Author pre-print version, there may be minor changes in the final version

Williams, O. and Annandale, E. (2018). Obesity, stigma and reflexive embodiment: *feeling* the 'weight' of expectation. *Health : An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*. doi: 10.1177/1363459318812007

See: https://journals.sagepub.com/doi/abs/10.1177/1363459318812007

Title

Obesity, Stigma and Reflexive Embodiment: *Feeling* the 'Weight' of Expectation

Authors

First Author: Oli Williams

Affiliation: University of Leicester and NIHR CLAHRC East Midlands

Mailing Address: Department of Health Sciences, University of Leicester, George Davies Centre, Lancaster Road, Leicester, LE1 7RH

E-mail: osw3@le.ac.uk

Second Author: Ellen Annandale

Affiliation: University of York

Mailing Address: Department of Sociology, University of York, Heslington, York, North Yorkshire, YO10 5DD

E-mail: ellen.annandale@york.ac.uk

Obesity, Stigma and Reflexive Embodiment:

Feeling the 'Weight' of Expectation

Abstract

The dominant obesity discourse which emphasises individual moral responsibility and lifestyle modification encourages weight-based stigma. Existing research overwhelmingly demonstrates that obesity stigma is an ineffective means by which to reduce the incidence of obesity and that it promotes weight-gain. However, the sensate experiences associated with the subjective experience of obesity stigma as a reflexively embodied phenomenon have been largely unexamined. This article addresses this knowledge gap by providing a phenomenological account. Data are derived from eleven months of ethnographic participant observation and semi-structured interviews with three single-sex weight-loss groups in England. Group members were predominantly overweight/obese and of low-socio-economic status. The analysis triangulates these two data sources to investigate what/how obesity stigma made group members *feel*. We find that obesity stigma confused participant's objective and subjective experiences of their bodies. This was primarily evident on occasions when group members *felt* heavier after engaging in behaviours associated with weight-gain but this 'weight' did not register on the weighing scales. We conceptualise this as the *weight of expectation* which is taken as illustrative of the perpetual uncertainty and morality that characterises weight-management. Additionally, we show that respondents ascribed their sensate experiences of physiological responses to exercise with moral and social significance. These *carnal cues* provided a sense of certainty and played an important role in attempts to negotiate obesity stigma. These findings deepen the understanding of how and why obesity stigma is an inappropriate and ineffective means of promoting weight-loss.

Keywords

Obesity; Stigma; Weight-management; Phenomenology; Exercise

Introduction

It is a popular truism that late-modernity has created a way of life that promotes weight-gain in the majority of post-industrial, consumer-driven societies. The incidence of obesity is written about as having reached 'epidemic' proportions globally (OECD, 2017). Obesity is presented by global agencies as a significant risk to individual and population-level health. For instance, the OECD has depicted it as a slow-burning catastrophe in both its health and economic impacts (Sassi, 2010). Despite the scale and recency suggesting obesity is social in origin and solution, the predominantly biomedically and psychologically informed obesity discourse emphasises the role of individuals by framing 'lifestyle' modification as the cause and cure (Crossley, 2004). In short, there has been a tendency to 'de-socialize obesity' (Rail, 2012: 232).

A prime example is the UK Government's main anti-obesity health campaign launched in 2009 and implemented across England and Wales, which encourages people to 'eat well, move more, live longer' (Department of Health, 2009). The implication is that maintaining what is considered a healthy weight is both simple and rational. Consequently this message implicitly endorses the popular notion that those (vast numbers of) people who do not conform to these normative standards of health are irresponsible, gluttonous, lazy, and deserving of scorn (Mata and Hertwig, 2018). Due to the dominant discursive construction of the obesity epidemic, those who are identifiable as overweight or obese are liable to negotiate stigma in their everyday lives.

In a sophisticated engagement with the morality of using stigma within public health, Bayer (2008) considered how opinion has gone full circle. With the rise of public health as a profession in the nineteenth century stigma was commonly used but the HIV/AIDS pandemic of the 1980s and beyond highlighted how stigmatisation can heighten vulnerability and actually impede attempts to treat and control disease. However, recent evidence of the damaging health-effects caused by passive smoking saw stigma become a common public health approach once more. Since he argued that stigmatisation is ethically defensible in at least some instances, e.g., drink driving, Bayer (2008) cautioned that there is no either/or solution, but rather a perpetual need to debate the use of stigmatisation so that each case can be judged in turn and over time. Responding to this need, this article addresses the ethics and effectiveness of moralising obesity by analysing the lived experience of obesity stigma.

The (in)effectiveness of weight stigma

There is no one definition of stigma (Link and Phelan, 2001). Sociologists and others commonly draw on Goffman's (1963) seminal definition of stigma as 'an attribute that is deeply discrediting' (1963: 3). While we consider this a useful starting point, we support calls to move beyond Goffman's analysis to ask questions pertinent to the role of power in what has been termed the political economy of stigmatisation (Scambler, 2009; Tyler and Slater, 2018); namely, investigating inequalities in the experience of stigma by questioning why and how shame and blame impacts the lives of some more than others.

Scambler (2009) argues that accounts can be deepened by giving appropriate attention to the social structural underpinnings of cultural norms and individual choice. This could be facilitated by defining stigma as when 'elements of labelling, stereotyping, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold' (Link and Phelan, 2001: 367). This definition neatly depicts the moral individualism in the dominant discursive construction of the obesity 'epidemic' where those deemed obese are cast as the 'grotesque Other' (Warin et al., 2008: 102): irresponsible individuals creating an avoidable burden on National Health Service (NHS) resources. Indeed, this framing has created a culture whereby people who are categorised as or perceived to be overweight/obese are considered perhaps the last acceptable targets of discrimination (Puhl and Brownell, 2001). Weight stigma is therefore an example of what Scambler (2018: 777) terms the 'weaponising of stigma' where stigma (norms marking an ontological deficit, non-conformance or shame) has been redefined as deviance (norms marking a moral deficit, non-compliance or blame). As such it is unsurprising that the effects of obesity stigma (also known as weight bias) have become a significant research inquiry.

As with stigma research generally, obesity stigma is a truly multidisciplinary field and, despite significant differences in research traditions, findings are characterised by coherence. Review articles conclude that not only is obesity stigma an ineffective means by which to reduce the incidence of obesity, it actually perpetuates the condition and has additional iatrogenic consequences (Brewis, 2014; Phelan et al, 2015; Puhl and Heuer, 2009). For example, in Puhl and Heuer's (2009) review, obesity stigma is shown to translate into structural inequities, e.g., in employment, healthcare, and education, as well as to increase individual vulnerability to

depression, low self-esteem, poor body image, maladaptive eating behaviours, and exercise avoidance.

Brewis (2014) proposes four mechanisms through which obesity stigma reinforces/promotes weight-gain/high body weight: direct behaviour change; indirect effects of psychosocial stress; indirect effects via changes in social relationships; and indirect structural effects of discrimination. Exhibiting the utility of interdisciplinarity, Tomiyama (2014) takes a biopsychosocial approach to create a generative model for this process of perpetuation: the cyclic obesity/weight-based stigma (COBWEBS) model. This depicts a 'vicious cycle' whereby people are 'caught' in COBWEBS. Weight stigma is characterised as a stressor that begets weight-gain through increased eating and other biobehavioural mechanisms (e.g., higher secretion of the fat storing hormone cortisol). In short, the evidence strongly indicates that obesity stigma augments the incidence of obesity, impedes attempts to promote lifestyle modification, exacerbates structural inequalities, and is associated with the development of additional social and medical conditions.

While these findings provide a compelling argument against using stigma to encourage weight-loss/management, dominant methods of measuring obesity stigma tell us far more about behavioural outcomes than they do about subjective experience. Numerous studies refer to the 'internalization' of weight stigma/bias having detrimental outcomes, such as rejecting dietary advice, binge eating, and exercise avoidance (e.g., Jackson and Steptoe, 2017; Ratcliffe and Ellison, 2015). However, in such studies, internalization is a cognitive process whereby overweight/obese people's endorsement of anti-fat attitudes and acceptance of weight-based stereotypes and blame lead them to behave in ways considered detrimental to health. Here cognition takes precedence over how it *feels* to experience obesity stigma.

Felt stigma is a concept proposed (together with enacted stigma) in Scambler and Hopkins' (1986) analysis of people's experience of epilepsy. For them, enacted stigma refers to discrimination on the grounds of perceived unacceptability or inferiority, whereas felt stigma 'refers principally to the fear of enacted stigma, but also encompasses a *feeling* of shame' (Scambler and Hopkins, 1986: 33, emphasis added). Yet when Phelan et al. (2015) address felt stigma in their review of the impact of obesity stigma on the quality of care and outcomes for obese patients, again, cognition prevails. 'Feel' is used as a synonym for 'think' as they

describe obese patients' expectations of poor treatment due to experience of discrimination. Barlösius and Philipps (2015) argue that few have examined felt stigma. They demonstrate that people in Germany internalize the 'blame frame of personal responsibility' from a young age which leads them 'to respond in nearly all social interactions as though they were being stigmatized, so their explanations and actions are those of people who have been made to *feel* at fault' (Barlösius and Philipps, 2015: 11, emphasis added). Although this helps to explain why particular outcomes of obesity stigma (e.g., exercise avoidance) occur, it does not stretch far into feeling. Likewise, Lewis et al.'s (2011) qualitative study of felt obesity stigma amongst a sample of Australian adults, illustrates a negative impact on the emotional health and wellbeing of people who are categorised as obese, but their findings are limited to participants' descriptions of negative emotions. In short, the literature reveals little about the carnal sensations evoked by obesity stigma, despite using concepts that might otherwise indicate that it would.

This suggests that phenomenology could make a significant contribution to our understanding of obesity stigma. Yet, Vartanian et al.'s (2014) promisingly titled *The phenomenology of weight stigma in everyday life* does little to bridge the gap. While their quantitative analysis of the incidence of weight stigma and the emotional response to it helps illustrate the quotidian nature of this discrimination, it does not reveal how it is experienced corporeally. This might otherwise be expected from a phenomenological account. One such account can be found outside of the research specifically addressing obesity stigma per se. Probyn (2009) critiques the tendency for critical obesity research to fixate on body image rather than feelings, emotions and affects. Her stated interest is 'the question of *feeling* big' or, in other words, 'the question of embodiment rather than representation' (Probyn, 2009: 119, emphasis original). Following this line of inquiry, Moola and Norman (2017: 6) approached the experience of the body, food and eating phenomenologically and, by focusing on their participants' 'sensate experiences', were able to delineate overlap in the anorexic and obese experience. They argue that 'thin and fat bodies both often experience a pressing sense of bodily shame' and relate that 'this common experience of shame is often not considered within the dominant reading of these bodies' (2017: 6). Logically, a common embodied experience of weight stigma appeared to inform this otherwise paradoxical accordance. We

argue that the field of obesity stigma would benefit from paying greater attention to these sensate experiences and their consequences.

The phenomenology of weight stigma: every*body* dys-appears

Researching the sensorial experience of obesity stigma necessarily involves a central concern with the body and the notion of embodiment. Despite this, Murray (2012: 289) argues an explicit focus on fat embodiment has been 'somewhat limited'. Phenomenology can help address this by explaining how obesity stigma gets under the skin and informs someone's sense of being-in-the-world (Merleau-Ponty, 1962). Crossley's (2006a) conceptualisation of reflexive embodiment can be applied to theorise how obesity stigma is internalised in a manner akin to Merleau-Ponty's (1962: 143) description of a hat, car or blind person's stick becoming incorporated over time into the 'bulk of our own body'.

Crossley (2006a: 2) outlines 'reflexive embodiment', explaining 'human bodies exist in two dimensions. We are our bodies (being) but sometimes perceive them as an object that we possess (having)'. This is how discursive constructions that lead to obesity stigma can make bodies *feel* particular ways and affect physical health. For Freund (2011), this process means we are all 'mindbodies' with the potential to self-initiate health states on a conscious-unconscious level. For instance, this is how depression resulting from being/having a stigmatised body may detrimentally impact physical health. This fortifies Kirkland's (2010: 195) contention that 'the way one thinks about something like health really makes a difference in what it is and becomes'.

As Rich (2011: 9) explains, obese/overweight bodies represent a 'future truth'. This is perhaps best illustrated by the World Health Organization's labelling of obesity itself as a disease (James, 2008) rather than more accurately as indicative of the possible risk of disease. This is significant because the 'obesed subject' (Rich, 2011: 14) becomes 'diseased' and as such 'death is written on the body' (Prior, 2000: 195). The resulting focus on combating obesity through lifestyle modification leads to 'everyone, everywhere' being considered 'at risk' (Gard and Wright, 2005: 36). Consequently, a combination of the social prestige and stigma attached to healthy and unhealthy bodies, respectively, will almost certainly influence how people understand and act upon their bodies. Here the commercial, superficial and medical

merge as health frequently reduces to *feeling* healthy which condenses to *looking* healthy which often equates, in turn, to looking *good* (Scambler, 2007).

We contend that the 'dys-appearing body' concept, proposed by Leder (1990) offers the foundations for a phenomenology of obesity stigma and an analysis of its reflexive embodiment. Leder's (1990) primary concern in *The Absent Body* is how people think about and understand their bodies. He contends that we are largely absent from our bodies when we are healthy; the healthy body disappears. However, when we experience illness our body (re)appears and we become aware of it. He merges the words dysfunction and appearance to depict a bi-directional process whereby illness makes the body noticeable. The dys-appearing body then is the body brought into our consciousness by the presence and/or labelling of dysfunction. Therefore, the dominant discursive construction of obesity and associated stigma has the potential to make every*body* dys-appear.

Grønning et al.'s (2012: 268) inquiry into the experience of people in Norway categorised as obese and seeking to lose weight asked, 'What does it do to people when a (supposed) lack of self-control is manifest "in layers" on one's body?' Based on semi-structured interviews, they found that despite participants explaining their 'weight problem' through factors they felt they had little or no control over, the majority were not spared from the shame, blame and embarrassment that appeared to be a shared (and detrimental) experience of those subjected to weight stigma. In our inquiry we adopted a methodology to reveal the sensate experience of this reflexively embodied stigma in order to strengthen the phenomenological account of obesity stigma.

Methodology

The data derive from a 16-month ethnography (conducted by the first author) investigating the impact of a ten year area-based intervention (designed to reduce national health inequalities) delivered in a severely deprived neighbourhood in central England (see Williams, 2017; Williams and Fullagar, 2018). Data-collection commenced approximately two years post-intervention and after obtaining ethical approval from the relevant university Research Ethics Committee. During this time three single-sex weight-loss groups (one male, two female) - initially established during the intervention - had continued to run, in part thanks to

efforts from volunteers and financial subsidy from an NHS agency. The groups met at a Local Authority run leisure centre built as part of the decade-long regeneration programme. This paper draws specifically from an 11 month ethnography involving participant observation alongside semi-structured interviews with these groups.

Given their differing epistemological bases, phenomenology and ethnography may appear incompatible. In the philosophical tradition of transcendental phenomenology (Husserl, [1931] 1960) the social world exists through the way it is experienced and interpreted by people. Enabled by 'phenomenological reduction' (Husserl, 1982), or the bracketing out of their own pre-conceptions, the theoretician's task is to describe experience as closely as possible to that of the others they encounter. In phenomenologically-inspired research this is typically operationalised through narrative interviews. For example, the psychological ideographic approach of interpretative phenomenological analysis (IPA) involves close examination and presentation of experiences and meaning-making of a small sample of persons (including single cases) (Smith et al., 2009). The focus within phenomenological research more generally on authentic description based on personal narratives may seem at variance with ethnography which intends to both *locate* and to *analyse* (by the generation of second-order constructs) an individual's understanding of their social world within the wider social, cultural and organisational contexts of which it is a part (Maso, 2001). However, under the variously termed 'phenomenological ethnography' (Maso, 2001), 'phenomenologically influenced ethnography' (Katz and Csordas, 2003) or 'phenomenology-based ethnography' (vom Lehn and Hitzler, 2015; Pfadenhauer and Grenz, 2015), a number of established researchers have argued that phenomenology and ethnography can be fruitfully aligned. The theoretical entré is the emphasis within Schutz's ([1932]1972) sociologically-oriented phenomenology of the lifeworld, on the importance of social relations and social action in the production of experience (vom Lehen and Hitzler, 2015). The utility of phenomenology-based ethnography lies in its capacity to bring *in situ* experience to the fore and to uncover the subjective experience that people attach to their actions (Honer and Hitzler, 2015; vom Lehn, 2018).

In the current study the first author participated in many of the activities alongside group members. This facilitated our analysis of the pre-conscious process of embodying culture and of how people construct their social world in interaction with others. However, his status in

the Schutzian (Schutz, [1942] 1976) sense as 'a stranger' who shared neither socio-economic status (SES) nor the experience of being classified as over-weight/obese with the groups enabled us simultaneously to observe and analyse established but unquestioned group norms. In common with other sociological phenomenologists, the aim of this analysis is 'not so much about trying to locate invariant structures of consciousness, but more akin to seeking generalities in the phenomenon often across a range of different participants' accounts' (McNarry et al., 2018: 4). This is done to place the subjective and sensate experiences associated with being overweight/obese within the wider socio-economic context and culture of what Scambler (2018) identifies as weaponised stigmatisation.

The two women's weight-loss groups met on weekdays (one evening, one mid-morning) and the men's on a weekday evening. Participation by the first author was negotiated with group leaders who acted as gatekeepers. Group sessions were 90 minutes long and 96 observations (approximately 144 hours) took place. Typically, 5-20 participants attended each session. There was significant variation in participants' age and ethnicity, however, all but a few had a BMI that classified them as overweight or obese. Both weight-loss and the perpetual task of 'weight-management' were (at least initially) stated motivations for attendance.

Group sessions were initially cost-free to attend and offered periodic nutritional advice and practical cooking tutorials. However, due to lack of funding, during observations it cost £2 to attend and sessions had just two components: group weigh-ins (30 minutes) and organised physical activities (60 minutes). The subsidised fee was considerably cheaper than similar commercially available services and meant these groups could be considered reasonably accessible to residents of this severely deprived neighbourhood. This was reflected in the predominance of group participants of low socio-economic status.

Structural inequities significantly influence people's capacity to comply with health advice (Scambler, 2012) and are associated with inverse social gradients in obesity, diabetes mortality rates, calorie consumption and leisure-time physical activity (Drewnowski, 2009; Elhakeem et al, 2017; Pickett et al., 2005). As such, people of low-SES are disproportionately disadvantaged by factors associated with weight-gain and particularly vulnerable to weaponised obesity stigma. Therefore, the weight-loss groups in the present study were a prime sample for exploring the sensate experiences of overweight/obese people of low-SES actively engaged with weight-management.

Barlösius and Philipps (2015) argue that feelings of inferiority are adopted in people's habits and perceptions, but within research on felt stigma inadequate attention has been paid to people's practices. They argue that the field is limited by a reliance on statements drawn from interviews. Our account pairs longitudinal participant observation, documented in extensive fieldnotes, with semi-structured interviews. This allowed data derived from what participants did (practices) to be triangulated with what they said (narratives).

Semi-structured interviews were conducted towards the end of data-collection. Questions addressed a range of themes that were identified and coded throughout analysis and deemed to be reaching data-saturation (e.g., responsibility, (un)predictability of weight-loss). Interviewees were purposively selected for their regular group attendance and relevance to exploring identified themes. All gave informed consent and were assured of anonymity and confidentiality (pseudonyms are used throughout). In all, 12 interviews (ranging from 18-65 minutes) were conducted with 17 people (on four occasions interviewees preferred to be interviewed with one or two others). With participants' permission, interviews were audio recorded and transcribed verbatim. Fieldnotes and interviews were thematically coded with data-collection refined and analysed in line with an approach typical of grounded theory (Charmaz and Mitchell, 2001). Analysis was aided by NVivo 10.

Findings and discussion

While the experience of obesity stigma was gendered in significant ways, we focus here on the elements of this experience common to both male and female participants. Both the weigh-in and physical activity components of sessions illustrated how weight-management was shrouded in the logics of moral individualism and obesity-related stigma. Specifically, we show two things. First, how obesity stigma became an embodied *feeling* that confused the objective and subjective experiences of group members' bodies. Second, how physiological responses to exercise were ascribed moral and social significance and provided 'certainty' in the form of carnal cues to combat this confusion.

The Weight of Expectation

A sense of moral duty to live a healthy lifestyle and maintain a 'healthy' weight has typically been associated with middle-class identity (e.g., White et al, 1995). The relative structural constraints that people lower down the socio-economic spectrum face are associated with cultural norms and lay views about health that tend to reject this moral obligation and contradict health norms (Hughner and Kleine, 2004). Consequently, it was anticipated that participants would readily question the norms of moral individualism applied to weight-management. However, this was not the case:

> Interviewer: Do you think it is easy living a healthy lifestyle?
>
> Jonny: If you wanted to, yeah. But I think it's all down to the individual and what they like to…
>
> Phil: …eat and do.
>
> Jonny: Yeah.
>
> Interviewer: …but in practice it's not…
>
> Phil: As easy to do, no.
>
> Jonny: No, I wouldn't have thought so, no. Like I say, it's all down to that person really, if he puts his mind to it, then he can do it and if he can't, he can't.
>
> (Joint-interview with two male participants)

> Interviewer: So is living a healthy lifestyle as simple as – eat less, move more, live longer? What do you think?
>
> Jackie: It should be, I think it should be because that's what we're trying to do now is eat less […]
>
> Interviewer: So when you say it should be…
>
> Jackie: Why isn't it? [Laughs] Because things creep in […]
>
> Interviewer: So you do feel that there is a responsibility to be healthy?
>
> Jackie: I feel that you are responsible for yourself. Nobody else is are they, really.
>
> (Lone-interview with female participant)

As their membership of these weight-loss groups perhaps indicated, generally participants viewed health as an individual responsibility that should be upheld. Illustrative of the relative agency associated with low-SES, participants acknowledged that it was difficult to conform to

normative standards of health, but individual resolve was identified as the determining factor. Alongside this sense of personal responsibility for health, it was apparent that both male and female participants were influenced by obesity stigma:

> Interviewer: So when you're out and about, do you ever wonder how people think about your body?
>
> Tamara: Yeah, I do
>
> Etta: Yeah, I think so, more so when I was fatter than I am now. I think people accept you better slimmer than as you are. People look at you and think, I think, 'fat cow'. I watched that Super Skinny[1] the other day and there was a huge girl and she said that she went out once, and she was in a pub, and somebody shouted from across the pub, 'I'm going to bag myself a pig,' meaning her, and I just think [mimes exasperation], you know.
>
> Tamara: Yeah, because I think that when you are big people seem to think that they've got the right to say whatever they like to you.
>
> Etta: Right, and they haven't, you know what I mean. What makes it right for him to walk down the street and say to you 'fat pig'? I mean he's got none and you're supposed to take that? Why should you take that? Because you're fat? Bollocks, it doesn't make me. You know what I mean; my weight doesn't make me who I am.
>
> (Joint-interview with two female participants)

> Interviewer: When you're out and about, do you ever wonder what other people think about your body and how you look?
>
> Arthur: Yeah, I am conscious of it you know. I don't like to think what they are thinking.
>
> Interviewer: Okay, so why's that, because you think that they are thinking not very nice things?
>
> Arthur: Yeah, because I have never felt, you know, good vibes about people of such a weight and now it's sort of come back on me and, in my mind, I think, you know, if someone is looking at me and they are saying 'you're overweight', you know, 'he's put on a few pounds', you know, I wouldn't like that.
>
> (Lone-interview with male participant)

Clearly group members considered themselves both personally responsible for their weight and wanted to avoid the perception of themselves as the 'grotesque Other' (Warin et al., 2008: 102). Despite this, while weight-loss was seen overwhelmingly as a positive

[1] Supersize vs Superskinny was a British television show

achievement, regular weight-loss was uncommon. Most fluctuated, week-to-week, but in the longer-term, maintained a relatively stable (over)weight. Therefore, to some extent there was a sense that they had a personal responsibility that they were failing to fulfil and were thus left exposed to obesity stigma. The focus here is on how a sense of personal failing and external stigma was experienced as a carnal sensation. In short, how obesity stigma was embodied and realised as a sensate experience.

Before being weighed at sessions, participants often spoke of '*knowing*' they had put on weight and then listed numerous reasons why, often referring to having 'indulged' in 'bad' behaviours (e.g., consuming high calorie foods and alcoholic drinks). Both men and women articulated this when asked to explain how they '*knew*'. For example:

> Alf: Well, I *know* because I've had a bad week at home 'avn't I? [laughs] I've been eating things I shouldn't do. I know that if I didn't go to the gym and play squash with Rob and all the rest of it this week and then I had fish and chips and stuff, I know pretty well that next week I'll have put weight on.
>
> (Lone-interview with male participant)

> Amy: If I've been out at the weekend and had quite a few pints of lager [laughs] and had a few takeaways then you think, 'OK, yeah I can accept the fact that I'm going to have put a couple of pound on'.
>
> (Lone-interview with female participant)

These explanations seem rational within the cause and effect logic established by the rhetoric of individual energy balance achieved through lifestyle. It often prompted clear cut and hence certain responses on what needed to be done, namely, revise calorie consumption, exercise more. Significantly, though, it was possible to observe in the ethnographic data that participants were actually very often wrong in their predictions of weight-gain and seldom '*knew*' when they had lost weight either. Consequently, it was very common for them to '*know*' they had 'put on' only to be proved quite wrong when they were weighed. Longitudinal observation demonstrated that 'knowing' was not merely a cerebral knowledge established through processes of rational thought, such as, 'I thought I'd put on because I ate lots of chocolate this week', but an embodied sense of stigma connected to the overweight/obese body and moralised behaviours associated with weight-gain. Consequently, when asked,

participants often found it difficult to articulate this observed sense of knowing, or to trust what the body may be telling them. The following explanation was typical:

> Interviewer: So, how do you 'know'?
>
> Jackie: It's just the feeling, you feel heavier somehow. I don't know, I can't explain how.
>
> (Lone-interview with female participant)

Pairing ethnographic fieldnotes with interviews strengthens analysis of the relations between the experience of felt stigma and people's practices. The following describes a generalisable weigh-in experience:

> Fran comes in and sits down. Even though no one is getting weighed she does not get up to be weighed herself. Eventually Melanie [group leader] says to her, "Are you getting weighed then Fran", to which she replies "No" and laughs. Fran had been telling us beforehand, "I *know* I've put on. You can just *feel* it can't you. I was at a barbeque at the weekend with Steph and boy did we eat, we didn't stop eating." Melanie convinces her to get weighed and says, "You can have a sneaky peek before I look", meaning that Fran can decide whether or not she wants it recorded on her card. When Fran gets weighed, it turns out that she has actually lost a bit of weight and she says, "I can't believe that. All that stuff we ate" and then rolls off a list of things she had; "Spare ribs, two big pieces of gateau with cream…" She went on to say, "I could *feel* it, you know when you can just *feel* that you've put on. Even my belly looked bigger. I'll probably put it on next week now". Shirley agrees with her and says, "That's normally how it works, yeah."
>
> (Fieldnotes, evening female group session: 3/9/2012)

Fran described a carnal sense of knowing, she could *feel* the weight-gained since last week's weigh-in, even claiming to have been able to see it, and yet she was wrong. Those in the women's groups in particular could be reluctant to even get on the scales. There was no point, the information could not counteract what they already *knew* and would just be demoralising. Yet, in a seeming paradox, Fran and many others were so often wrong in their predictions that there was a general appreciation that the experience of weight-management was not accurately captured by the lifestyle-focused 'energy-in-energy-out' equation. Despite this, the behaviours that, as a consequence of being informed by this simplistic equation, carried negative moral connotations still had metaphorical weight such that group members quite

literally *felt* the gravity of them. Illustrating how weaponised stigma (Scambler, 2018) affects those whose agency is disproportionately inhibited by social inequality and indicating the fidelity of the COBWEBS model (Tomiyama, 2014), the traumatic and obdurate nature of this experience was underscored by the leader of one of the women's groups who explained in reference to post-session Facebook messages from disheartened members, 'it's too much sometimes the weigh-in bit…they do get very disappointed by it and take it home with them and it just keeps going, it's a cycle, it'll keep going, keep going' (Lone-interview with female instructor of morning female group session).

That participants *felt* heavier - based on their calculation of an imbalance between 'good' and 'bad' behaviours - but were often wrong, is particularly significant because it demonstrates that they were not merely articulating their expectations based on what they had done but rather had come to embody the stigma associated with such behaviours and their presumed consequences: they quite literally *felt* the effects of stigmatised ill-discipline. Illustrating a psychosomatic response to the weaponising of stigma (a 'body shot' if you will), the weigh-loss group members did not just *know* they had been deviant, they *felt* it and this was the case even when the 'evidence' (additional weight) was absent.

In this sense there was a '*weight of expectation*' that did not register on the scales. This fits with Leder's (1990) notion of the dys-appearing body and is analogous to the 'phantom limb' phenomenon that Merleau-Ponty (1962) used to illustrate perception is embodied. In the same way that the absence of a limb may not stop the experience of pain, the absence of weight did not stop participants *feeling* the weight they expected their ill-discipline would equate to. In line with Moola and Norman's (2017) finding that the affective experiences of anorexic and obese women are remarkably similar, the *weight of expectation* demonstrates further similarity in the phenomenological experiences of these seemingly paradoxical bodies. Part of the anorexic experience has been characterised as irrationally *feeling* fat and/or heavy. The *weight of expectation* illustrates that this (mis)perception of weight is a *feeling* that is shared by overweight/obese people. Moola and Norman (2017) argue that shame marks both of these bodies. But, of course, their responses to shame produce remarkably different behaviours and bodily forms.

Predicting weight-gain was, however, not always a reaction to feeling heavier. For example, Becky explained how it can function as a defence mechanism:

Interviewer: So a lot of the time I hear people say, 'Oh I know that I'm going to put weight on', and then they get weighed and they've not…

Becky: Yeah, that surprises me; I've had that happen to me.

Interviewer: So is it that you're basing the knowledge…

Becky: [Interrupts] Yeah, you probably just assume that you're going to have put weight on. So if you think it's going to be bad, anything less than that is better.

(Lone-interview with female participant)

Here predicting weight-gain is also a form of confessional designed to protect self-esteem. Often this led to flippant comments when the scales proved them wrong, such as '*I'll stop going to the gym and carry on eating cake then*'. But it also led to expressions of relief: a sense of sins going unpunished. While this technique of self-preservation could on the surface seem relatively positive it could be construed less positively. At one weigh-in a woman was particularly pleased after having unexpectedly lost weight on consecutive weeks. As she stepped off the scales the instructor said in a friendly manner, 'Yeah well, just don't get confident because, you know what they say, when you get confident you'll put on the next week' (Fieldnotes, evening female group session: 20/8/2012). There was general agreement within the room that this was accurate and useful advice. Group members' weight-management was characterised by this perpetual uncertainty. In part, managing expectations of losing weight was a strategy for coping with feeling personally responsible for maintaining a 'healthy' weight (and thus liable to blame if they fail to do so) but also occupying a social position that inhibited their capacity to conform to this standard. Although many were not making concerted efforts to lose weight, they appreciated that engaging in behaviours that deviated from the discipline of weight-loss could make them *feel* bad. For instance, as described in the fieldnotes above (dated: 3/9/2012), a number of women pre-weighed themselves while the instructor was out of the room before deciding if they were going to be weighed 'officially'. It was understood that women may not want to get weighed 'officially' because the 'black mark' against their name was considered too much of an emotional body blow: aligning them too closely with the 'grotesque Other'. In the men's group, where the weigh-in was public and (unlike the women's groups) weights made known to others, spoiled identities were managed more collectively with, for example, joking disparagement of self

and others. In short, the stigmatisation of weight-gain had an embodied morality which led participants to experience psychosomatic stress.

As regular 'confessions' throughout the fieldwork and the majority of group members maintenance of a relatively stable (over)weight attest, this embodied experience of obesity stigma was not enough to ensure disciplined weight-loss. However, it encouraged participants to develop strategies for coping with the moral minefield of weight-management. As the social gradient in obesity and associated behaviours demonstrates, the necessity of these coping mechanisms will be greater for those lower down the socio-economic spectrum and thus they are illustrative of the disproportionate burden of weaponised stigma.

Carnal cues: sweat as salvation and finding 'certainty'

Attending the weight-loss groups to participate in physical activities was one way in which group members negotiated the experience of felt stigma. Participants tended to gauge the relative worth of different activities against whether or not they would/did '*get a sweat on*'. This expression was commonly used by men and women alike. When following up on the significance of sweat, interview responses were telling:

> Interviewer: How do you feel after a session if your clothes are wet with sweat?
>
> Amy: I feel as though you've done something [laughs]. We quite often say 'I'm soaking wet, at least we feel as though we've done something tonight'. There's been times when we've walked out and thought that we've not done anything […] You feel much better when you've sweat and you feel tired, you feel as though 'okay, that was a good one, I've done something worthwhile.'
>
> (Lone-interview with female participant)
>
> Interviewer: Okay, so how do you feel after a session if your clothes are wet with sweat?
>
> Arthur: That's good. That's when I know what I have done, that's when I've worked and put some effort into it you know. Oh yeah, that's no problem. I will go home and strip off and have a shower at home and feel good about myself.
>
> Interviewer: That's good. So if you come out and your clothes are dry, how does that make you feel?
>
> Arthur: I think that we've not done anything you know, quite disappointed.
>
> (Lone-interview with male participant)

While Coffey (2015) found that young people who regularly engaged in body work described health as a *feeling* achieved through exercise, it was clear that for the weight-loss group members, exercise per se was not seen as an inherently positive force. Such appraisal was reserved for those activities where getting '*a sweat on*' would/did occur, whereas activities that generated a lack of sweat could actually promote negative feelings**.** Sweat was representative of effort and its presence allowed participants to *feel* good about themselves. Others have shown that although sweat is more generally thought of as dirty and something to be avoided it is quite typical in exercise contexts for it to be experienced positively (e.g., Heikkala, 1993). However, the weight-loss groups members were atypical bodies (low-SES people categorised as overweight/obese) to find in these contexts. Therefore, there is something novel about their experiences – shedding light on some latent embodied outcomes of weaponised stigma experienced by people of low-SES.

Sweating as a consequence of physical activity formed an important part of the coping strategies that these overweight/obese participants engaged in to negotiate embodied obesity stigma. Participants explained that the sight of sweat and feeling wet meant '*you know you've done something*', by which they meant something 'good'. Just as negative moral connotations attached to behaviours associated with weight-gain led them to *feel* the *weight of expectation*, positive moral connotations attached to physical exertion cultivated a positive sensate experience that allowed them to feel good about themselves more generally despite no significant visible change to their stigmatised physical form.

Though it was not just sweat, the sensate experience of exertion both during and after activities also played an important role in this embodied process:

Interviewer: What's a good activity for you?

Shannon: Boxercise

Interviewer: Why's it good?

Shannon: Because I feel like I've done something all over. I like the ten point plan and the tabatas [all high-intensity activities]

Suzie: It's an all-body work-out

Interviewer: So you like ones where you feel like you've really done something?

Suzie: Yeah, when you know you've done something

Shannon: Yeah, where I would have never have said that. Ten point plan or that tabatas, the first time I did it, that killed me and I was like 'no!', and the next time we did it… you really feel like you've done something and I feel good in myself. I'm absolutely bright red and I come out of there knackered, but I feel better in myself and I'm alright for the rest of the day

(Joint-interview with two female participants)

Interviewer: Okay, so I hear some of the group talking about activities being 'bad but good'? How do you feel about these activities?

Becky: I like them.

Interviewer: You like them. Why?

Becky: Because of what they do, like how you *feel* the next day, you hurt the next day and it *feels* like you've actually done something productive.

Interviewer: So when you say productive, you mean?

Becky: You've done something to your body; your body is aching so you must be doing some good like you've worked something. Whereas sometimes you can do it and you don't feel like you've done anything and you leave and it's almost like you've pranced around for an hour.

(Lone-interview with female participant)

Group members relied upon their bodies to offer evidence of exertion (i.e., physiological and sensate 'proof' of energy expenditure), which to some extent helped them to negotiate the more general experience of weight-management as an endeavour characterised by perpetual uncertainty. Consequently, visible and felt signs of physical exertion took on great personal and social significance. These sensate experiences helped group members negotiate the embodied sense of stigma that confused the objective and subjective experiences of their bodies**.** Crawford (2004; 2006) has argued that contemporary 'health consciousness' is also 'danger-consciousness' and that a pedagogy of danger is combined with a pedagogy of recommended practices in a spiral of control > anxiety > control > anxiety. The sensate experiences of exertion acted as '*carnal cues*' allowing group members to feel some 'certainty' and thus experience some sense of control. This appeared to be particularly significant because their bodies and more general experience of weight-management were characterised by a lack of control and certainty.

Zanker and Gard (2008: 49-50) argue that the 'moral crusade explicitly linked with a war on fatness' has created a 'moral universe of sport and physical activity'. Similarly, Crossley (2006b: 25) writes of the 'moral career' of gym-goers. In this moral universe, sweating and other sensate experiences of exertion, such as delayed onset muscle soreness and flushed faces, visibly and experientially demonstrate 'doing' health in culturally appropriate and valorised ways. In the current study, these sensate experiences acted as 'evidence' of effort and moral uprightness and therefore offered a sensate salvation of sorts that contradicted the dominant discursive construction of overweight/obese bodies.

Lean, taut and exercised bodies signify moral excellence (Lupton, 1995), while overweight/obese bodies have become a 'visual representation of non-control' (Evans et al., 2008: 38). These representations present the physically active overweight/obese body as somewhat paradoxical. Our findings illustrate that the embodied 'evidence' of effort in the form of physiological responses to exertion was particularly important for those who are/have overweight/obese bodies. Those who have embodied obesity stigma can use (what we have conceptualised as) *carnal cues* as signs to themselves and others that they have put in the effort they are assumed to have shirked. These cues allowed group members subjectively to repudiate the notion that they were the gluttonous, morally inferior, grotesque Other. In short, these sensate experiences were instrumental to informing a sense of being-in-the-world that to some extent counterbalanced (if only temporarily) some of the deleterious effects of obesity stigma. If the evidence of regular physical activity rendering overweight/obese conditions benign (e.g., Ortega et al, 2013) was more widely known, their sense of being-in-the-world and engagement with physical activities would likely have been markedly different and more positive. Instead, the combination of the experience of being the target of weaponised stigma and inhibited by their socio-economic position appeared to reduce physical activity for the participants into a mechanism through which to temporarily feel 'good' in/as a 'bad' body.

Conclusions

Multidisciplinary research on obesity stigma overwhelmingly demonstrates that obesity stigma has deleterious and obstructive impacts on health. Our findings support this and thus

provide yet more evidence to fortify arguments for a public health approach to obesity that rather than promoting moral individualism (either explicitly or implicitly) instead recognises and responds to the inequalities that promote obesity (including inequalities in the experience of obesity stigma) with appropriate support. However, they also offer an original contribution to the field where to date the *feeling* flesh of phenomenology has been a marginal influence.

Our analysis has demonstrated that obesity stigma actually makes people who are categorised as overweight/obese people *feel* heavier as the embodiment of moral individualism provokes a sensation we have conceptualised as the '*weight of expectation'*. This concept bridges the two traditions that have typified social science's engagement with the body: the discursive body and the lived body. It has done so by combining data from ethnographic observation with semi-structured interviews to reveal discursive constructions of the body as embodied and thus *felt* by the lived body. The notion of sweat and sensate experiences of physical exertion acting as '*carnal cues'* that influence a sense of self-worth has similarly illustrated that discursive constructions of bodily practices come to be *felt* both on and under the skin.

Illustrating the collateral damage of weaponising stigma, obesity stigma confused group members' objective and subjective experiences of the body so as to redefine the *felt* effects of gravity and to render physical activity a largely compensatory practice. This stems from the embodiment of dominant discursive constructions of obesity which moralise behaviours and bodies which, we have shown, confuses carnal senses. Although obesity stigma makes bodies dys-appear and thus heightens our consciousness of them, in the process of doing so, it makes our bodies less knowable/familiar to us. This has been illustrated by weight-loss group members' sense of 'knowing' so often being incorrect and their craving of 'certainty' through *carnal cues*.

Group members were predominantly overweight/obese and of low-SES. The social gradients in obesity and health behaviours would therefore suggest that they represent a public health priority. Rather than members representing ill-informed and/or irresponsible people who would do well to follow the 'eat well, move more' mantra, it was apparent that their social position and experience of obesity stigma inhibited attempts to live a 'healthy lifestyle'. Therefore, while our findings may have transferability it is important to recognise that relative

agency throughout the socio-economic scale will inform the experience of obesity stigma, embodied or otherwise.

In this case it led to the majority of participants seeking to maintain a relatively stable (over)weight whilst having to negotiate additional psychosocial stress derived from obesity stigma. Our findings show that those who regularly engage in physical activity but are also overweight/obese are forced to negotiate a contradictory identity. Their public identity (i.e., visible form) exposes them to stigma that belies their personal identity (established through everyday practices). Combatting obesity stigma and offering greater social support to address the social gradient in the associated health behaviours would go a long way to improving public health.

References

Barlösius E and Philipps A (2015) Felt stigma and obesity: Introducing the generalized other. *Social Science & Medicine* 130: 9-15.

Bayer R (2008) Stigma and the ethics of public health: not can we but should we. *Social Science and Medicine* 67 (3): 463-472.

Brewis A A (2014) Stigma and the perpetuation of obesity. *Social Science and Medicine* 118(1): 152-158.

Charmaz K and Mitchell R G (2001) Grounded theory in ethnography. In: P. Atkinson, A. Coffey, S. Delamont, J. Lofland, and L, Lofland (eds) *Handbook of Ethnography.* London: Sage Publications, pp.160-174.

Coffey J (2015) 'As long as I'm fit and a healthy weight, I don't feel bad': Exploring body work and health through the concept of 'affect', *Journal of Sociology 51*(3): 613-627.

Crawford R (2006) Health as a meaningful social practice. *Health* 10(4): 401-420.

Crawford R (2004) Risk ritual and the management of control and anxiety in medical culture. H*ealth* 8(4): 505-528.

Crossley N (2004) Fat is a sociological issue: obesity rates in late modern, body-conscious societies. *Social Theory and Health* 2(3): 222-253.

706 Crossley N (2006a) *Reflexive Embodiment in Contemporary Society.* Berkshire: Open
707 University Press.

708 Crossley N (2006b) In the gym: motives, meaning and moral careers. *Body and Society* 12
709 (3): 23-50.

710 Department of Health (2009) *Change4life Marketing Strategy: In Support of Healthy Weight.*
711 *Healthy Lives.* London: Crown.

712 Drewnowski A (2009) Obesity, diets, and social inequalities. *Nutrition Reviews* 67(s1): S36-
713 S39.

714 Elhakeem A, Hardy R, Bann D, Caleyachetty R, Cosco T D, Hayhoe R P, Muthuri S G, Wilson, R
715 and Cooper R (2017) Intergenerational social mobility and leisure-time physical activity in
716 adulthood: a systematic review. *Journal of Epidemiology and Community Health* 71(7): 673-
717 680.

718 Evans J, Rich E, Davis B, Allwood R (2008) *Education, Disordered Eating and Obesity Discourse:*
719 *Fat Fabrications.* Abingdon, Oxon: Routledge.

720 Freund, P (2011) Embodying psychosocial health inequalities: bringing back materiality and
721 bioagency. *Social Theory and Health* 9(1): 59-70.

722 Gard M and Wright J (2005) *The Obesity Epidemic: Science, Morality and Ideology.* London:
723 Routledge.

724 Goffman E (1963) *Stigma: Notes on the Management of Spoiled Identity.* London: Penguin.

725 Grønning I, Scambler G, and Tjora A (2012) From fatness to badness: the modern morality of
726 obesity. H*ealth* 17(3): 266-283.

727 Heikkala J (1993) 'Discipline and excel: Techniques of the self and body and the logic of
728 competing. *Sociology of Sport Journal 10*(4): 397-412.

729 Honer, A and Hitzler, R (2015) Life-World-Analytical Ethnography: A Phenomenology-Based
730 Research Approach. *Journal of Contemporary Ethnography* 44(5): 544–562.
731
732 Hughner R S and Kleine S S (2004) Views of health in the lay sector: a compilation and
733 review of how individuals think about health. *Health* 8(4): 395-422.

Husserl, E (1960) *Cartesian Mediations: An introduction to Phenomenology,* trans. D Cairns. The Hague : M. Nijhoff.

Husserl, E (1982) *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy: First book, General introduction to a pure phenomenology,* trans F Kersten. Boston: Kluwer Academic Publishers.

Jackson S E and Steptoe A (2017) Association between perceived weight discrimination and physical activity: a population-based study among English middle aged and older adults. *BMJ Open 7*(3): e014592.

James W P T (2008) WHO recognition of the global obesity epidemic. *International Journal of Obesity* 32: S120-S126.

Katz, J and Csordas, T (2003) Phenomenological ethnography in sociology and anthropology. *Ethnography* 4(3): 275-288.

Kirkland A (2010) Conclusion: what next? In: J M Metzl and A Kirkland (eds) *Against Health: How Health Became the New Morality.* London: New York University Press, pp.195-203.

Leder D (1990) *The Absent Body.* London: University of Chicago Press.

Lewis S, Thomas S L, Blood R W, Castle D J, Hyde J and Komesaroff P A (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(9): 1349-1356.

Link B G and Phelan J C (2001) Conceptualizing stigma. *Annual review of Sociology 27*(1): 363-385.

Lupton D (1995) *The Imperative of Health: Public Health and the Regulated Body.* London: Sage.

Maso, I (2001) Phenomenology and Ethnography. In: P. Atkinson, A. Coffey, S. Delamont, J. Lofland & L. Lofland (eds) *Handbook of Ethnography*. London: Sage, pp.136-144.

Mata J and Hertwig R (2018) Public beliefs about obesity relative to other major health risks: representative cross-sectional surveys in the USA, the UK, and Germany. *Annals of Behavioral Medicine* 52(4): 273-286.

McNarry G, Allen-Collinson J and Evans A B (2018) Reflexivity and bracketing in sociological phenomenological research: researching the competitive swimming lifeworld. *Qualitative Research in Sport, Exercise and Health* DOI: 10.1080/2159676X.2018.1506498.

Merleau-Ponty M (1962) *The Phenomenology of Perception* (Translated from French by C Smith). London: Routledge and Kegan Paul.

Moola F J and Norman M E (2017) On judgement day: Anorexic and obese women's phenomenological experience of the body, food and eating. *Feminism & Psychology* 27(3):259-279.

Murray S (2012) Editor's introduction: rethinking fatness – a critical dialogue. *Feminism & Psychology* 22 (3): 287-289.

OECD (2017) Obesity Update 2017. https://www.oecd.org/els/health-systems/Obesity-Update-2017.pdf, accessed 16 October 2017

Ortega F B, Lee D C, Katzmarzyk P T, Ruiz J R, Sui X, Church T S and Blair S N (2013) The intriguing metabolically healthy but obese phenotype: cardiovascular prognosis and role of fitness. *European Heart Journal* 34(5): 389-397.

Pfadenhauer, M and Grenz, T (2015) Uncovering the Essence: The why and how of supplementing observation with participation in phenomenology-based ethnography. *Journal of Contemporary Ethnography* 44(5): 598-616.

Phelan S M, Burgess D J, Yeazel M W, Hellerstedt W L, Griffin J M and Ryn M (2015) Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. O*besity Reviews 16*(4): 319-326.

Pickett K E, Kelly S, Brunner E, Lobstein T and Wilkinson R G (2005) Wider income gaps, wider waistbands? An ecological study of obesity and income inequality. *Journal of Epidemiology and Community Health* 59(8): 670-674.

Prior L (2000) Reflections on the 'mortal' body in late modernity. In: S J Williams, J Gabe and M Calnan (eds) *Health, Medicine and Society: Key Theories, Future Agendas*, London: Routledge, pp.186-202.

790 Probyn E (2009) Fat, feelings and bodies: a critical approach to obesity. In: H Malson. and M
791 Burns. (eds) *Critical Feminist Approaches to Eating Disorders.* London: Routledge, pp.113-123.

792 Puhl R and Brownell K D (2001) Bias, discrimination and obesity. *Obesity 9*(12): 788-805.

793 Puhl R M and Heuer C A (2009) The stigma of obesity: a review and update. *Obesity 17*(5):
794 941-964.

795 Rail G (2012) The birth of the obesity clinic: confessions of the flesh, biopedagogies and
796 physical culture. *Sociology of Sport Journal* 29(2): 227-253.

797 Ratcliffe D and Ellison N (2015) Obesity and internalized weight stigma: A formulation model
798 for an emerging psychological problem. *Behavioural and Cognitive Psychotherapy* 43(2):
799 239-252.

800 Rich E (2011) 'I see her being obesed!': Public pedagogy, reality media and the obesity crisis.
801 *Health* 15 (1): 3-21.

802 Sassi, F (2010) Obesity and the Economics of Prevention: Fit not Fat. OECD.

803 Scambler G (2007) Social structure and the production, reproduction and durability of health
804 inequalities. *Social Theory and Health* 5(4): 297-315.

805 Scambler G (2009) Review article: health-related stigma. *Sociology of Health and Illness* 31
806 (3): 441-455.

807 Scambler G (2012) Review article: health inequalities. *Sociology of Health and Illness* 34 (1):
808 130-146.

809 Scambler G (2018) Heaping blame on shame: 'weaponising stigma' for neoliberal times. *The*
810 *Sociological Review Monographs* 66 (4): 766-782.

811 Scambler G and Hopkins A (1986) Being epileptic: coming to terms with stigma. *Sociology of*
812 *Health and Illness* 8 (1): 26-43.

813 Schutz, A ([1932]1972) *Phenomenology of the Social World*, trans. G. Walsh and F. Lehnert.
814 London: Heinemann Educational.

815 Schutz, A. ([1942] 1976) The Stranger. In: A. Brodersen (ed) *Alfred Schutz Collected Papers II*,
816 The Hague: Nijhoff, pp. 91-105.

817 Smith J A, Flowers P and Larkin M (2009) *Interpretative phenomenological analysis: Theory,*
818 *method and research*. London: Sage.

819 Tomiyama A J (2014) Weight stigma is stressful. A review of evidence for the Cyclic
820 Obesity/Weight-Based Stigma model. *Appetite* 82(1): 8-15.

821 Tyler I and Slater T (2018) Rethinking the sociology of stigma. *The Sociological Review*
822 *Monographs* 66(4): 721-743.

823 Vartanian L R, Pinkus R T and Smyth J M (2014) The phenomenology of weight stigma in
824 everyday life. *Journal of Contextual Behavioral Science* 3(3): 196-202.

825 vom Lehn, D (2018) Phenomenology-based ethnography for management studies and
826 organizational analysis. *British Journal of Management,* Vol. 00, 1–15
827 https://onlinelibrary.wiley.com/doi/abs/10.1111/1467-8551.12309

828 vom Lehn, D and Hitzler, R (2015) Phenomenology-based ethnography. *Journal of*
829 *Contemporary Ethnography* 44(5): 539–543.

830 Warin M, Turner K, Moore V and Davies M (2008) Bodies, mothers and identities: rethinking
831 obesity and the BMI. *Sociology of Health and Illness* 30(1): 97-111.

832 White P, Young K and Gillett J (1995) Bodywork as a moral imperative: some critical notes
833 on health and fitness. *Loisir et Société* 18: 159-182.

834 Williams O (2017) Identifying adverse effects of area-based health policy: an ethnographic
835 study of a deprived neighbourhood in England. *Health & Place 45*: 85-91.

836 Williams O and Fullagar S (2018) Lifestyle drift and the phenomenon of 'citizen shift' in
837 contemporary UK health policy. *Sociology of Health and Illness* doi: 10.1111/1467-
838 9566.12783

839 Zanker C and Gard M (2008) Fatness, fitness, and the moral universe of sport and physical
840 activity. *Sociology of Sport Journal* 25(1): 48-65.