly, this work explores stigmatization which is foremost a psychosocial inflicted harm.

In study 1, we had a large, final data ( $n=68,311$ ). The response rate was 63%, and the drop-out informants are unknown concerning characteristics such as weight, age, and psychological distress. Hence, the results could have been different with a higher response rate. Another possible limitation was the skewed data. Among the 68,311 respondents, only 940 men belonged to the highest BMI category—obesity II. When age as a variable further fragmented the data, there were only 59 men in the 18-24 years/obesity II category, while for example, there were 4,000 men in the overweight category aged 65 to 74. We created a controlling age-gender variable in this study. There are other parameters we could have accounted for such as socioeconomic status, level of education, or ethnicity to mention just a few. Meanwhile, when we started to analyze data, we noticed that this age-gender variable had an immediate impact on the association between fatness and psychological distress. Thus we deemed this to be a sufficient discovery of its own.

Examinations of validity and reliability also refer to the instruments included in the studies. In both quantitative studies, we used the General Health Questionnaire 12 (Goldberg 1972) to measure psychological distress. While the GHQ-12 is considered a somewhat blunt measurement of perceived general health, its internal consistency in terms of Cronbach's alpha was set to .90. This high score means that the set of 12 questions in a reliable way measures degrees of psychological distress. This part also applies to the second study where the same instrument was used.

### *Study II*

This study had a response rate of 60%. After a selection in which only individuals with a BMI 18.5 to 60, aged 18-65 were taken into account, the final data consisted of 26,287 individuals. Out of these, 4,152 individuals were categorized as obese, and a group of 22,135 individuals was categorized as a control group. This difference in data size between group and control group is large, but at the same time, the group of individuals with obesity is a large sample. The reason for also putting the overweight category in the control group adheres to the results of the first study showing that the association between overweight and psychological distress was the same as for the normal weight category. The large data may also weigh up for the cell size differences where those reporting only condescending response were proportionally few compared with those who received only appreciative responses.

The respondents did not answer the specific questions about perceived interpersonal responses in relation to their weight. Other questionnaires may be designed especially for measuring weight-related attitudes from others while in our case the respondents' declarations of height and weight were only two marginal sources of information among 150 other more ample

questions related to their everyday life.<sup>4</sup> I propose that this “separation of issues” in the questionnaire strengthens our results. When measures ask respondents how to distress in relation to their weight (examples include the *Body Esteem Scale*, BES, and the *Weight on Quality of Life-Lite*, IWQOL-Lite), the social consciousness of individuals tells them they *should* feel bad in their fatness and could, therefore, increase the risk for confirmation-biased answers. Due to the cross-sectional design of the study, we make no claims as to causality from the results. The wide confidence intervals for the obesity group who perceived only condescending response are noticeable and should contribute to some caution when drawing conclusions. Meanwhile, the association pattern was clear, especially for women where the confidence intervals were not overlapping implying a statistically significant difference between the odds ratios. Future research could focus on establishing causality, but here we settled with finding an association that is noteworthy and important regardless of causality.

### *Study III*

By a qualitative method, one focuses on processes and meanings that are not measured in terms of quantity. Qualitative researchers seek answers to how social experience is created and given meaning (Denzin & Lincoln 2000; Guba & Lincoln 1994). Quality is not the same as research rigor, but rather extends beyond it (Sin 2010); the main strength being the ongoing reflexivity, questioning and interrogating stance of the researcher during the research process (Agee 2009; Creswell 2003). From the beginning, a qualitative research question needs to address details of the social and cultural intentions and perspectives of people involved in social interactions (Agee 2009; Geertz 1973). At the same time, a limitation would be exactly this integral role of the researcher. When data are mixed with interpretations of the data during the entire process, researcher subjectivity may decrease the study’s transferability or replicability. On the other hand, this is not the intention of qualitative research where understanding rather than establishing a phenomenon is the goal.

In study 3, I performed a directed content analysis of 10 episodes of a reality TV weight-loss show called *Darling, You’ve Become a Fatty*. It was a conscious choice to focus only on this specific show. This TV show was explicit in expressing aversion for the fat body and thus offered an opportunity to understand how an open bullying of the Other could pass in a welfare society that puts pride in an anti-discriminatory stance toward difference.

A content analysis of this small size and directed aim needs to be critically treated regarding what type of knowledge it can provide. Sven Windahl and Benno Signitzer (1992) lists five types of knowledge a content analysis can aim for:

- The sender’s picture of reality
- The sender’s intentions
- The sender’s picture of the receiver
- The receiver’s possible reactions
- The cultural climate of current society (Windahl & Signitzer 1992).

My directed content analysis follows scholars who view reality TV shows as “governable spaces: (Rose 1999: 31), as sites preoccupied with the modification and the perfectibility of the self (Giroux 2008), and as milieus for intervention rather than sources of representation (Wood &

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<sup>4</sup> Liv och Hälsa 2008.

Skeggs 2008). In this context, very little room is left for different interpretations of the content as the sender's picture of reality as well as the receiver's belong to the intention to govern a problematic body. The receiver's possible reactions mirror what is "desired" in current society, and the space left for interpretation circulates around *how* these things are done.

The reliance upon the researcher's interpretation is posed as one of the greatest disadvantages of media analyses where the approach to culture as "texts" to be "read" risks reflecting the values and assumptions of the researcher rather than the participants (Phillipov 2013). Meanwhile, content analyses can articulate dimensions that other empirical methods cannot. "Research is always a construction, rather than a representation, involving a range of selective devices, such as highlighting, editing, cutting, transcribing, and inflecting" (McRobbie 1991: 69). It is important to acknowledge that empirical research methods such as ethnographic studies, for example, offer no guarantee that the researcher will not impose his or her interpretations of the cultural form under examination (Phillipov 2013).

Media content analyses are also criticized for being devoid of a theoretical base, making it hard for the researcher to draw meaningful inferences of what is implied in the study. Ethnographic studies are supposed to avoid this dilemma because they prioritize the experiences of the research subjects rather than those of the researcher, thus making "a shift from strictly theoretical formulations to a domain that is concrete and material" (Cohen 1993: 132). In this study, however, I did have a theoretical base, a theory of affective economies (Ahmed 2004)—a conceptual tool that guided both the research question, the analysis, and the conclusions that could be drawn.

### 5.5.3 The critical systems theory perspective

A critical systems theory perspective was used to discuss and contextualize the studies. This perspective was also used in the fourth study consisting of a theoretical development of recognition theory (Honneth) and the "ecology of mind" theory by systems theoretician Gregory Bateson. The paragraph on theorizing also applies to this fourth study.

Depending on the design of a study, the validity and reliability concepts can have different meanings (Alvesson & Sköldbberg 2008; Lincoln & Guba 1985). I have followed Lincoln and Guba's (1985) terminology where a study's dependability evaluates whether the process of research is logical, traceable, and clearly documented.

Fatness stigmatization as an emerging social problem could have been discussed from perspectives other than critical systems theory. A grounded theory perspective could have developed an understanding free from pre-theoretical assumptions. Meanwhile, this concept of not recognizing the embeddedness of the researcher and thus obscuring the researcher's considerable agency in data construction and interpretation (Bryant & Charmaz 2007) would not have suited my declared situated knowledge very well. My lived experience had already led to the development of a theoretical mind-set due to the personal stake in, as well as a relational bond with, the field. In fact, this situated knowledge alone speaks for a systemic abstraction.

Hypothetically, an ethnomethodological perspective could have worked. Such conduct could have involved field studies of how fat individuals interact and speak of their sense of reality in different, possibly stigmatizing situations. Meanwhile, my specific interest in systems theory and critical research is, in fact, partly a reaction to the shortcomings of ethnomethodology. The assumption was that the genesis of fatness stigmatization remained unsolved *despite* a

pronounced will from governments and core institutions not to stigmatize socially disadvantaged groups. The main function of complexity thinking, as a crucial part of systems theory, is that it can help us decipher apparently intractable situations (Payne 2011) that continue to exist *regardless* of what individuals seemingly do, say, or how they interact.

Theoretical studies are sometimes criticized for their distance from the empirical world. There is no guarantee, however, that theories derived from empirical data would be more reliable than theorizing without empirical data. When Irving Zola studied how different ethnicities searched medical help for the same physical condition, doctors interpreted them so differently that the theorizing from these data was completely distorted (Zola 1966). In addition to pure prejudice and personal ways of looking at data, researchers will always make new historical discoveries, their empirical data will land in new social contexts, and they will continue to develop new ways of reasoning and debate (Myers & Klein 2011). In terms of the traditional meanings of validity and reliability, theorizing is weak because of the major role of the observer. Meanwhile, in terms of transformative possibilities, theorizing is key, especially regarding phenomena where the intertwinement of valid and reliable empirical research has landed in the status quo and become incalculable or even harmful for groups of people.

#### 5.5.4 Ethical considerations

The surveys used in the first two studies are approved by the boards of the County Councils of Uppsala, Sörmland, Västmanland, Värmland, and Örebro. They are also conducted under the jurisdiction of Swedish law, the Declaration of Helsinki, and international guidelines. An approval from an ethics committee was not applicable because the data are anonymous. Studies 3 and 4 do not involve encounters with any respondents, the third performing a content analysis of a reality TV show and the fourth being a theoretical exploration.

Worth discussing is how the group of stigmatized people is referred in this work. The term fat, fatness, and fat people were used to describe the “stigma marker” of their bodies. “Obesity” is a pathological label that does not go well with critical social science (Cooper 2009; O’Hara & Gregg 2012). According to the new disciplinary research fields, Fat Studies and Critical Weight Studies, this term along with the term “overweight” refer not only to the size of a body but also signals that this body is diseased (Monaghan et al. 2013). In her dissertation, Aimee Ekman explains how critical researchers consider overweight to be a socially constructed problem (Ekman 2012) calling for both a liberation of body shape from the medical hegemony and a challenge of negative assumptions, stereotypes, and stigmatization of fat people.

Paradoxically, the term fatness may offend people in an everyday context, as a generalized flabbiness that “materializes the lack of willpower that disqualifies one from embodied citizenship in Western culture” (Carden-Coyne 2009). Meanwhile, the term “fat” is according to fat activist and researcher Charlotte Cooper, practical in an activist context (Cooper 2009). An example of how other activists have resolved similar problems around labels is how Queer Nation and other queer movements restored control over classifications to homosexuals, bisexuals, and transgender persons: “We’re here! We’re Queer! GET USED TO IT!” While the very term “fat” has become a source of some controversy, it is not only an adjective that carries value judgments, but also a noun referring to properties that are subject to cultural interpretation (Forth 2015). In my use of the words fat and fatness, I refer to a specific type of body that is, currently, subject to negative cultural interpretations.

## 6. Results

First, in this chapter, the findings of the separate studies will be presented. After this, from a systemic perspective, these findings and their respective implications will be seated within the context laid out in previous chapters and explored with the benefit of a systemic stigmatization theory.

### 6.1 Article 1: BMI and psychological distress

It seems that the theory that fat is bad and more fat is worse is perhaps not as clear-cut as was first thought, and recent research is now challenging this orthodoxy.

(Maguire & Haslam 2010: 53)

In the first study, we found that any association between BMI and psychological distress was almost erased when controlling for two of the most foundational social factors in social research—age and gender ( $n = 68,311$ ). Regardless of BMI, the odds of reporting psychological distress decreased with increasing age, a result even more clear for women. There was no difference in the odds for reporting psychological distress among people in the normal weight, overweight, or obesity I category; that is, in the BMI range of 18.5 to 34.9. When controlled for age and gender, any noticeable increase in self-reported psychological distress was first seen at a BMI over 35 (Obesity II, 3.4% of the population), yet with only a 7% increase for women and a 5% increase for men. These results questioned the previously granted positive association between an increasing weight and ill health.

According to WHO standards, 6% of the respondents were considered normal weighted (BMI 18.5-24.9), 39% were overweight BMI 25-29.9), 11.6% had obesity I (BMI 30-34.9) and 3.4% had obesity II (BMI>35). Respondents came from a merger of three large surveys on life and health distributed among the general population in a mid-Swedish region<sup>5</sup>.

While our focus was on psychological distress, other studies also question the association between increasing body weight and ill health in general. In these other studies, it is not only the strength of these associations that is being scrutinized but so is their overall applicability (Rail et al. 2010; Evans & Colls 2009; Cobb 2007; Oliver 2006). For example, a review of 25 meta-analyses and 15 cohort studies showed that being overweight did not increase the risk of disease more than being of so-called normal weight. First, at a BMI above 30, there was a slightly elevated risk for some of the diseases studied. This review questions the widespread notion that BMI and weight would determine health status—even when someone is severely obese (Padwal et al. 2012). Risk and harm may be correlated, but causal connections are far less clear (Merry & Voigt 2014; Mehta & Chang 2011).

The findings in this study, combined with the results from earlier studies show that the construction of knowledge is never certain. Knowledge is constantly redefined, clarified,

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<sup>5</sup> Liv och Hälsa 2008, 2004, 2000.

challenged, and reorganized with implications for a social work discipline devoted to social justice. It has to do with a fair production of knowledge, how the questions are posed, whether the results are applicable, and whom this knowledge serves. Our main result, that there was no association between BMI and psychological distress when age and gender were accounted for, except for the 3.4% with the highest BMI, call for new important cutting-points for determining at what point being fat clearly constitutes a threat and when it is not. From a social justice perspective, taken-for-granted associations about stigmatized groups cannot stand unchallenged, or we risk developing policies trying to normalize variations that were not abnormal in the first place—that is, we risk engaging in moral speculations.

## 6.2 Article 2: Psychological distress in people labeled with obesity

In our second study, we focused on those fat people who *do* report psychological distress. The aim was to investigate whether interpersonal negative and positive responses were factors that could alter this association. The assertion was made that accounting for both condescending and appreciative response in combination would compose a more nuanced representation of how the trajectories of fat individuals' relationships associated with their self-perceived health. We created an interpersonal response model to investigate how responses affected the odds for reporting psychological distress in 26,287 respondents divided into one obesity group and one control group. Because of their already known effects on well-being, controls were implemented for age, gender, and employment status. Individuals with a BMI above 30 (considered obese by WHO measures) were addressed as the obesity group.

Considerably more individuals in the obesity group reported condescending response than in the control group. When applying the interpersonal response model, both the combination of appreciative and condescending responses as well as only condescending responses were significantly associated with self-reported distress, for both men and women in both the obesity group and the control group. While odds ratios for reporting psychological distress under the influence of only perceived condescension was high in the obesity group in both men and women, there were gendered differences. The divergence in psychological distress between no response and condescending response in men in the control group was considerably stronger than in women of the same weight category (O.R. men: 5.26; O.R. women: 3.12) whereas the divergence between no response and condescending response in men with obesity was much smaller than in women with obesity (O.R. in men: 7.69; O.R. in women: 11.11). These results suggest that the relative combination of appreciative and condescending response mediates the odds for reporting psychological distress in already stigmatized groups such as fat people—especially in fat women.

These results can be summarized in four steps. 1) When “only condescending responses” were perceived, the odds for reporting psychological distress increased by 7 times compared to “no response,” and by 3.5 times compared to “appreciative and condescending responses in combination” in all respondents. 2) When separating control group and obesity group, these numbers diverged. When “only condescending responses” were perceived, the odds for reporting psychological distress increased by 4 times compared to “appreciative and condescending responses in combination” in the control group, and by 9.5 times in the obesity group. 3) When separating the obesity group by gender, a new divergence showed where the odds for reporting distress in the “only condescension” category increased by more than 11 times for women and by

almost 8 times for men. 4) When separating the control group by gender, the odds for reporting distress in the “only condescension” category diverge in favor of the women, with a 5-times increase in men and a 3-times increase in women. These results can be interpreted in two equally intriguing ways. Either, perceiving only condescending response has profound effects on psychological health in general, much more so in fat individuals, and even more so in fat women. Alternatively, it is the lack of appreciation in this category that is responsible for this result.

Our results followed Carr et al.’s (2007) conclusion that excessive body weight is not necessarily distressing, while interpersonal strains associated with this weight may be so. We also joined studies that suggest that women experience more weight stigmatization in part because they are more fragile before the Western “thin ideal” relating to beauty and sexual desirability (Roehling et al. 2007; Puhl & Heuer 2009). Moreover, we relate our findings to what theorists focusing on reinforcements of human dignity say about the significant impact of appreciative responses (Fuller 2006; Hall & Lamont 2009; MacLean et al. 2009; Marmot 2005; Reis et al. 2000)—especially, as we found, in fat people.

Relating our findings to social work research, we agree with Finch et al. (1999) who claimed that the prevailing belief that negative response outweighs positive response is over-generalized. It is more complex than that, both connected to the measurements, as Finch et al. (1999) acknowledge but also, we suggest, to how results are interpreted. A one-sided focus on negative responses in stigma research may have us search for one-sided solutions to the social problem of stigmatization. The social work profession should focus just as much on developing pro-dignity attitudes as on finding anti-stigmatizing techniques in client treatment. A lack of appreciation could prove to be just as detrimental to psychological health as enacted condescension, in general, and specifically for fat individuals.

The application of an interpersonal model to the comprehension of psychological distress in fat individuals could sensitize social workers to how clients may be more or less fragile before implicit harm, depending on whether they belong to a culturally stigmatized group. Institutions with a legal right to act on people put great demands on welfare systems not to be oppressive. The findings of this study suggest that a heightened awareness of the chronic stress that fuels the sensitivity to responses by some groups would strengthen not only the quality of offered treatments but also their possibilities to succeed—if ethical enough to be applied at all.

### 6.3 Article 3: Justifying fatness stigmatization

The primary aim of this study was to explore how explicit bullying of fat individuals can be justified. A directed content analysis was made of a Swedish reality TV show called *Darling, You’ve Become a Fatty*. The content of the show was analyzed by a theory of affective economies developed by Sara Ahmed (2004).

Following Nicholas Rose’s theory that reality TV should be seen as a governable micro space that animates how the structures of the public sphere are reconfigured at another level (Rose 1999), this specific show was viewed as an important site for social analysis of fatness stigmatization. The analysis suggested that, via a circulation of affective signs, negative or good capital could be “drawn” to the individual parts of the show at a subconscious level behind words. A Self/Other relation was narrated where the Self (the not-fat partner) was animated not as a “stigmatizer” but as being violated by the Other in his or her Self-expansion. In the midst of open bullying, a circulation of signs of love for one of the core values in Western civilizations—

the perfectibility of Self in terms of being an energized, sexual and productive subject—managed to animate the not-fat partner as a Self in crisis. This accumulation of “good capital” to the Self surfaced the fat Other as “bad” by her- or himself. This is what an affective economy does; it bypasses explicit communication and establishes a narrative at a more sub-conscious level of emotion.

What this study highlighted and that can be related to social work practice and research was how power relations are able to circulate cultural values in ways invisible to the non-analytical eye. Studies have shown that racism persists, especially among those who resist the idea of white privilege (Constance-Huggins, 2012). Research has also shown that mistrust and wounding still exist between clients and social workers (Chambon 2013) despite destigmatizing efforts. Here, highlighting how affective economies work to obscure the existence of prejudice holds important keys to the resolution of Self/Other tensions in social work where the risk of becoming yet one more governing bio-pedagogical site needs to be minimized. A self-conscious social work should involve itself in analyzing the power relations and dominant assumptions and beliefs that at the same time oppress and marginalize certain groups (Allan 2009) to make sure not to apply stigma by any means of justification. This study showed how even the most explicit bullying can appear to be a celebration of values—violated by the Other.

## 6.4 Article 4: The trap of a misrecognition mind-set

In article 4, focus was on a process that may hinder a destigmatization of fat individuals. The aim of this theoretical fourth paper was to argue that the adoption of a misrecognition mind-set to come to terms with fatness stigma could prove to be a trap. This reasoning applies both to the transformative possibilities of critical weight studies as well as the emancipatory potential among fat activists struggling for equal worth within an ideologically driven thin-equals-health culture. In response to a culture where fat people are undesirable, I argued for the risk of appealing to others’ good will to recognize them as worthy subjects.

The argumentation in this article was that due to an emerging self-reference (Geyer 2002), individuals have come to share a “misrecognition mind-set,” making us translate every sense of deficiency as an unfortunate misrecognition from others. Instead, it is within our social fragility as parts of a whole, rather than in the intersubjective efforts to overcome this social fragility as parts of a dualism, that a true acknowledgment of one’s circumstances has transformative possibilities. Being oppressed (or actively stigmatized) is something completely different from being misrecognized. At least the shape of resistance must differ.

In this article, I turn to Gregory Bateson’s ecology-of-mind concept, where our fragile ability to sense harm should be taken as an opportunity to raise questions about harmful systems instead of urging a betterment of the Self. It is a holistic mind-set where sensed harm is an active revealing of a pattern that somehow allows for this harm to emerge. It connects to social justice because it would require that rather than all people being known or respected as “who they really are,” they would not be reduced to any characterization that someone else has suggested (Markell 2003: 7). To Bateson, self-realization by recognition determines the results by its purpose, whereas the outcome of self-reliant agency within a living system (ecology of mind) will always depend on how the situation is interpreted (Bateson 1972). This reasoning adheres to the important distinction between first- and second-order realities.

Bateson warned us of the idea that we should always strive for recognition. Instead, he says, we are already worthy subjects. Anything that tells us we are not is the true disturbance, not in ourselves, but in a greater pattern. *How we understand* this disturbance is the phenomenon to focus on, at least if we are to become agents for transforming the world rather than rational enhancers of ourselves. Scambler claims that without a notion of the difference between perceived and applied stigma, all the stigmatized individuals can do is to *handle* the perceived stigmatization. To *resist and change* stigmatizing processes, the stigmatized themselves must gain knowledge of the applied stigmatization as it contains a mix of concrete actions of exclusion and silent condescension (Scambler 2004). In fact, today, several scholars adhere to the idea that fat people are oppressed in the medical and the moral system (Lawrence et al. 2012; Scambler 2004; Parker & Aggleton 2003). Some critical researchers even use the term “fascism” to describe the current pressure that our governments put on fat individuals (Rail et al. 2010).

This theoretical elaboration also recognized that there is resistance. Fat people are not “cultural dopes” determined by a subordination that is somehow ascribed to them. The point is that if this resistance is misguided and rooted in a self-assertive negotiation over bodily norms, we risk missing the systemic processes that allow for social denigration to occur. Transformation demands that people interpret their internalized self-discrimination as a systemic disturbance—instead of something to overcome therapeutically. This is a theoretical discussion of importance to a social work profession that deals with improving peoples’ lives. Of special interest is the delicate notion of empowerment, a goal where the means for achieving personal strengths can be seen to balance between an internal, therapeutic healing of harm and a more external development of a critical and knowledgeable subject position.

## 6.5 The systemic stigmatization of fat people

The aim of this work was to advance knowledge and awareness about the stigmatization of fat people by viewing this phenomenon as a systemic construction in a second-order reality. Four studies were performed to address this issue. In the first study, any linear association between BMI and psychological distress was erased when controlling for an age/gender variable. It was first at a BMI over 35 that a minor rise of the odds for reporting distress showed. These findings are consistent with an increasing amount of critical research that claims that the construction of fatness knowledge is highly conflicting and that a general assumption that fat people are diseased people does not hold.

In the second study, we investigated the relative role of negative and positive response to fat people’s psychological distress. The discoveries displayed a process of stigmatization where individuals labeled with obesity seemed to internalize both negative and positive responses to a far greater degree than the control group. This pointed toward a heightened overall sensitivity to response in a culturally devalued group.

The third study exposed how explicit bullying of a fat individual can be justified by animating a non-fat partner as being violated in his or her core ideological values—such as the perfectibility of self—by the fatness of his or her partner. In this process, via a circulation of affective signs, the bullying managed to pass as a celebration of the “good” (being thin) rather than an ill-willed condescension of something “bad” (the fat person). By viewing a reality show, like this one, as a performance site for citizen governing, a parallel could be drawn to built-in

processes of justification in the epidemiological rhetoric where human fatness is targeted as a public health “time bomb” (Barry et al. 2009) or a “terror within” (Monaghan 2008).

In the fourth article, the argumentation was that a re-focusing from feeling misrecognized in one’s fatness to viewing fatness stigmatization as a systemic oppression could hold more profound possibilities for a destigmatization of fat individuals.

To grasp a full systemic perspective of the stigmatization of fat people, the results of these studies need to be contextualized because, as several scholars have pointed out, stigmatization must be connected to the power relations where it resides (see: Gracia-Arnaiz 2010; Link & Phelan 2001; McPhail 2009; Monaghan 2007; Townsend 2009). Moreover, in this context, due to an extended web of ideologies and interpretations, stigmatizing processes are actively produced by practices that devalue *some* differences (Farrugia 2009). The specific context in which fatness is a highly devalued trait was suggested to comprise a) a historical aversion toward the fat body, b) the onset of a global obesity epidemic, c) the simultaneous rise of a new public health ideology that equates health with thinness, d) a documented failure to reverse or even put a halt to this obesity epidemic, and finally, permeating the entire context, e) a market of weight-loss stakeholders that thrive on keeping the negative meanings of fatness alive.

Thornicroft and co-researchers used the concept of an overarching stigma problem and proposed that a stigma problem contains three problems: ignorance, discrimination, and prejudice (Thornicroft et al. 2007). While Thornicroft et al. spoke of a three-piece *stigma problem*, a systemic stigmatization is something else. Such processes are systemically active, constantly injecting and enhancing each other to form a system that is *more* than the sum of these processes. It is in the intertwining of structural, internalized, and applied that the systemic stigmatization manifests, which is also where the possibilities for a social transformation toward a destigmatization of fat people reside. In fact, the systemic stigmatization of fat people is a second-order artifactual construction where it is the processes of response to fatness as difference that keeps this stigmatization alive.

On two accounts, this work builds further on Guthman’s claim that the obesity epidemic is an “artifactual construction,” in which it is “how we know the obesity epidemic” that is socially constructed (Guthman 2013). First, the artifactual construction I turn to is not the “obesity epidemic” but the systemic stigmatization of fat people. In this work, the artifactual construction of an obesity epidemic is but one of the processes involved. Second, and in line with this, my specific contribution is the *systemic* perspective, where the structural, internalized, and applied responses to fatness co-produces its stigma mark.

The structural response process is where knowledge about fatness as an epidemic disease is reciprocally produced by a science that delivers facts, media that report and commercialize these facts and air moral issues, and governments that address the fatness problem and create evidence-based policies. This is a knowledge that is highly unsettled, regarding both how dangerous fatness is and especially eventual cutting-points where any danger is supposed to show. This was evident in our first study and supported by critical stigma research. From the systemic perspective, this unsettled fatness knowledge is not a social problem but *becomes* a social problem of *ignorance* when only one part of this knowledge is applied in professional settings responsible for assuring scientific certainty. This is especially so as this knowledge is produced amid a historical aversion toward the fat body and where all interventions built on this knowledge have failed.

The internalized response process is where the heightened social awareness of fat individuals, as members of a culturally devalued group, urges them to incorporate discriminatory practices

more actively into their self-image. In isolation, the internalization of stigma in fat individuals could be viewed as a personal problem apt for therapeutic healing. Viewed from the systemic perspective, though, this problem extends beyond the individual level, when the knowledge they were supposed to have failed to put into practice, in fact, is highly unsettled. The result is that these individuals take up a “false” subject position as failures.

The applied response process designates when “what is known and believed” about fat people is communicated to them in different manners. For example, the internalization process is further reinforced as the failures to reverse the obesity epidemic are blamed on the fat individuals’ inability to put the delivered knowledge into practice. Campaigners, health professionals, and mere opportunists are here informing fat individuals on how to lose their weight, legitimized by the medicalized idea that fatness is a disease believed to be easily cured by educational speech. For this blame to work, these educational speeches must be justified in order not to pass as ill-willed prejudice. This is done, I claim, by the upholding of the “good” values of the healthy thin citizen within a current health- and self-production ideology.

The transformative possibilities of a destigmatization of fat people, developed in the fourth article, reside, as I see it, in 1) viewing the stigmatization of fat people as a second-order systemic oppression rather than a first-order interpersonal misrecognition, and 2) viewing this social problem as *orientational* rather than intellectual (see: Shotter 2009). What this means is that a transformation of this problem is possible only by *responding* to the stigmatized trait *differently* from the beginning. The stigmatization of fat people is kept alive by how fatness is responded to in terms of an ignorant knowledge production, unethical applications of this knowledge accumulation, and a heightened sensitivity to discrimination among the recipients of these applications. Implementing anti-stigmatizing techniques side by side with these current responses to human fatness has already proven not to work (see: Forhan & Ramos 2013; Himes & Thompson 2007; Paluck & Green 2009; Puhl et al. 2013). The systemic perspective highlights why.

According to Meeuwisse and Swärd (2013), social problems are about social exclusion where fragile groups are put in the position of not being able to establish as full citizens. While the original intention with our welfare system was to include and reintegrate targeted groups by way of evidence-based and ethical responses, the current responses to human fatness ascribe a significance to the fat body that manages to change the including character of this welfare systemic function to a stigmatizing systemic function instead.

## 7. Discussion

There are systemic binds between, or a “pattern that connects” (Bateson 1972), response processes directed toward human fatness. This pattern presents itself as an artifactual construction in a second-order reality where processes of structural ignorance, applied prejudice, and self-discrimination together form a systemic stigmatization of fat people. Fatness has been declared something to frown upon, something to resist, combat, and control, and we have not taken the full responsibility of the negative meanings these responses project on the fat human beings themselves.

Diseases do not exist until we agree that they do by responding to them (Eller 2014; Rosenberg & Golden 1997: xiii). Hence, it is the response that brings the disease to life. Regardless of a highly conflicting science that cannot agree whether fatness is a disease, the second-order artifacts—the governmental techniques, attitudes, practices, conventions, methods, and measurements used for approaching fatness—continue to *construct* fatness as a disease. The fact that all these efforts have failed demands that the one-sided knowledge production that legitimize these responses is openly challenged.

While critical researchers and fat activists are questioning this knowledge production, these claims are not reflected in the second-order reality where fatness is responded to by news media, health professionals, governments, stakeholders at the weight-loss market, or the dieting “entrepreneurial self” (Monaghan et al. 2010). Instead, all light falls on the fat individuals who, in their fat bodies, seem unable to put a *seemingly* consensual knowledge into practice. Methods are developed to motivate, encourage, push, or inform fat individuals to lose the weight, and this heightened concern about the fatness problem has managed to override the evidence about the impotence of the solutions (Herman & Polivy 2011) and, while doing so, manages to violate at least 13 acts in the Human Rights Declaration (O’Hara & Gregg 2012). This shows the need for a heightened ethical awareness before targeting groups that are already devalued, not only historically and culturally, but by an entire market of stakeholders that thrives on these devaluations.

These findings also highlight the importance that we firmly distinguish between real disease and characteristics that we just happen to find disturbing if we are not to engage in moral speculations (Leach Scully 2004). This is especially crucial against the background of the new public health ideology in which both health and citizen worth are aesthetically connected to the thin body. In addition to the historical aversion toward the fat body as representing an incapable and immoral human being, prejudice also risks being warranted by this “healthism” ideology (Greenhalgh & Wessely 2004), reinforcing the negative significance of the fat body because of everything it is *not*.

This systemic perspective on stigmatization is a vital tool for the social work profession, where practices, to a certain extent, mimic the power imbalance of the medical model, the one between experts and laymen (Holmes & Saleebey 1993). Both these welfare institutions are managing the paradox where healing efforts risk turning into harm. Judith Gruber and Edison Trickett (1987) illuminated this fundamental paradox of social work by describing how the very institutionalized structure in which a “we” is put in the position to empower a “them” per definition undercuts exactly what empowerment or liberation are believed to represent. Within

its extensive practice, social work has not yet come to involve fat individuals as a clientele for empowering or harm-reducing interventions. Meanwhile, knowledge about systemic stigmatization, in general, is up to date with an increasingly complex societal web where new power relations and the emergence of new Others interfere with old truisms in ways for which a vibrant social work profession should be prepared.

Organizational self-scrutiny is important. Many response processes in welfare society are put under constant critical evaluations. In police work, for example, a periodic assessment of one's professional response to clients is crucial to citizen safety and harm reduction in difficult situations (Eck 2010). In social work, one part of evidence-based treatment is to systematically evaluate the selected as well as the deselected interventions according to how well they worked out for the client in question. The same goes for the medical profession. The responses from these institutions have in common the task to avoid at all costs becoming part of or enhancing the problem at stake. Indeed, the *meaning* of these response processes is for them to be part of the solution to the challenges posed by troubled citizens. From the systemic perspective on stigmatization, however, self-scrutiny must go beyond the organizational culture and involve an awareness of how knowledge construction, ideology, human vulnerability, and power connect.

A systemic stigmatization of a specific trait, such as fatness, has no self-regulating evaluation of responses simply because this is a macro system in its widest term. While analyses of micro and meso systems deal with physically well-defined and well-framed units, a macro system communicates meaning at a larger-scaled level believed to affect specific individuals, communities, or even humanity as a whole. In a systemic stigmatization, there is no isolated responding unit—no targetable initiator—to hold accountable for the sense of exclusion among the targeted individual. Therefore, an ethically informed social work needs what Marcus Hertz described as a theoretical framework that ensures that we do not *reproduce* negative conceptions of the people we strive to support (Hertz 2016). This work suggests that a systemic perspective of the stigmatization of fat individuals represents such a theoretical framework.

## 7.1 Critical reflections

In this section, some critical reflections will be made concerning the trustworthiness of some methodological strategies in this work. To reflect in hindsight on how a possible personal bias may have influenced the findings, I have tried to imagine how a researcher without a personal fatness experience could have influenced the findings in another direction. This was a useful exercise, where I suggest that the consistency and therefore also the study's reliability lean against the transformational, systemic, standpoint approach. The underlying goal of this approach, to make a positive difference on the way to a systemic destigmatization of fat people, could perhaps have produced somewhat different transformative keys for different researchers. However, with the same transformative and, therefore, value-laden point of departure, I suspect the results would stay within the boundaries of the generated theory of systemic stigmatization seated in how human difference is responded to—regardless of the body composition of the researcher.

In the first two studies, psychological distress was used as the dependent variable to investigate the association between fatness and ill health. This implicit equating of psychological distress and ill health could be questioned. Meanwhile, fat people are already legitimately labeled as diseased, and my interest was to understand how this *labeling* connects to how sick

these individuals *feel*. Perhaps this is a way of relating to the health concept, that provokes the pathological definitions of who is ill. That said, this work has made me aware that a thorough scrutiny of the health concept is something a critical social work science should engage even more in, considering the current wave of categorizing people via pathologizing diagnoses.

The measurement of appreciative and condescending response in the second study calls for some reflections. It would be easy to imagine how a person in distress, because of his or her fatness, could tend to overestimate the amount of perceived negative attitudes. The critique here would be that it, in fact, *is* fatness and not, as I claim, the responses to fatness that give rise to the distress. Meanwhile, the theoretical notion of biographical competence or a heightened socio-cultural awareness in fat individuals suggest that, yes, they are more sensitive to condescending response, but more because they are fat in a culture permeated by a fatness aversion than by any inherent condescension from the fat cells themselves.

Another reflection on this second study is that we chose not to define the concepts appreciation or condescension explicitly. Instead, we reached for the respondents' perceived experiences, regardless of whether they had *sensed* condescension or appreciation or a combination of both. In that way, we left the interpretation of the concepts to the respondents. Had we asked these respondents to reflect on more thoroughly defined responses, the outcome could have been different and is something to take into account if developing this issue further.

Regarding the third study, a legitimate question would be what type of knowledge an analysis of a TV show can produce. Cultural sociology and especially notions of cultural performances can contribute to a clarification. Jeffrey Alexander described that for a cultural performance to “work”—that is, for a TV show even to be aired—it must be able to settle in the audience in terms of psychological identification and symbolic extension by tuning into prevailing meanings, ideologies, and beliefs (Alexander 2003). Because of this, a TV show that, for example, celebrates racism will not be aired today on contemporary prime-time television. In this sense, television has always to some symbiotic degree mirrored and reconstructed our ideological reality. What is interesting in this specific case is that a second season of this TV show was never launched in Sweden, cautiously suggesting that the justification of explicit bullying of fat individuals by means of a self-perfection ideology did not create enough psychological identification or symbolic extension to last longer than that. The show did receive much criticism, not least from people with an awakened awareness of the emerging stigmatization of fat people.

The mix of methods, that from the beginning was merely a manifestation of an eagerness to try them all, must retrospectively be deemed a strength in trying to make complexity intelligible. The mix of theorizing, a qualitative content analysis, and two quantitative approaches has enriched and helped to produce a more comprehensive set of findings. All these methods have strengths and weaknesses that complement each other and have opened my eyes to different ways to reach knowledge and what type of knowledge they can each produce. At the same time, a mix of methods could, as any methodological choice, be criticized for its specific propensity for bias. Jenny Symonds and Stephen Gorard make the interesting claim that mixing methods is wrong, not because methods should be kept separate, but because they should not have been divided at the outset (Gorard in Symonds & Gorard 2008). By this critique, they suggest that researchers should be freed from the restrictions of methodological paradigms in the overall context of discovery. I agree. My suggestion in response to this is that the systemic perspective is to be viewed as a way to resolve such restrictions. A systemic research is not a divided research, but a way of making all methods matter in the revealing of a pattern that connects.

The empirical findings in this work constituted parts of the larger theory and a possible confusion could be the mix of empirical studies and systems-theoretical development of this work. Meanwhile, the aim of this work was, from the beginning, to make fatness stigmatization intelligible as a systemic construction in a second-order reality, and the empirical results were abstracted according to this aim. Importantly, a systemic perspective is not to be equated with traditional analysis. Where an analysis is often a process of separating an abstract entity into its constituent elements, a systemic perspective is about finding patterns that manifest as something beyond its obvious elements. Via abstraction—or a “zooming out” to view the larger picture—transformative keys can be discovered in relational cracks that are invisible from the analytical perspective. This abstraction can, at the same time, however, be criticized for diverging too much from the context of justification in a research project. To address this, I have strived to be transparent in what I have done and why. The knowledge claim that can be made here was that an awareness of systemic binds can make intelligible why fat people who are targeted by a welfare health system designed to be including end up stigmatized instead.

## 7.2 Bringing the curiosity further

Social scientists need to sharpen their critical focus regarding obesity policies, and after finishing this work, I can see one particularly interesting pathway for future transformative research on the stigmatization of fat people. One part has to do with bringing in more voices as “very little of the social scientific research on obesity involves actually talking to fat people themselves” (Boero 2013: 377). As said earlier, it was a conscious choice not to interview fat individuals in this work. Because of my situated knowledge, I deemed it necessary in a first step to distance myself from people with the same experience, to instead frame a theoretical platform from which relevant future questions that will benefit the stigmatized in a transformative way could be constructed. This brings me to the second part of such a possible research pathway.

Rhea Almeida proposed a framework of cultural equity to further the production of knowledge in what she calls liberation-based healing (Almeida et al. 2007). She defined healing as a second-order change in which individuals challenge, resist, and question the denigrating effects of privilege, power, and oppression in their own lives and the lives of others (Almeida 2013). The transmission of prejudice, discrimination, and denigration within the systemic stigmatization of fat people is possible in part because of the use of imagined lay persons—a cultural template of the fat individual. When experts and media imagine the position of lay persons, they also predetermine their competences and become the creators and originators of the laypersons they are set to care for (Maranta et al. 2003).

A fruitful way to go further would be to involve the concept of the imagined fat layman to the framework of cultural equity in narrative interviewing of not only fat individuals but also the creators and reinforcers of a failed and harmful knowledge paradigm. How are fat individuals narrated in the minds of knowledge creators and appliers? How does this connect to the idea of cultural equity? What are the “healing narratives” in the minds of fat individuals; how do these narratives shape their lives in the midst of a stigmatizing system, and how do they connect to the cultural equity framework? Such attention would be of special interest to a critical social work with one of its crucial tasks being to “help people understand the narratives that shape their lives” (Adlin Bosk 2013).

While this work highlighted the systemic stigmatization of fat people, the intention of an upcoming project would be to qualitatively elaborate the “silenced interpretations” (Boero 2013), the knowledge, the narratives, the art of the struggles that are missing in the public debate on fatness. A prioritized obesity science will continue to receive even more funding for finding solutions to the declared epidemic of fatness. These efforts have so far contributed to the stigmatization of fat people and should be met with advocacy from a social work discipline to assure that stereotyping, prejudice, and discrimination cannot hide behind a public health ideology that allows for moral distinctions between folks and folks. Making the imagined fat layman “real” could be liberating both to fat people themselves but also to those who, hopefully unknowingly, keep the stigmatizing system they reside in alive.

### 7.3 Closure

Regarding how human fatness is systemically responded to, we need to move toward more flexible, fair and including social welfare systems. I argue that implementing anti-stigmatizing techniques—and expect them to work—is impossible in a system that is already stigmatizing by its artifactual, second-order construction.

Some scholars would claim that the stigmatizing system “works” by discouraging people from considering becoming obese in the first place (Pulver 2008). Dargan Ware goes even further to propose that the policies toward the declared obesity epidemic *depend* on stigmatization and that a destigmatization would stand in clear conflict with these public health incentives (Ware 2013). In most Western societies, fatness provokes a stigmatizing response, making interventions extremely difficult to apply *without* engaging in arbitrary value judgments toward others seen to be making unacceptable lifestyle choices (Forhan & Ramos 2013; Merry & Voigt 2014). This said, is a destigmatization of fat people even desirable? If we aim to solve this social problem, we must inevitably put forward the crucial question of whether social change is what “we” really want. Because if governments, caring professionals, market stakeholders, the media, the public, and even the targeted individuals themselves believe that responding to their body composition with aversion is a necessary undertaking for the betterment of a future citizen, then all destigmatizing incentives, be they technical *or* orientational, will be in vain.

Let me finally recall the fact that, with a few exceptions, fat people are not yet protected under any law of anti-discrimination (O’Hara & Gregg 2012). This establishes a situation in which it is almost impossible for fat people to speak out against harmful treatments such as shaming, prejudice, discrimination, and ignorance regarding their physical and mental ability. Due to this lack of protection, harmful responses can pass as “health concerns,” while complaints against these concerns can be neglected as some kind of “offended identity” politics. Considering all this, I would suggest that the double-bind where fat people are systemically stigmatized and silenced at the same time, should be framed as a social problem of historic proportions.

## References

- Adlin Bosk A (2013) Between badness and sickness: reconsidering medicalization for high risk children and youth. *Children and Youth Services Review* 35: 1212-1218.
- Agee J (2009) Developing qualitative research questions: a reflective process. *International Journal of Qualitative Studies in Education* 22 (4): 431-447.
- Ahmed S (2004) Affective economies. *Social Text* 79 (22): 117-139.
- Albala K (2002) *Eating right in the Renaissance*. Berkeley: University of California Press.
- Alexander J (2003) *The meanings of social life: a cultural sociology*. Oxford: Oxford University Press.
- Allison DB (2011) Evidence, discourse and values in obesity-oriented policy: menu labeling as a conversation starter. *International Journal of Obesity* 35 (4): 464-471.
- Almeida R (2013) Cultural equity and the displacement of Othering. *Encyclopedia of Social Work* (1-22). Oxford: Oxford University Press.
- Almeida R, Dolan-Del Vecchio K and Parker L (2007) Foundation concepts for social justice-based therapy: critical consciousness, accountability, and empowerment. In E Aldarondo (Ed.), *Promoting social justice through mental health practice*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Alvesson M and Sköldböck K (2008) *Tolkning och reflektion. Vetenskapsfilosofi och kvalitativ metod*, 2 uppl. Lund: Studentlitteratur.
- Andreyeva T, Puhl RM and Brownell KD (2008) Changes in perceived weight discrimination among Americans, 1995-1996 through 2004-2006. *Obesity* 16: 1129-1134.
- Arborelius E (2001) *Varför gör dom inte som vi säger: teori och praktik om att påverka människors levnadsvanor*. Partille Upjohn AB.
- Ashmore JA, Friedman KE, Reichmann SK and Musante GJ (2008) Weight-based stigmatization, psychological distress, and binge eating behavior among obese treatment-seeking adults. *Eating Behavior* 9 (2): 203-209.
- Ayo N (2012) Understanding health promotion in a neoliberal climate and the making of health conscious citizens. *Critical Public Health* 22 (1): 99-105.
- Bacon L and Aphramor L (2011) Weight science: evaluating the evidence for a paradigm shift. *Nutrition Journal* 10 (9).
- Ballard K and Elston MA (2005) Medicalization: A multi-dimensional concept *Social Theory & Health* 3: 228-241.
- Barry CL, Brescoll VL, Brownell KD and Schlesinger M (2009) Obesity metaphors: how beliefs about the causes of obesity affect support for Public Policy. *The Milbank Quarterly* 87 (1): 7-47.
- Bateson G (1972) *Steps to an ecology of mind*. New York, NY: Ballantine Books.
- BBC News (2013) <http://www.bbc.co.uk/news/23011804> [2013-06-25]
- Beausoleil N (2009) An impossible task? Preventing disordered eating in the context of the current obesity panic. In J Wright and V Harwood (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies* (93-107). London and New York: Routledge.
- Beausoleil N and Ward P (2009) Fat panic in Canadian public health policy: obesity as different and unhealthy. *Radical Psychology* 8 (1).
- Beer S (1981) *Brain of the firm* (2nd Ed.). New York, NY: Wiley.

- Bell AV (2016) The margins of medicalization: Diversity and context through the case of infertility. *Social Science & Medicine* 156: 39-46.
- Berreby D (2013) The Obesity Era. <http://www.aeonmagazine.com> [2013-06-19]
- Best J (1990) *Threatened children: Rhetoric and concern about child-victims*. Chicago: University of Chicago Press.
- Betts M (2010) Doctors 'should tell overweight patients that they are fat' Herald Sun. <http://www.heraldsun.com.au/news/national/doctors-should-tell-overweight-patients-that-they-are-fat/story-e6frf716-1225898699043> [2012-12-01]
- Bhaskar R (2008) *A realist theory of science*. London & New York: Routledge.
- Blaikie N (2007) *Approaches to social enquiry* (2nd Ed.) Cambridge: Polity Press.
- Boero N (2013) Obesity in the media: social science weighs in. *Critical Public Health* 23 (3): 371–380.
- Boero N (2012) *Killer fat*. New Jersey: Rutgers University Press.
- Bogart WA (2013) Law as a tool in “The War on Obesity”: Useful interventions, maybe, but, first, what’s the problem? *The Journal of Law, Medicine & Ethics* 41 (1): 28-41.
- Borrell LN, Jacobs DR, Williams DR, Pletcher MJ, Houston TK and Kiefe CI (2007) Self-reported racial discrimination and substance use in the coronary artery risk development in adults study. *American Journal of Epidemiology* 166 (9): 1068-1079.
- Bos AER, Pryor JB, Reeder GD and Stutterheim SE (2013) Stigma: advances in theory and research. *Basic and Applied Social Psychology* 35: 1-9.
- Bowell T (2015) Feminist standpoint theory. *Internet Encyclopedia of Philosophy*. <http://www.iep.utm.edu/fem-stan/>[2016-04-17]
- Braithwaite J (1989) *Crime, shame and reintegration*. New York: Cambridge University Press.
- Brewis AA (2014) Stigma and the perpetuation of obesity. *Social Science and Medicine* 118: 152-158.
- Brown I (2006) Nurses’ attitudes towards adult patients who are obese: literature review. *Journal of Advanced Nursing* 53 (2): 221-232.
- Brown T (2011) School based interventions. In J Cawley (Ed.) *The Oxford Handbook of the Social Science of Obesity* (665-682). Oxford University Press.
- Bryant A and Charmaz K (Eds.) (2007) *The SAGE Handbook of Grounded Theory*. London: SAGE.
- Burris S (2008) Stigma, ethics and policy: a commentary on Bayer's “Stigma and the ethics of public health: Not can we but should we”. *Social Science of Medicine* 67: 473-475.
- Burrows L (2009) Pedagogizing families through obesity discourse. In J Wright and V Harwood (Eds.), *Biopolitics and the ‘obesity epidemic’: Governing bodies* (127-140). London and New York: Routledge.
- Börjeson B (2008) *Förstå socialt arbete*. Malmö: Liber.
- Callahan D (2013) Chasing an elusive epidemic. *Hastings Center Report* 43 (1): 34-40.
- Campos P (2004) *The obesity myth: why America’s obsession with weight is hazardous to your health*. New York, NY: Gotham.
- Canguilhem G (1989) *The normal and the pathological*. New York, NY: Zone Books.
- Cannella GS and Lincoln YS (2009) Deploying qualitative methods for critical social purposes. In NK Denzin and MD Giardina (Eds.), *Qualitative Enquiry and Social Justice* (53-80). CA, USA: Left Coast Press.
- Carden-Coyne A (2009) *Reconstructing the body: classicism, modernism, and the first world war*. Oxford: Oxford University Press.

- Carleheden M (2014) On Theorizing: C.S. Peirce and Contemporary Social Science. In Arto Laitinen et al. (Eds.), *Sisäisyys & suunnistautuminen: juhlakirja Jussi Kotkavirrälle* (428-459). Jyväskylän yliopisto: SoPhi 125.
- Carr D, Jaffe K J and Friedman MA (2008) Perceived Interpersonal Mistreatment Among Obese Americans: Do Race, Class, and Gender Matter? *Obesity* 16: 60-68.
- Carr D, Friedman MA and Jaffe K (2007) Understanding the relationship between obesity and negative and positive affect: The role of psychosocial mechanisms. *Body Image* 4 (2): 165-177.
- Carr D and Friedman MA (2006) Body weight and interpersonal relationships, *Social Psychology Quarterly* 69: 127-149.
- Carr D and Friedman MA (2005) Is Obesity Stigmatizing? Body Weight, Perceived Discrimination, and Psychological Well-Being in the United States. *Journal of Health and Social Behavior* 46: 244-259.
- Cawley J (Ed.) (2011) *The Oxford Handbook of the Social Science of Obesity*. Oxford: Oxford University Press.
- CDC (Centers for Disease Control and Prevention) (2014) Division of Nutrition, Physical Activity and Obesity. [http://www.cdc.gov/nccdphp/dnpao/\[2014-03-09\]](http://www.cdc.gov/nccdphp/dnpao/[2014-03-09])
- Chaloupka FJ (2011) Lessons for Obesity Policy from the Tobacco Wars. In J Cawley (Ed.), *The Oxford Handbook of the Social Science of Obesity* (620-638). Oxford: Oxford University Press.
- Chandon P and Wansink B (2007) The biasing health halos of fast-food restaurant health claims: lower calorie estimates and higher side-dish consumption intentions. *Journal of Consumer Research* 34 (3): 301-314.
- Charles JLK (2013) Mental Health Provider-Based Stigma: Understanding the Experience of Clients and Families, *Social Work in Mental Health* 11 (4): 360-375.
- Chen EY (2007) Depressed mood in class III obesity predicted by weight-related stigma. *Obesity Surgery* 17 (5): 669-671.
- Choi BCK, Pang T, Lin V, Puska P, Sherman G and Goddard M, Ackland MJ, Sainsbury P, Stachenko S, Morrison H and Clotey C (2005) Evidence based public policy and practice: Can scientists and policy makers work together? *Journal of Epidemiology and Community Health* 59: 632-637.
- Chong D and Druckman JN (2007) A theory of framing and opinion formation in competitive elite environments. *Journal of Communication* 57: 99-118.
- Clarke AE, Shim JK, Mamo L, Fosket JR and Fishman JR (2003) Biomedicalization: Technoscientific transformations of health, illness, and US biomedicine. *American Sociological Review* 68 (2): 161-194.
- Cobb N (2007) Governance through publicity: Anti-social behavior orders, young people, and the problematization of the right to anonymity. *Journal of Law and Society* 34 (3): 342-373.
- Cohen S (1993) Ethnography and popular music studies. *Popular Music* 12: 123-138.
- Conrad P (2007) *The Medicalization of Society: on the transformation of human conditions into treatable disorders*. Baltimore: John Hopkins University Press.
- Conrad P (2005) The Shifting Engines of Medicalization. *Journal of Health and Social Behavior* 46 (1): 3-14.
- Conrad P (1992) Medicalization and social control. *Annual Review of Sociology* 18: 209-32.
- Conrad P and Potter D (2000) From Hyperactive Children to ADHD Adults: Some Observations on the Expansion of Medical Categories. *Social Problems* 47 (4): 559-582.

- Conrad P and Schneider J (1992) *Deviance and Medicalization: From Badness to Sickness*. Philadelphia, Pennsylvania: Temple University Press.
- Cooper C (2009) Fat Activism in Ten Astonishing, Beguiling, Inspiring and Beautiful Episodes. In C Tomrley and A Kaloski Naylor. *FSUK: Fat Studies in the UK* (19-31). York: Raw Nerve Books.
- Corrigan P (Ed.) (2014) The Stigma of Disease and Disability: Understanding Causes and Overcoming Injustices. *PsycCRITIQUES* 59 (13), Article 1.
- Corrigan P and Lam C (2007) Challenging the structural discrimination of psychiatric disabilities: Lessons learned from the American disability community. *Rehabilitation Education* 21: 53-58.
- Corrigan P and Watson AC (2002) The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice* 9 (1): 35-53.
- Corrigan P, River LP, Lundin RK, Uphoff Wasowski K, Campion J, Mathisen J, Goldstein H, Bergman M, Gagnon C and Kubiak MA (2000) Stigmatizing attributions about mental illness. *Journal of Community Psychology* 28: 91-102.
- Coveney J (2000) *Food, Morals and Meaning: the Pleasure and Anxiety of Eating*. London and New York: Routledge.
- Crawford R (2006) Health as a meaningful social practice. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 10 (4): 401-420.
- Creswell JW (2007) *Qualitative inquiry & research design: Choosing among five approaches*, second edition. Thousand Oaks, CA: Sage Publications.
- Creswell JW (2003) *Research design: Qualitative, quantitative, and mixed method*, second edition. Thousand Oaks, CA: Sage Publications.
- Daigneault P-M (2013) Reassessing the concept of policy paradigm: aligning ontology and methodology in policy studies. *Journal of European Public Policy* 21 (3): 453-469.
- Danielsdottir S, O'Brien KS and Ciao A (2010) Anti-Fat Prejudice Reduction: A Review of Published Studies. *Obesity Facts* 3: 47-58.
- Daniels J and Schulz AJ (2006) Whiteness and the construction of health disparities. In L Mullings and AJ Schulz (Eds.), *Gender, race, class, and health* (89-127). San Francisco, CA: Jossey-Bass.
- Denzin NK and Lincoln YS (2000) *Handbook of Qualitative Research*. 2nd edition. Thousand Oaks, CA: Sage.
- Dew K (2012) *The Cult and Science of Public Health: A Sociological Investigation*. New York, NY: Berghahn Books.
- Dominelli L (2002) *Anti-oppressive social work theory and practice*. London, ENG: Palgrave.
- Domoff SE, Hinman NG, Koball AM, Storfer-Isser A, Carhart VL, Baik KD and Carels RA (2012) The Effects of Reality Television on Weight Bias: An Examination of the Biggest Loser. *Obesity* 20: 993-98.
- Dovidio JF, Major B and Crocker J (2000) Stigma: Introduction and overview. In TF Heatherton et al. (Eds.) *The social psychology of stigma* (1-28). New York: Guilford.
- Ebneter DS, Latner JD and O'Brian KS (2011) Just world beliefs, causal beliefs, and acquaintance: Associations with stigma toward eating disorders and obesity. *Personality and Individual Differences* 51: 618-622.
- Eck JE (2010) *Assessing Responses to Problems: An Introductory Guide for Police Problem-Solvers*. Center for Problem-Oriented Policing, Inc.

- Economus CD and Sliwa SA (2011) Community Interventions. In J Cawley (Ed.), *The Oxford Handbook of the Social Science of Obesity* (713-740). Oxford University Press.
- Edwards P and Roberts I (2009) Population adiposity and climate change. *International Journal of Epidemiology* 38: 1137-1140.
- Eisenberg ME, Neumark-Sztainer DR, Haines JI and Wall MM (2006) Weight-teasing and emotional wellbeing in adolescents: longitudinal findings from Project EAT. *Journal of Adolescent Health* 38: 675-683.
- Eisenberg MD, Neumark-Sztainer D and Story M (2003) Associations of Weight-Based Teasing and Emotional Well-Being among Adolescents. *Archives of Pediatrics and Adolescent Medicine* 157: 733-38.
- Ekman A (2012) *A Fat Life: An articulation of the weight order, based on fat people's experience*. Dissertation from Linköping University.
- Eknoyan G (2006) A History of Obesity, or How What Was Good Became Ugly and Then Bad. *ACKD* 13 (4): 421-427.
- Elbel B, Gyamfi J and Kersh R (2011) Child and adolescent fast-food choice and the influence of calorie labeling: A natural experiment. *International Journal of Obesity* 35: 493-500.
- Elbel B, Kersh R, Brescoll VL and Dixon LB (2009) Calorie labeling and food choices: A first look at the effects on low-income people in New York City. *Health Affairs* 28: 1110-1121.
- Eliassi B (2006) Diskriminerande föreställningar inom socialtjänsten [Discriminatory beliefs within the social service] In M. Kamali (Ed.), *Den segregrande integrationen. Om social sammanhållning och dess hinder [The segregating integration. On social cohesion and its obstacles]* (251-294). Stockholm, SE: Fritzes.
- Eller GM (2014) On Fat Oppression. *Kennedy Institute of Ethics Journal* 24 (3): 219-245.
- Evans B (2006) 'Gluttony or sloth': critical geographies of bodies and morality in (anti) obesity policy. *Area* 38: 259-267.
- Evans B and Colls R (2009) Measuring fatness, governing bodies: the spatialities of the body mass index (BMI) in anti-obesity politics. *Antipode* 41 (5): 1051-83.
- Fabricatore AN, Wadden TA and Foster GD (2005) Bias in health care settings. In RM Puhl et al. (Eds.), *Weight Bias: Nature, Consequences, and Remedies* (29-41). London: The Guildford Press.
- Faith MS, Leone MA, Ayers TS, Heo M and Pietrobelli A (2002) Weight criticism during physical activity, coping skills, and reported physical activity in children. *Pediatrics* 110: 23-31.
- Farrell AE (2011) *Fat shame: Stigma and the Fat Body in American Culture*. New York University Press.
- Farrugia D (2009) Exploring stigma: medical knowledge and the stigmatization of parents of children diagnosed with autism spectrum disorder. *Sociology of Health and Illness* 31 (7): 1011-1027.
- Fayet F, Petocz P and Samman S (2012) Prevalence and correlates of dieting in college women: A cross sectional study. *International Journal of Women's Health* 4 (1): 405-411.
- Feagin J and Bennefield Z (2014) Systemic racism and U.S. health care. *Social Science & Medicine* 103:7-14.
- Fikkan J and Rothblum ED (2005) Weight Bias in Employment. In KD Brownell, RM Puhl, MB Schwartz and L Rudd (Eds.), *Weight Bias: Nature, Consequences and Remedies* (15-28). New York: The Guilford Press.

- Finch JF, Okun MA, Pool GJ and Ruehlman LS (1999) A Comparison of the Influence of Conflictual and Supportive Social Interactions on Psychological Distress. *Journal of Personality* 67 (4).
- Finn JL (1994) The promise of participatory research. *The Journal of Progressive Human Services* 5: 25-42.
- Fish S and Hardy M (2015) Complex issues, complex solutions: applying complexity theory in social work practice. *Nordic Social Work Research* 5 (1): 98-114.
- Flegal KM, Carroll MD, Ogden CL and Johnson CL (2002) Prevalence and Trends in Obesity Among US Adults, 1999–2000. *JAMA* 288 (14): 1723-1727.
- Flegal KM, Kit BK, Orpana H and Graubard BI (2013) Association of all-Cause Mortality with Overweight and Obesity using Standard Body Mass Index Categories: A Systematic Review and Meta-Analysis. *JAMA* 309 (1): 71-82.
- Folkvord F, Anschutz DJ, Buijzen M and Valkenburg PM (2012) The effect of playing advergames that promote energy-dense snacks or fruit on actual food intake among children. *American Journal of Clinical Nutrition* 97 (2): 239-245.
- Fook J (2002) *Social work: critical theory and practice*. London: Sage.
- Forhan M and Ramos X (2013) Inequities in Healthcare: A Review of Bias and Discrimination in Obesity Treatment. *Canadian Journal of Diabetes* 37: 205-209.
- Forth CE (2015) On Fat and Fattening: Agency, Materiality and Animality in the History of Corpulence. *Body Politics* 3 (5): 51-74.
- Foucault M (2007) *Security, Territory, Population: Lectures at The Collège de France 1977–78*. Houndmills: Palgrave Macmillan
- Foucault M (1988) Technologies of the self. In LH Martin, H Gutman and PH Hutton (Eds.), *Technologies of the self*. Amherst: University of Massachusetts Press.
- Foxcroft L (2012) *Calories and corsets: a history of dieting over 2 000 years*. Profile Books.
- Freire P (1973) *Education for critical consciousness*. New York, NY: Seabury.
- Friedman JM (2004) Modern science versus the stigma of obesity. *Nature Medicine* 10: 563-569.
- Friedman KE, Ashmore JA and Applegate KL (2008) Recent experiences of weight-based stigmatization in a weight loss surgery population: psychological and behavioral correlates. *Obesity* (Silver Spring) 16 (Suppl. 2): 69-74.
- Friedman KE, Reichmann SK, Costanzo PR, Zelli A, Ashmore JA and Musante GJ (2005) Weight stigmatization and ideological beliefs: relation to psychological functioning in obese adults. *Obesity Research* 13 (5): 907-916.
- Fuller R (2006) *All rise. Somebodies, Nobodies and the Politics of Dignity*. San Francisco: Berrett-Koehler Publishers.
- Gard M and Wright J (2005) *The obesity epidemic: Science, morality, and ideology*. London and New York: Routledge.
- Gee GC, Ro A, Gavin A and Takeuchi DT (2008) Disentangling the effects of racial and weight discrimination on body mass index and obesity among Asian Americans. *American Journal of Public Health* 98 (3): 493-500.
- Geertz C (1973) *The interpretation of cultures: Selected essays*. New York: Basic Books.
- Geyer F (2002) The march of self-reference. *Kybernetes* 31 (7-8): 1021-42.
- Gilman SL (2010) *Obesity: The Biography*. Oxford University Press.
- Gilman SL (2008) *Fat: A Cultural History of Obesity*. Cambridge: Polity Press.
- Giroux H (2008) Hollywood film as public pedagogy: Education in the crossfire. *Afterimage* 35 (5): 7-13.

- Goetzel RZ, Kowlessar N, Chung Roemer E, Pei X et al. (2011) Workplace Obesity Prevention Programs. In J Cawley (Ed.), *The Oxford Handbook of the Social Science of Obesity* (683-712). Oxford University Press.
- Goffman E (1963) *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster.
- Goldberg DP (1972) *The detection of psychiatric illness by questionnaire: a technique for the identification and assessment of non-psychotic psychiatric illness*. London: Oxford University Press.
- Gracia-Arnaiz M (2010) Fat bodies and thin bodies. Cultural, biomedical and market discourses on obesity. *Appetite* 55 (2): 219-225.
- Grammarist (2015) Systematic vs Systemic. <http://grammarist.com/usage/systematic-systemic/> [2015-07-18]
- Greenhalgh T and Wessely S (2004) 'Health for me': a sociocultural analysis of healthism in the middle classes. *British Medical Bulletin* 69: 197-213.
- Gruber J and Trickett EJ (1987) Can we empower others? The paradox of empowerment in the governing of an alternative public school. *American Journal of Community Psychology* 15 (3): 353-371.
- Guba EG and Lincoln YS (1994) Competing paradigms in qualitative research. In NK Denzin and YS Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Gunderman RB (2013) "Is Obesity Really a Disease?" The Atlantic Online. <https://www.theatlantic.com/health/archive/2013/06/is-obesity-really-a-disease/277148/> [20163012]
- Guthman J (2016) Opening Up the Black Box of the Body in Geographical Obesity Research: Toward a Critical, Political Ecology of Fat. In M-P Kwan (Ed), *Geographies of Health, Disease, and Well-being* (65-71). London and New York: Routledge.
- Guthman J (2013) Fatuous measures: the artifactual construction of the obesity epidemic. *Critical Public Health* 23 (3): 263-273.
- Guthman J (2009) Teaching the politics of obesity: Insights into neoliberal embodiment and contemporary biopolitics. *Antipode* 41 (5): 1110-1133.
- Guthman J (2007) Fat Ontologies? Towards a political ecology of obesity. University of Berkeley. *Presented to Berkeley Environmental Politics Colloquium, March 9.*
- Hacking I (2006) The curse of the Western world: a history of obesity. Rear Vision ABC Radio National. <http://www.abc.net.au/radionational/programs/rearvision/the-curse-of-the-western-world-a-history-of-obesity/3352282> [2013-10-10]
- Hacking I (1999) *The social construction of what?* Harvard University Press.
- Hall P and Lamont M (2009) *Successful Societies. How Institutions and Culture Affect Health*. Cambridge University Press.
- Halse C (2009) Bio-Citizenship: Virtue discourses and the birth of the bio-citizen. In J Wright and V Harwood V (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies* (45-59). London: Routledge.
- Hansson LM, Naslund E and Rasmussen F (2010) Perceived discrimination among men and women with normal weight and obesity. A population-based study from Sweden. *Scandinavian Journal of Public Health* 38 (6): 587-596.
- Haraway D (1988) Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies* 14 (3): 575-599.

- Harding S (Ed.) (2004) *The Feminist Standpoint Theory Reader*. New York and London: Routledge.
- Harvey L (1990) *Critical Social Research*. London: Unwin Hyman/ Routledge.
- Harvey EL, Summerbell CD, Kirk SFL and Hill AJ (2002) Dietitians' views of overweight and obese people and reported management practices. *Journal of Human Nutrition and Dietetics* 15 (5): 331-347.
- Hatzenbuehler ML, Phelan JC and Link BG (2013) Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health* 103 (5): 813-821.
- Hatzenbuehler ML, Keyes KM and Hasin DS (2009) Associations between perceived weight discrimination and the prevalence of psychiatric disorders in the general population. *Obesity* 17 (11): 2033-2039.
- Hayden-Wade HA, Stein RI, Ghaderi A, Saelens BE, Zabinski MF and Wilfley DE (2005) Prevalence, characteristics, and correlates of teasing experiences among obese vs. non-obese peers. *Obesity Research* 13: 1381-1392.
- Hebl M, King EB and Perkins A (2009) Ethnic differences in the stigma of obesity: Identification and engagement with a thin ideal. *Journal of Experimental Social Psychology* 45 (6): 1165-1172.
- Hebl MR and Mannix LM (2003) The weight of obesity in evaluating others: a mere proximity effect. *Personality and Social Psychology Bulletin* 29 (1): 28-38.
- Hebl MR, Xu J and Mason MF (2003) Weighing the care: Patients' perceptions of physician care as a function of gender and weight. *International Journal of Obesity Related Metabolic Disorders* 27: 269-275.
- Herek GM (2007) Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues* 63: 905-925.
- Herman CP and Polivy J (2011) The self-regulation of eating: Theoretical and practical problems. In KD Vohs and RF Baumeister (Eds.), *Handbook of self-regulation: Research, theory, and applications* (2nd Ed., 522-536). New York: Guilford.
- Hertz M (2016) *Levande social arbete: vardagsliv, sörjbarhet och sociala orättvisor*. Stockholm: Liber förlag.
- Hilbert A and Ried J (2009) Obesity in print: an analysis of daily newspapers. *Obesity Facts* 2: 46-51.
- Hilgartner S and Bosk CL (1988) 'The rise and fall of social problems: a public arenas model. *The American Journal of Sociology* 94 (1): 53-78.
- Himes SM and Thompson JK (2007) Fat stigmatization in television shows and movies: a content analysis. *Obesity* (Silver Spring) 15 (3): 712-718.
- Hinshaw SP (2010) *The mark of shame: Stigma of mental illness and an agenda for change*. Oxford University Press.
- HM Government (2011) No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213761/dh\\_124058.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf) [2016-11-07]
- Holmes GE and Saleebey D (1993) Empowerment, the medical model and the politics of clienthood. *Journal of Progressive Human Services* 4 (1): 61-78.
- Hooks b (1984) *From Margin to Center*, Boston: South End Press.
- Ikeda J, Lyons P, Schwartzman F and Mitchell R (2004) Self-Reported Dieting of Women with Body Mass Indexes of 30 or More. *Journal of the American Dietetic Association* 104: 972-974.

- Ippolito PM (2011) Regulation of Food Advertising. In J Cawley (Ed.), *The Oxford Handbook of the Social Science of Obesity* (741-751). Oxford University Press.
- Jansen T, Chioncel N and Dekkers H (2006) Social cohesion and integration: Learning active citizenship. *British Journal of Sociology of Education* 27 (2): 189-205.
- Jasanoff S (2004) *States of Knowledge: The Co-production of Science and Social Order*. London: Routledge.
- Júlíusdóttir Sigrún (2006) The Emerging Paradigm Shift in Social Work. *Social Work & Society* 4 (1): 38-52.
- Jutel A (2001) Does size really matter? Weight and values in public health. *Perspectives in Biology and Medicine* 44: 283-296.
- Järvinen M (2013) Ett maktperspektiv på mötet mellan klient och system. In A Meeuwisse and H Swärd (Eds.) *Perspektiv på sociala problem* (281-297). Stockholm: Natur och Kultur.
- Kira IA, Lewandowski L, Ashby JS, Templin T, Ramaswamy V and Mohanesh J (2014) The Traumatogenic Dynamics of Internalized Stigma of Mental Illness Among Arab American, Muslim, and Refugee Clients. *Journal of the American Psychiatric Nurses Association* 20 (4): 250-266.
- Knorr-Cetina K (1981) *The Manufacture of Knowledge: an Essay on the Constructivist and Contextual Nature of Science*. Oxford: Pergamon Press.
- Komesaroff P and Thomas S (2007) Combating the obesity epidemic: Cultural problems demand cultural solutions. *Internal Medicine Journal* 37 (5): 287-289.
- Krippendorff K (2003) *Content Analysis: An Introduction to its Methodology*. London: Sage.
- Krippendorff K (1989) Content analysis. In E Barnouw et al. (Eds.) *International encyclopedia of communication* (Vol. 1: 403-407). Oxford University Press.
- Kuczmarski RJ and Flegal KM (2000) Criteria for Definition of Overweight in Transition: Background and Recommendations for the United States. *American Journal of Clinical Nutrition* 72 (5): 1074-1091.
- Kvaale EP, Haslam N and Gottdiener WH (2013) The 'side effects' of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. *Clinical Psychology Review* 33: 782-794.
- Latner J, O'Brien KS, Durso LE, Brinkman LA and MacDonald T (2008) Weighing obesity stigma: relative strength of different targets of bias. *International Journal of Obesity* 32: 1145-1152.
- Latner JD and Stunkard AJ (2003) Getting Worse: The Stigmatization of Obese Children. *Obesity Research* 11: 452-456.
- Lawrence SA, Hazlett R and Abel EM (2012) Obesity Related Stigma as a Form of Oppression: Implications for Social Work Education. *Social Work Education: The International Journal* 31 (1): 63-74.
- Leach Scully J (2004) What is a disease? Disease, disability and their definitions. *EMBO reports* 5 (7): 650-653.
- LeBesco K (2010) Fat panic and the new morality. In J Metzel and A Kirkland (Eds.), *Against Health: How Health Became the New Morality* (72-82). New York University Press.
- Leppänen V and Linné S (2007) Överviktens betydelse. *Sociologisk forskning* 1: 7-24.
- Lewis S, Thomas SL, Blood W, Castled DJ, Hydee J and Komesaroff PA (2011) How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A qualitative study. *Social Science & Medicine* 73: 1349-1356.

- Lewis S, Thomas SL, Hyde J, Castle D, Blood RW and Komesaroff PA (2010) 'I don't eat a hamburger and large chips every day!' A qualitative study of the impact of public health messages about obesity on obese adults. *BMC Public Health* 10: 309.
- Lewis T (2008) Changing rooms, biggest losers and backyard blitzes: A history of makeover television in the United Kingdom, United States and Australia. *Continuum: Journal of Media & Cultural Studies* 22 (4): 447-58.
- Leydesdorff L (2011) "Meaning" as a sociological concept: A review of the modeling, mapping, and simulation of the communication of knowledge and meaning. <http://www.leydesdorff.net> [20160907]
- Liebman B (2001) Defensive Eating. *Nutrition Action Health Letter* 28 (10): 7.
- Lincoln YS and Cannella GS (2004) Dangerous discourses: Methodological conservatism and governmental regimes of truth (Special issue). *Qualitative Inquiry* 10: 5-14.
- Lincoln YS and Guba E (1985) *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Link BG, Yang LH, Phelan JC and Collins PY (2004) Measuring mental illness stigma. *Schizophrenia Bulletin* 30 (3): 511-541.
- Link BG and Phelan JC (2001) Conceptualizing stigma. *Annual Review of Sociology* 27: 363-385.
- Livingstone JD and Boyd JE (2010) Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine* 71: 2150-2161.
- Luhmann N (1995) *Social Systems*. Stanford University Press.
- MacLean L, Edwards N, Garrard M, Sims-Jones N, Clinton K and Ashley L (2009) Obesity, stigma, and public health planning. *Health Promotion International* 24 (1): 88-93.
- Maguire T and Haslam D (2010) *The Obesity Epidemic and its Management*. London: Pharmaceutical Press.
- Malterud K and Ulriksen K (2010) Norwegians fear fatness more than anything else – a qualitative study of normative newspaper messages on obesity and health. *Patient Education and Counseling* 81 (1): 47-52.
- Mann T, Tomikaya AJ, Westling E, Lew AM, Samuels B and Chatman J (2007) Medicare's search for effective obesity treatments: Diets are not the answer. *American Psychologist* 62 (3): 220-233.
- Maranta A, Guggenheim M, Gisler P and Pohl C (2003) The Reality of Experts and the Imagined Lay Person. *Acta Sociologica* 46: 150.
- Markell P (2003) *Bound by recognition*. Princeton, N.J.: Princeton University Press.
- Marmot M (2005) *The Status Syndrome: How Social Standing Affects our Health and Longevity*. New York, NY: Henry Holt & Company.
- Mayoh J and Onwuegbuzie AJ (2015) Toward a Conceptualization of Mixed Methods Phenomenological Research. *Journal of Mixed Methods Research* 9 (1): 91-100.
- McKinnon RA, Orleans CT, Kumanyika SK, Haire-Joshu D, Krebs-Smith SM, Finkelstein EA, Brownell KD, Thompson JW and Ballard-Barbash R (2009) Considerations for an Obesity Policy Research Agenda. *American Journal of Preventive Medicine* 36 (4): 351-357.
- McPhail D (2009) What to do with the 'Tubby Hubby'? 'Obesity,' the Crisis of Masculinity, and the Nuclear Family in Early Cold War Canada. *Antipode* 41 (5): 1021-1050.
- McRobbie A (1991) *Feminism and youth culture: From 'Jackie' to 'Just Seventeen'*. Basingstoke: Macmillan.

- Medin J och Alexanderson K (2000) *Begreppen hälsa och hälsofrämjande – en litteraturstudie* (The concept of health and health promotion – a literature review). Lund: Studentlitteratur.
- Meeuwisse A and Swärd H (2013) *Perspektiv på sociala problem*. Andra upplagan. Stockholm: Natur och Kultur.
- Mehta NK and Chang VW (2011) Secular Declines in the Association Between Obesity and Mortality in the United States. *Population and development review* 37 (3): 435.
- Merry MS and Voigt K (2014) Risk, harm and intervention: the case of child obesity. *Medical Health Care and Philosophy* 17 (2): 191-200.
- Mertens DM (2011) Mixed methods as tools for social change. *Journal of Mixed Methods Research* 5 (3): 195-197.
- Metzl J (2006) "Against Health: Resisting the Invisible Morality." Presented at a conference in Ann Arbor October 2006: <http://irwg.research.umich.edu/againsthealth/speakers.html> [2015-09-10]
- Mik-Meyer N (2016) Othering, ableism and disability: A discursive analysis of co-workers' construction of colleagues with visible impairments. *Human Relations* 69 (6): 1-23.
- Miller DP, Spangler JD, Vitolins MZ, Davis SW, Ip EH, Marion GS and Crandall SJ (2013) Are medical students aware of their anti-obesity bias? *Academic Medicine* 88 (7): 978-982.
- Misheva V (2000) *Shame and guilt: Sociology as a poietic system*. Uppsala: Acta Universitatis Upsaliensis.
- Monaghan LE (2008) Men, physical activity and the obesity discourse: Critical understandings from a qualitative study. *Sociology of Sport Journal* 25 (1): 97-129.
- Monaghan LE (2007) Body Mass Index, masculinities and moral worth: Men's critical talk about 'appropriate' weight-for-height. *Sociology of Health & Illness* 29 (4): 584-609.
- Monaghan LE, Colls R and Evans B (2013) Obesity discourse and fat politics: research, critique and interventions. *Critical Public Health* 23 (3): 249-262.
- Monaghan LE, Hollands R and Pritchard G (2010) Obesity Epidemic Entrepreneurs: Types, Practices and Interests. *Body & Society* 16 (2): 37-71.
- Muennig P (2008) The Body Politic: The Relationship between Stigma and Obesity- Associated Disease. *BMC Public Health* 8: 128-38.
- Myers MD and Klein HK (2011) A set of principles for conducting critical research in information systems. *MIS Quarterly* 35 (1): 17-36.
- NBHW (2010) National Board of Health and Welfare: 'Nationella riktlinjer för sjukdomsförebyggande metoder...'. Article nr. 2010-10-15. [www.socialstyrelsen.se](http://www.socialstyrelsen.se) [2011-03-19]
- Nicholls S (2013) Standards and classification: A perspective on the 'obesity epidemic'. *Social Science and Medicine* 87: 9-15.
- Office of the Surgeon General (2001) Call to Action to Prevent and Decrease Overweight and Obesity. <http://www.surgeongeneral.gov/topics/obesity/index.htm> [2009-05-05]
- Ogden J and Flanagan Z (2008) Beliefs about the causes and solutions to obesity: A comparison of GPs and lay people. *Patient Education and Counseling* 71 (1): 72-78.
- O'Hara L and Gregg J (2012) Human Rights Casualties from the "War on Obesity": Why Focusing on Body Weight Is Inconsistent with a Human Rights Approach to Health. *Fat Studies: An Interdisciplinary Journal of Body Weight and Society* 1 (1): 32-46.
- Oliver JE (2006) *Fat Politics: The Real Story behind America's Obesity Epidemic*. Oxford University Press.

- Padwal RS, Wang X and Sharma AM (2012) The impact of severe obesity on post-acute rehabilitation efficiency, length of stay and hospital costs. *Journal of Obesity* 2012: 972365.
- Paluck EL and Green DP (2009) Prejudice reduction: what works? A review and assessment of research and practice. *Annual Review of Psychology* 60: 339-367.
- Parham ES (2013) Meanings of Weight among Dietitians and Nutritionists. In J Sobal and D Maurer (Eds.), *Weighty Issues: Fatness and Thinness as Social Problems* (183-205). London: Aldine Transaction.
- Parker R and Aggleton P (2003) HIV and AIDS related stigma and discrimination: a conceptual framework and implications for action. *Social Science and Medicine* 57 (1): 13-24.
- Parsons T (1951) *The Social System*. New York, NY: Free Press.
- Payne M (2011) *Humanistic social work: core principles in practice*. Chicago, IL: Lyceum Books.
- Penny H and Haddock G (2006) Anti-fat prejudice among children: the “mere proximity” effect in 5–10 year olds. *Journal of Experimental Social Psychology* 43: 678-683.
- Peretti J (2013) Fat profits: how the food industry cashed in on obesity. *The Guardian*, Aug 7.
- Perspectives in Public Health (2014) 1 November 2014 Vol 134 No 6.
- Phelan JC, Link BG and Dovidio JF (2008) Stigma and prejudice: One animal or two? *Social Science and Medicine* 67: 358-367.
- Phillipov M (2013) In Defense of Textual Analysis: Resisting Methodological Hegemony in Media and Cultural Studies. *Critical Studies in Media Communication* 30 (3): 209-223.
- Porta M (2008) *A Dictionary of Epidemiology*. Oxford University Press.
- Powell LM and Chiqui JF (2011) Food Taxes and Subsidies: Evidence and Policies for Obesity Prevention. In J Cawley (Ed.), *The Oxford Handbook of the Social Science of Obesity* (639-664). Oxford University Press.
- Pryor JB and Reeder GD (2011) HIV-related stigma. In JC Hall et al. (Eds.) *HIV/AIDS in the Post-HAART Era: manifestations, treatment, and Epidemiology* (790-806). Shelton, CT: PMPH-USA.
- Puhl RM (2011) Bias, Stigma and Discrimination. In J Cawley (Ed.), *The Oxford Handbook of the Social Science of Obesity* (553-571). Oxford University Press.
- Puhl RM, Latner JD, O’Brien KS, Luedicke J, Danielsdottir S and Ramos Salas X (2015) Potential Policies and Laws to Prohibit Weight Discrimination: Public Views from 4 Countries. *The Milbank Quarterly* 93 (4): 691-731.
- Puhl RM, Brownell KD and DePierre JA (2014) Bias, Discrimination and obesity. In GA Bray and C Bouchard (Eds.), *Handbook of Obesity: Epidemiology, Etiology and Physiopathology* (461-470). Boca Raton, FL: CRC Press.
- Puhl R, Luedicke J and Peterson JL (2013) Public Reactions to Obesity-Related Health Campaigns. A Randomized Controlled Trial. *American Journal of Preventive Medicine* 45 (1): 36-48.
- Puhl RM and Heuer CA (2010) Obesity stigma: Important considerations for public health. *American Journal of Public Health* 100: 1019-1028.
- Puhl RM and Heuer CA (2009) The Stigma of Obesity: A Review and Update. *Obesity* 17: 941-964.
- Puhl RM, Andreyeva T and Brownell KD (2008) Perceptions of weight discrimination: Prevalence and comparison to race and gender discrimination in America. *International Journal of Obesity* 32: 992-1000.

- Puhl RM and Latner JD (2007) Stigma, obesity, and the health of nation's children. *Psychological Bulletin* 133: 557-580.
- Puhl RM and Brownell KD (2006) Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Individuals. *Obesity* 14: 1802-15.
- Puhl RM and Brownell KD (2003) Psychosocial origins of obesity stigma: toward changing a powerful and pervasive bias. *Obesity Reviews* 4: 213-227.
- Pulver AR (2008) An imperfect fit: Obesity, public health, and disability antidiscrimination law. *Columbia Journal of Law and Social Problems* 41 (3): 365-415.
- Quiroga SS (2007) Blood is thicker than water: Policing donor insemination and the reproduction of whiteness. *Hypatia* 22 (2): 143-161.
- Rail G, Holmes D and Murray SJ (2010) The politics of evidence on 'domestic terrorists': Obesity discourses and their effects. *Social Theory and Health* 8: 259-279.
- Raphael D (2004) *Social determinants of health: Canadian perspectives*. Toronto: Canadian Scholar's Press.
- Raphael D and Bryant T (2002) The limitations of population health as a model for a new public policy. *Health Promotion International* 17 (2): 189-199.
- Ratcliffe D and Ellison N (2015) Obesity and Internalized Weight Stigma: A Formulation Model for an Emerging Psychological Problem. *Behavioral, Cognitive Psychotherapy* 43 (2): 239-252.
- Rathcliff D and Ellison N (2013) Obesity and Internalized Weight Stigma: A Formulation Model for an Emerging Psychological Problem. *Behavioral and Cognitive Psychotherapy/FirstView*: 1-14.
- Reis HT, Sheldon KM, Gable SL, Roscoe R and Ryan R (2000) Daily well-being: The role of autonomy, competence, and relatedness. *Personality and Social Psychology Bulletin* 26: 419-435.
- Rice C (2007) Becoming the fat girl: Acquisition of an unfit identity. *Women's Studies International* 30: 158-174.
- Rich E and Evans J (2005) 'Fat ethics'—the obesity discourse and body politics. *Social Theory and Health* 3 (4): 341-358.
- Rich E, Holroyd R, and Evans J (2004) Hungry to Be Noticed: Young Women, Anorexia and Schooling. In: J Evans, B Davies and J Wright (Eds.), *Body Knowledge and Control: Studies in the Sociology of Physical Education and Health* (173-190). London and New York: Routledge.
- Roberto CA and Brownell KD (2011) The Imperative of Changing Public Policy to Address Obesity. In J Cawley (Ed.), *The Oxford Handbook of the Social Science of Obesity* (587-608). Oxford University Press.
- Robinson BE and Bacon JG (1996) The 'If Only I Were Thin..' Treatment Program: decreasing the stigmatizing effects of fatness. *Professional Psychological Research Practice* 27: 175-183.
- Roehling MV, Roehling PV and Pichler S (2007) The relationship between body weight and perceived weight-related employment discrimination: The role of sex and race. *Journal of Vocational Behavior* 71: 300-318.
- Rose N (2009) Normality and pathology in a biomedical age. *The Sociological Review* 57: 66-83.
- Rose N (1999) *Powers of Freedom: Reframing Political Thought*. Cambridge University Press.
- Rosenberg CE and Golden J (Eds.) (1997) *Framing Disease: Studies in Cultural History*. New Jersey: Rutgers University Press.

- Rouse J (2009) Standpoint Theories Reconsidered. *Hypatia* 24 (4): 200-209.
- Sandberg H (2004) *Medier och fetma: en analys av vikt*. Lund Studies in Media and Communication 8. Lund University.
- Scambler G (2004) Re-framing stigma: felt and enacted stigma and challenges to the sociology of chronic and disabling conditions, *Social Theory and Health* 2 (1): 29-46.
- Schoenfeldt MC (1999) *Bodies and Selves in Early Modern England: Physiology and Inwardness in Spencer, Shakespeare, Herbert and Milton*. Cambridge University Press.
- Schvey N, Puhl RM and Brownell KD (2011) The impact of weight stigma on caloric consumption. *Obesity* 19 (10): 1957-62.
- Schwartz MB, Chambliss HO, Brownell KD, Blair SN and Billington C (2003) Weight bias among health professionals specializing in obesity. *Obesity Research* 11: 1033-1039.
- Shakespeare T, Watson N and Abu Alghaib O (2016) Blaming the victim, all over again: Waddell and Aylward's biopsychosocial (BPS) model of disability. *Critical Social Policy*, May 26.
- Shannon P (2013) Value-Based Social Work Research: Strategies for Connecting Research to the Mission of Social Work. *Critical Social Work* 14: 1.
- Sharma S, Wharton S, Forhan M and Kuk JL (2011) Influence of weight discrimination on weight loss goals and self-selected weight loss interventions. *Clinical Obesity* 1: 153-60.
- Shaw I and Woodward L (2004) The Medicalization of Unhappiness? The Management of Mental Distress in Primary Care. In I Shaw and K Kauppinen Aldershot (Eds.) *Constructions of Health and Illness: European Perspectives* (125-138). United Kingdom: Ashgate Press.
- Shotter J (2009) Bateson, Double Description, Todes, and Embodiment: Preparing Activities and Their Relation to Abduction. *Journal for the Theory of Social Behaviour* 39 (2): 219-245.
- Shugart HA (2011) Shifting the Balance: The Contemporary Narrative of Obesity. *Health Communication* 26 (1): 37-47.
- Sikorski C, Luppá M, Kaiser M, Glaesmer H, Schomerus G, König HH and Riedel-Heller SG (2011) The stigma of obesity in the general public and its implications for public health - a systematic review. *BMC Public Health* 11: 661.
- Sin S (2010) Considerations of Quality in Phenomenographic Research. *International Journal of Qualitative Methods* 9 (4).
- Smith MC (2009) Obesity as a social problem in the United States: application of the public arenas model. *Policy, Politics, and Nursing Practice* 10 (2): 134-142.
- Sobal J and Maurer D (Eds.) (2013) *Weighty Issues: Fatness and Thinness as Social Problems*. London: Aldine Transaction.
- Socialstyrelsen (2014) [http://www.1177.se/Stockholm/Fakta- och-rad/ Sjukdomar/Fetma/](http://www.1177.se/Stockholm/Fakta-och-rad/Sjukdomar/Fetma/) [2014-12-19]
- Solheim IH (2013) *Identitet, kropp og hverdagsliv i et folkelig perspektiv : og erfaringskunnskapens plass innen folkehelseetnkningen*. Dissertation from Karlstad University Press.
- Sorde Marti T and Mertens DM (2014) Mixed Methods Research With Groups at Risk. New Developments and Key Debates. *Journal of Mixed Methods Research* 8 (3): 207-211.
- Starky S (2005) *The obesity epidemic in Canada*. Ottawa: Library of Parliament.
- Stoner L and Cornwall J (2014) Did the American Medical Association make the correct decision classifying obesity as a disease? *American Medical Journal* 7 (11): 462-464.
- Strandmark M (2006) Health means vital force – a phenomenological study on self-image, ability and zest for life. *Vård i Norden* 79 (26:1): 42-7.

- Swedberg R (2012) Theorizing in sociology and social science: turning to the context of discovery. *Theory and Society* 41: 1-40.
- Swift JA, Hanlon S, El-Redy L, Puhl RM and Glazebrook C (2013) Weight bias among UK trainee dietitians, doctors, nurses and nutritionists. *Journal of Human Nutrition and Dietetics* 26 (4): 395-402.
- Syme SL (2004) Social Determinants of Health: The Community as an Empowered Partner. *Public Health Research and Practice Policy* 1 (1): 1-5.
- Symonds JE and Gorard S (2008) The Death of Mixed Methods: Research Labels and their Casualties. The British Educational Research Association Annual Conference, Heriot Watt University, Edinburgh, September 3-6.
- Szwarc S (2004–2005) Putting facts over fears: examining childhood anti-obesity initiatives. *International Quarterly of Community Health Education* 23: 97-116.
- Takahashi H and Mori M (2013) Characteristics and significance of criteria for obesity disease in Japan 2011. *Japanese Journal of Clinical Medicine* 71 (2): 257-261.
- Teater B (2014) *An introduction to applying social work theories and methods*, Second Edition. Berkshire: Open University press, McGraw-Hill Education.
- ten Have M, de Beaufort ID, Texeira PJ, Machenbach JP and van der Heide A (2011) Ethics and prevention of overweight and obesity: an inventory. *Obesity reviews* 12: 669-679.
- ten Have M, de Beaufort I and Holm S (2010) No Country for fat children? Ethical questions concerning community-based programs. In E Waters, B Swinburn, J Siedel and R Uauy (Eds), *Preventing childhood obesity: Evidence policy and practice* (31-39). Oxford: Blackwell.
- Thomas SL, Hyde J, Karunaratne A, Herbert D and Komesaroff PA (2008) Being fat in today's world: a qualitative study of the lived experiences of people with obesity in Australia. *Health Expectations* 11: 321-330.
- Thomas SL, Lewis S, Hyde J, Castle D and Komesaroff P (2010) The solution needs to be complex. 'Obese adults' attitudes about the effectiveness of individual and population based interventions for obesity. *BMC Public Health* 10: 420.
- Thomson DM (2007) Spectacular decapitations: The body politics of shaming fat with personal responsibility. Paper presented at the annual meeting of the NCA 93rd Annual Convention, TBA, Chicago, IL, 15 November. [http://www.allacademic.com/meta/p191218\\_index.html](http://www.allacademic.com/meta/p191218_index.html). [2011-05-17]
- Thompson L and Kumar A (2011) Responses to health promotion campaigns: resistance, denial and Othering. *Critical Public Health* 21 (1): 105-117.
- Thornicroft G (2006) *Shunned: Discrimination against People with Mental Illness*. Oxford University Press.
- Thornicroft G, Rose D, Kassam A and Sartorius N (2007) Stigma: ignorance, prejudice or discrimination? *British Journal of Psychiatry* 190: 192-193.
- Throsby K (2007) 'How could you let yourself get like that?' Stories of the origins of obesity in accounts of weight loss surgery. *Social Science and Medicine* 65: 1561-1571.
- Tischner I and Malson H (2012) Deconstructing Health and the Un/Healthy Fat Woman. *Journal of Community & Applied Social Psychology* 22: 50-62.
- Townend L (2009) The moralizing of obesity: A new name for an old sin? *Critical Social Policy* 29: 171.
- Triggle N (2010) NHS should use the term fat instead of obese, says minister, BBC news. <http://www.bbc.co.uk/news/uk-10789553> [2012-12-01]

- Truong K and Sturm R (2011) Schooling and Human Capital. In J Cawley (Ed.), *The Oxford Handbook of the Social Science of Obesity* (517-530). Oxford University Press.
- Tsenkova VK, Carr D, Schoeller DA and Ryff CD (2011) Perceived Weight Discrimination Amplifies the Link Between Central Adiposity and Nondiabetic Glycemic Control (HbA1c). *Annual Behavioural Medicine* 41: 243-251.
- Ture K and Hamilton C (1967) *Black power*. New York: Random House.
- Ulrich W (2000) Reflective practice in the civil society: the contribution of critically systemic thinking. *Reflective Practice* 1 (2): 247-268.
- Urban LE, Dallal GE, Robinson LM, Ausman LM, Saltzman E and Roberts SB (2010) The accuracy of stated energy contents of reduced-energy, commercially prepared foods. *Journal of the American Dietetic Association* 110: 116-123.
- Vaidya V (2006) Psychosocial aspects of obesity. *Advances in Psychosomatic Medicine* 27: 73-85.
- Vartanian LR and Smyth JM (2013) Primum Non Nocere: Obesity Stigma and Public Health. *Journal of Bioethical Inquiry* 10 (1): 49-57.
- Walls HL, Peeters A, Proietto J and McNeil JJ (2011) Public Health Campaigns and Obesity - A Critique. *BMC Public Health* 11: 136.
- Wang S and Brownell KD (2005) Public Policy and Obesity: The Need to Marry Science with Advocacy. *Psychiatric Clinics of North America* 28: 235-252.
- Wansink B, Just DR, Cawley J, et al. (2016) From Coke to Coors: a field study of a sugar-sweetened beverage tax and its unintended consequences.  
<http://dx.doi.org/10.2139/ssrn.2079840> [20161212]
- Ware D (2013) Against the weight of authority: can courts solve the problem of size discrimination? *Alabama Law Review* 64 (5): 1175-1214.
- Warin M (2011) Foucault's progeny: Jamie Oliver and the art of governing obesity. *Social Theory and Health* 9 (1): 24-40.
- Watzlawick P (1990) Reality adaptation or adapted `reality'? Constructivism and Psychotherapy. In P Watzlawick (Ed.), *Münchhausen's Pigtail: Or Psychotherapy and `reality' Essays and Lectures*. New York, NY: WW Norton & Co.
- Watzlawick P, Weakland JH and Fisch R (1974) *Change: Principles of problem formation and problem resolution*. Oxford UK: WW Norton.
- Warschburger P (2005) The unhappy obese child. *International Journal of Obesity* 29 (2): 127-129.
- Webb H (2009) *Doctor-patient interactions during medical consultations about obesity*. University of Nottingham: Thesis for the degree of Doctor of Philosophy.
- Werle COC and Cuny C (2012) The boomerang effect of mandatory sanitary messages to prevent obesity. *Marketing Letters* 23 (3): 883-891.
- Whitehead K and Kurz T (2008) Saints, sinners and standards of femininity: discursive constructions of anorexia nervosa and obesity in women's magazines. *Journal of Gender Studies* 17 (4): 345-358.
- WHO (2017) Overweight and Obesity.  
<http://www.who.int/mediacentre/factsheets/fs311/en/index.html> [2017-01-07]
- WHO (2014) Controlling the global obesity epidemic.  
<http://www.who.int/nutrition/topics/obesity/en/> [2017-08-30]
- WHO (1999) Health 21 – health for all in the 21st century. Copenhagen: World Health Organisation Regional Offices for Europe.

- Windahl S and Signitzer B (1992) *Using Communication Theory. An Introduction to Planned Communication*. London: Sage.
- Witkin S (2014) Change and Deeper Change: Transforming Social Work Education. *Journal of Social Work Education* 50: 587-598.
- Wood H and Skeggs B (2008) Spectacular morality: Reality Television, individualization and the remaking of the working class. In D Hesmondhalgh and J Toynbee (Eds.) *The Media and Social Theory* (177-193). London: Routledge.
- Wright J (2000) Disciplining the body: Power, knowledge, and subjectivity in a physical education lesson. In A Lee and C Poynton (Eds.) *Culture and text: Social research and cultural studies* (152-169). Sydney: Allen and Unwin.
- Wright J and Dean R (2007) A balancing act: Problematizing prescriptions about food and weight in school health texts. *Utbildning och Demokrati* 16 (2): 75-94.
- Yang LH, Kleinman A, Link BG, Phelan JC, Lee S and Good B (2007) Culture and Stigma: Adding moral experience to stigma theory. *Social Science & Medicine* 64: 1524-1535.
- Zerubavel E (1997) *Social Mindscapes: an invitation to cognitive sociology*. London: Harvard University Press.
- Zola IK (1966) Culture and symptoms: An analysis of patients presenting complaints. *American Sociological Review* 3: 615-630.



## A systemic stigmatization of fat people

There are social groups in society that are categorically connected, for example by their physical, cultural or psychological markers. For political, or moral, reasons, some of these groups seem to trigger special attention in form of forceful response processes at several societal levels. This is the case with the contemporary ‘obesity epidemic’ phenomenon; postulated by the World Health Organization as one of the most severe threats to the health of future mankind. One of the downsides with such special attention is that the fat individuals find themselves caught up in seemingly unavoidable processes of devaluation.

Instead of investigating the catastrophic (well-known) psycho-social consequences of these individuals, this work focuses on connecting the devaluing processes that form a systemic stigmatization of fat individuals. From this critical perspective, it is argued that the pervasive stigmatization of fat people is not an unfortunate consequence of structural norms that passively exclude its ‘non-fits’, but an intelligible outcome of a highly active set of processes that continuously construct and re-construct a historical aversion towards fat people.

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