Are fat bodies sick bodies? Representations and experiences of obesity among experts and young people in Catalonia

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Through an ethnographic study of obesity in both clinical and virtual spaces, our research analyzes representations of fatness and the experience of being overweight among young people in Catalonia (Spain)[3]. In this paper, we demonstrate that the increasing social rejection of fat people can be traced not only to moralizing discourses on "excessive" food consumption or the commodification of slenderness and health, but also to the recent definition of obesity as a disease. The process of medicalizing fatness, far from helping to de-stigmatize obese people, is becoming a way of (re)signifying it.

1. Thou shalt not get fat: from lipophobia to lipophobism

Many historical and ethnographic studies on eating and body habits have shown that fatness was welcomed, as it still is by many societies in which gluttony and gorging are not only socially accepted but even well thought of. And more importantly, they were experiences that were neither undergone nor qualified as illnesses (De Garine & Pollock, 1995). In the industrialized societies, however, *(lipo)phobia* (Fischler 1995), understood as the systematic rejection of fats and the fear of getting fat, is a relatively recent phenomenon. Note that we say 'relatively recent', because although concern about weight and body shape increased during the 20th century, the problemization of excess is by no means exclusive to the present (Vigarello 2009). In classical antiquity and the Judaeo-Christian tradition, the cultural images pertaining to fatness were ambivalent (Csergo 2009:8), fluctuating between mockery and disdain, respect and enjoyment, and sensuality and health. Although biomedicine has tended to neglect the role of these images, in the belief that

[3] In 2006, with the support of the MEC [Ministry of Education and Science] and the Generalitat of Catalunya, I began an ethnographic study in Catalunya (Spain) about the social dimensions of obesity which was part of a broader state-wide program of research focalized in two specific projects *The emergence of obesogenic societies or obesity as a social problem* (CSO2009-07683) and The *Images and experiencies of obesity in young people* (AJOVES 2008 00017). Work is being carried out on three main levels: a) a bibliographical review that focuses on socio-anthropological and epidemiological literature; b) the study of nutritional recommendations and health strategies; and c) a medical ethnography carried out on representations and practices in obesity in the health care system. We have worked in two public hospitals, two primary care centres and a private institution that prescribes diets and slimming products. In order to be able to apply techniques of qualitative analysis (direct observation, in-depth interviews and focal groups), we have selected quite a low number of informants. On the one hand, we interviewed 20 young people diagnosed with obesity between 15 and 30 years old, and 5 young adults between 30 and 35 years old. Of these 56% were women and 44% men. A total of 50% were from the low to lower-middle classes, 38% from the middle-middle class, and 12% from the upper-middle class. On the other hand we also included in the study 5 parents of overweight young people, 5 secondary education professionals, 8 health professionals and 7 young people who were not overweight. On Internet we analyzed the written exchanges between people registered in the forums www.adelgazar.com and www.obesos.org. Compiling the verbatims was by no means straightforward because it was difficult to find authors of texts dealing with the priority topics. In the end we located 18 young people resident in Catalonia.

their definitions of illness are a long way from ethical and aesthetic fundamentals, it is certainly true that their perceptions of fatness are largely influenced by the predominant ways of thinking in each context. In fact, overweight and its possible health risks had attracted the attention of the physicians of antiquity. Hippocrates associated it with sudden death and sterility, and Celso connected the protruding bellies of the elite to the abundant intake of sweets and fats. Fatness also interested the physicians of the Middle Ages, who established relations between overweight and eating. Obesity was first included as a term in medical dictionaries in the 18th century, and numerous studies on treatment, pathogeny and therapeutics were made during the 19th century (Csergo 14-15), the result of which led to it being considered as a body state associated with functional problems that affected the metabolism of fats.

The phenomenon of lipophobia became increasingly entrenched as the 20th century advanced, the result of the changing epistemological status given by medicine to fatness and the promotion of thinness. Medical knowledge, like other forms of knowledge, includes conceptions and practices that depend on the social and historical situation to which they belong and they are constantly renegotiated. These constructions determine the different ways in which the body, food and illness can be perceived and represented. Today, the majority opinion about fatness is negative. This negativity has been considerably influenced by the morality of the Christian West, which calls for moderation and restraint when eating and scorns gluttony; the evolution of scientific knowledge, which has demonstrated a close connection between diet and health; and the changes that have taken place in the representations of the body, which have converted thinness into a sign of health and obesity into just the opposite.

Although medicine has pointed out numerous functional causes of the excessive accumulation of fat (metabolic, genetic, medicinal, hormonal), from this point on fat people are regarded as “big” eaters, people who eat too much. This perception is partly linked to the moral interpretation that science has made of the *so-called societies of abundance*. The current definition of obesity as a pathology caused by the excessive accumulation of fat coincides, curiously enough, with the only period in the history of humanity in which, in some contexts, food is available in abundance, the result of the changes that took place during the 20th century in production, distribution and consumption. Fatness is little more than a sort of “defect” that is part of the process of civilization. The pathological images surrounding obesity in fact express a preoccupation for social order and have acquired a punitive significance. In this case, it is a sign of a society that is not on the right track and fat people, as transgressors of the order, must be reprimanded (Sontag 2005).

As diet and body have undergone a process of normalization (Gracia 2009a, Gracia, forthcoming, 2010), fat people have been increasingly stigmatized, accused of being some sort of nutritional delinquents (Basdevant 2009: 120). Although difference is discursively accepted as a valued characteristic of humankind, fatness is an exception to the rule and is considered to be almost a crime. In fact, of the stereotypes that have been constructed in the West about fatness—those sweet-toothed fat people whose jollity makes them socially accepted and the gluttonous fat people whose selfishness and laziness lead to their being rejected—it is the latter that has finally triumphed: fat people have insatiable appetites and transgress the rules of sharing and discipline. Slimness is portrayed not only as attractive but also as a sign of moderation, effort and discipline. Fatness, on the other hand, is regarded as physically and morally unhealthy and obscene, typical of the idle and the gluttonous. The positive and negative appraisals of physical attributes, then, are projected onto standard patterns of behaviour correlated with moral attributes: self-control and self-indulgence, respectively. The effect is similar to the effect on other stigmatized groups: fat people end up being discriminated against because of their physical and behavioural attributes, and this has a considerable influence on their personal relations and daily life. If, as we have said above, lipophobia is the systematic fear or rejection of fats or of getting fat, lipophobism arises from the discriminatory treatment of people for being fat.

2. Biomedical conceptions and practices in relation to obesity

Obesity is disapproved of by the whole of society, and the mass rejection undoubtedly has an effect on biomedical conceptions and practices (Apfeldorfer 2009:136). The health sector promotes normative discourses that are also, in part, stigmatizing. The definition of obesity as a disease and of obese people as suffering from an illness is characterized by ambivalence. While biomedicine considers young fat people to

be victims of a permissive consumer society (sick people), they are also identified as persons who have transgressed the normative patterns designed to avoid obesity (guilty people): a balanced diet and "normal", healthy body weight. Hence, although it is true that the concept of disease excuses the patient of all blame for his/her condition, in the case of obesity this is not necessarily the case. Some of the opinions expressed maintain that it is, in part, a self-inflicted condition, a behavioral choice to wilfully overeat, and the sufferers should not be relieved of their responsibility for their condition (Heshka & Allison 2001).

Fatness has acquired its negative qualities because of the way in which it has been interpreted by society. Biomedicine has legitimated the particular way in which it is conceived. Most physicians in Catalonia agree that obesity arises out of a combination of endogenous factors: genetic, hormonal and metabolic. “Some people get fatter than others even though they eat the same…. There’s probably a genetic component but we don’t know how to measure it,” (endocrinologist 1 from a public hospital). Some suggest that the energy imbalance is caused by functional issues: “The causes of obesity are multifactorial. Not only do people have to eat a lot and not burn it off; they have to eat a lot, not burn it off and have a metabolism that predisposes to the condition,” (paediatrician from a public hospital). And they even accept that the proof that obesity is inexorably a disease is somewhat limited: “Some things have been assumed to be true but have not been proved. Not everybody who is overweight is ill. I don’t know whether these people should be demonized and told that they are suffering from a disease,” (CP family doctor from a private clinic). Nevertheless, it is very unusual for health professionals to adopt a relativistic approach, and it is more normal for them to attribute the aetiology of obesity to external factors and, in particular, to the amount of food consumed.

Although, on occasion, the same old environmental reasons are offered in explanation—“We have transport, computers… People don’t walk anywhere any more.” (CP doctor in nutrition)—the origin of the problem is easily blamed on individual behaviour and, in particular, on what are believed to be inappropriate lifestyles, as if these did not depend, in turn, on structural factors: “The obese are people who consume the maximum and expend the minimum,” (HP endocrinologist 1 from a public hospital). Indeed, it is believed that the main cause of obesity is the excessive intake of unhealthy food. An excess of fat is the result of an excess of food. According to many health professionals, young people do not know how to eat properly, or do not want to. They have no family discipline and no personal will power: “eating habits acquired at home are very important. If they are not educated from an early age and are given everything that they like, they will take the easy way out, they will eat what is most readily accepted by their palate. If the family does not lay down the law, they will eat what they like,” (endocrinologist 3 from a public hospital). As far as doctors are concerned, then, the young obese are “children” of the society of abundance and fast food, and, in particular, of an age that does not set limits and which encourages parental indulgence: “Many parents come here with excuses. They say they have tried everything and that there is no way they can get their children to eat vegetables or fish. Well, if the parents cannot assert themselves, what chance have we got?” (primary care doctor from a private clinic). This emphasis on individual cases makes it easier to blame parents and children for their inability to act rationally and, therefore, legitimates health intervention: “If they do not know how to eat, they must be taught,” (dietician from a public hospital).

Determining the optimum diet and regulating weight as the main therapeutic tool calls on individual responsibility and requires nutritional competence (Ascher 2005). It is a twofold process of medicalization and moralization that preaches that the “bad” eating habits of young people should be changed and transformed into a new set of habits that conform to the more rational scientific rules of nutrition: “Your health is not the only reason for eating better. You feel better and fitter if you eat properly,” (dietician from a private clinic). This hygienist logic perceives overweight as the prelude to obesity and those who are one or two kilos over their ideal weight as people who are about to fall ill: “An excess of fat that cannot be proved to cause physical problems is probably a pre-pathological condition,” (nutritional doctor from a private clinic). This idea that there is an inevitable continuum of weight gain throughout the life cycle and that overweight will, therefore, inevitably lead on to obesity is constantly referred to: “It’s absolutely clear that overweight, if you are not careful, is just a preamble. Overweight at 20 will probably be class 1 obesity in adult life,” (paediatrician from a public hospital). Obviously to reach extreme obesity you have to pass through a phase of overweight, but not all obese young adults were fat children. However, many people have been known to be overweight throughout their lives, and they suffered no health consequences (Flegal et al. 2005).

Accepting that obesity is a disease obliges doctors to intervene and the patients to follow a course of treatment. Although medical intervention can involve drugs and surgery, the most common treatment for losing weight is dietetic prescription. If the problem is caused by an imbalance between calories consumed and calories expended, going on a diet seems to be the most logical solution to correct it. *Nutritional rehabilitation* is the central axis around which treatments for obesity revolve. Its aim is, in all cases, to get patients to achieve and maintain their normal body weight and to adopt healthy eating habits (Gracia 2009b). In the same way, nutritional rehabilitation is seen by doctors as being fundamental to ensuring that patients recover from the illness not just physically and psychologically, but also socially. They consider that the diet must be followed to the letter over months or years if necessary, because it makes them feel secure, provides order in their lives and helps them to combat their obsession with weight and food: "What we do is education, diet, exercise, etc. We use drugs if necessary or we assess the possibility of bariatric surgery [but the solution is] a healthy balanced diet and not for just a month of two but forever," (HP endocrinologist 1).

A dietary routine is introduced because patients are believed to have destructured habits and to follow self-imposed food restrictions or binges which have no rational foundation. Consequently, nutritionists demand that patients improve their dietary knowledge and change their erroneous dietary practices. Their habits must include what clinicians define as *a normal diet,* ingested over a correct period of time and accompanied by civilized habits: "It is a change of eating habits. People have to eat healthily independently of whether they are thin or a little overweight. This is what we try to teach them," (endocrinologist 1 from a public hospital). The ultimate aim is to inculcate healthy habits by means of the *optimum diet* which is administered almost as if it were a medicine: "We try to improve matters by modifying the pattern of physical activity and eating habits. But they will always be predisposed to obesity: the diet is like their medicine," (paediatrician from a public hospital).

Surprisingly, health professionals who define patients diagnosed with obesity in terms of their obsession with dieting, use the same strategy to treat their illness: that is, they put them on a diet. Nutritional intervention is oriented towards inculcating a strict dietary model in the patients regarding what they must eat, in what quantities, where, who with and how many times a day (2009b:199). The paradox lies in that the patients' exaggerated predisposition towards dieting (non-optimum) should find its solution precisely in putting them on another diet (optimum). From the therapeutic point of view, it is less a question of stigmatizing the diet itself than of rejecting those facets which, by their content or form, deviate from the bio-medical nutritional model.

However, many of the therapeutic approaches based on individual prescription to change diet and the pattern of physical activity fail, and, although some people manage to lose some weight temporarily, the results in the long term are largely insufficient. It is known that the repeated prescription of diets can lead to both weight loss and weight gain, and that this is the cause of many obesities (Alemany 2003). Although numerous professionals say that they try to personalize the diets they prescribe, they put particular emphasis on the distribution of groups of food, their nutritional content, their distribution through the day and the way in which they are cooked. Although these are important aspects, they do not take into account either the reasons or the contexts of the people who decide to eat in one way or another: "What we always try to do is to get obese people to change their attitude. If they believe they are on a diet, then they are not cured. When they go to a restaurant and choose a salad without thinking that they are on a diet … when they automatically walk up the stairs to get to the third floor … that is when they are cured," (paediatrician at a primary care centre).

Weight gain is attributed to patients' bad habits and, likewise, the failure of treatments to their attitude and inability to follow instructions. Health professionals thus avoid all responsibility: "The battle against obesity is constant. It's difficult, obviously, but diets must be followed. People are not aware; they have lost their will power," (endocrinologist from a public hospital). Specialists regard the patients' inability to follow recommendations as the reason for treatment failure. In fact, the obese are disobedient patients: "The problem they have is that they cannot follow instructions; they have no will power. The success rate of therapy is very low. It is a thankless speciality, and most of the people who come to the surgery are not at all prepared to improve or make an effort to improve," (endocrinologist 2 from a public hospital). Doctors do not even consider that the adverse result may be because of the intervention proposed, in the sense that dietetic

prescription may not be the best solution for certain patients or certain types of obesity: “The treatment fails if it is ordered and is seen not to work. If patients ‘do not want’ to initiate a treatment like following a diet, is that a failure of the treatment or a lack of awareness?” (paediatrician from a public hospital). It is the patients who lack readiness and awareness, and therefore make it difficult to resolve the illness and spoil all the therapeutic efforts made by the health professional.

If obesity is a disease, then am I ill?

The notion of the human body as a social and individual project, as an entity under construction (Shilling, 1993: 5), takes on particular interest in our work in that it can shed light on how ideas about the size and shape of the socially and medically “correct body” and physical and psychic readiness can affect people’s daily life. This interpretation of whether one follows or deviates from the norm often legitimates particular forms of stigmatization. The reproving medical gaze that falls on the obese for being—and remaining—fat is finally accepted by the patients as the logical result of their unacceptable behaviour and this makes them feel even more guilty. Several studies have focused on the various ways in which obesity is stigmatized and how this affects a person’s position in society (Sobal, 1995; and Tibère et. al 2007, Poulain 2009). According to Cahnman (1968), young fat people undergo a threefold discrimination: they are looked down on by others; they are given to understand that they are the only ones responsible; and they also end up accepting being treated badly. The discrimination is both cross-sectional and longitudinal: it affects all areas of social relationships and lasts for the whole of the life cycle.

The ‘demonization” inflicted on the overweight nowadays is shared by most of the young people interviewed. In general they seem hardly to be relieved by the fact that obesity has turned into a disease: “Although I have always been obese, I have never got used to it. I find it hard to put up with all the comments made by other people, my parents and my wife. It’s difficult to convince people that obesity is a medical problem, not just a problem of personality.” (Sila, 31 years old). There is no exoneration because health professionals do not believe people who are overweight to be mere victims of a permissive consumer society. On the contrary, the biomedical insistence that the disease depends on the ability to regulate eating habits is the most common argument used by the young people to blame themselves for being fat.

This recognition that it is their own fault is part of the stigmatization that accompanies the obese. Goffman (2003) regards stigmatization as a process that tends to discredit people in that they are classified as “not normal” or “deviated”. This discredit comes about interactionally and is caused by those people who regard themselves as normal. While the stigma is being constructed, particular forms of discrimination and social exclusion arise (Gracia et al. 2010). According to Goffman, those affected are witnesses to a phenomenon of reduction: the attribute that stigmatizes them becomes central. All other attributes are secondary. Those stigmatized are enclosed in a vicious circle and often end up accepting the negative opinions of others as normal. This acceptance leads to a lack of self-respect and social isolation, but above all it convinces them that the discrimination they are subject to is legitimate.

The process of stigmatization thus transforms victims into guilty parties: “My hobbies are watching TV and playing on my Play Station. I spend six hours a day in this room. In general I feel a bit guilty. When I’m in the middle of a game I think I should be out walking.” (Carles, 15 years old). Personal self-neglect prompted by particular difficulties is also put forward as one reason for the increase in weight. This self-neglect is regarded as being the result of their behaviour and it is also used as a self-incriminating argument: “You start letting yourself go, getting fatter. Yes, it’s our fault. I put on 22 kilos when I was pregnant, and when we split up I got really depressed and I put on a lot more weight. I didn’t feel like doing anything. What did I do? I just ate! Of course it’s our fault.” (Irene, 35 years old). Obese people take notice of the medical and social judgements and accept that they are incapable of controlling themselves and following norms: “You feel guilty, impotent, angry with yourself … and ashamed,” (Laura, 34 years old). Shame is a recurrent theme because, somehow, they feel like sinners who are unable to resist the temptation to eat: “Obesity is the result of not making an effort or letting myself go.” (Pau, 32 years old). They also feel that they are weak because

they have always been easily led by others: “When I was being brought up I was constantly snacking. My mother did, so I did too.” (Mercè, 23 years old); “My problem is genetic, but my eating habits don’t help any. At one point I weighed 160 kilos. That’s not just genetics.” (Celia, 28 years old).

Nevertheless, some young people do not agree with being tagged as “big passive eaters” and point out that there are other, non-behavioural reasons for weight gain independently of their will power: “With what they eat, some people should be extremely fat but they’re not. I don’t eat a great deal. In fact, I don’t eat much at all.” (Silvia, 15 years old). Although science has proved that not all bodies accumulate the same amount of fat if they consume the same amount of food (Alemany 2003) and this should be sufficient to understand that fat people are not necessarily big eaters, the medical warning is always to eat less: “The imbalance between what is consumed and what is expended can only be redressed by decreasing intake,” (endocrinologist 2 from a public hospital). Neither do these young people share the doctors’ opinion that the solution is to adopt healthy lifestyles because some of them already have done: “Everyone thinks that you don’t look after yourself, that you don’t know how to eat. They think that you are the problem because you eat too much, because you snack between meals. That’s not true. Stress makes me fat. If you have a thyroid problem like I do, everything you eat makes you gain twice as much weight as other people. No one realises that. I ride a bike, I walk, I go swimming … and I still have a lot of trouble losing weight.” (Yvonne, 33 years old).

The class of obesity and age are key factors in whether obese people believe their fatness to be the result of an illness. In the case of people with diagnosed metabolic problems, it is important to insist on this point because they say that they follow all the recommendations but something beyond their control lets them down: “I have a considerable amount of self control, and when I decide not to do a certain thing, I do not do it. If I have to eat less, I eat less. I don’t know what is wrong.” (Laura, 34 years old). Some young people do not believe they are ill because the fact that they are overweight does not prevent them from “functioning” normally and there is no sign of any physical cause or other associated pathology; others, however, do believe they are ill for just the opposite reasons. Their weight makes it more difficult for them to get dressed, wash, go to work and even sleep. Those who are closer to so-called extreme or morbid obesity are more likely to believe they are ill and claim that their condition is a pathological one. The main reason is due not so much as to the fact that weight gain is accompanied by associated diseases such as diabetes or hypertension, but to fact that moving and carrying out daily activities are much more difficult: “Obesity is more a health issue than an aesthetic one: I can feel it when I go upstairs because I get tired. When I walk, I only feel it when I talk as well because I feel breathless. If you don’t take care of yourself, it catches up with you.” (Mercè, 23 years old).

Although being labelled as sick people hardly exempts them of all blame, they believe that they can only question the stigma of being regarded as a sort of “nutritional delinquent” if obesity is accepted as a chronic, evolving pathology: “I would like to say that obesity is one of the least understood diseases because those who do not have the problem believe that fat people are simply slovenly. They feel obliged to ‘hide’ when they eat so that they are not judged, as if they were criminals.” (Marta, 24 years old).

Conclusions

The biological and/or cultural factors are underestimated in medical narratives and individual behaviour and responsibility are emphasized. For this reason, the increasing medicalization of fatness, the fact that obese people are classified as being sick, is not helping to exonerate them. The lack of understanding that young people have for those who supposedly defend that obesity is a disease and that they are patients increases their feeling of guilt. After all, fatness synthesizes a threefold failure: personal, medical and social. And worry about whether their weight might affect their health often does not prompt them to slim: much more important in this decision is their attempt to change what is, for them, a personal and cultural torture. Shunned because of their abnormal and unattractive bodies, most of them decide to go on a diet, a decision legitimated by the increasing lipophobism and the anti-obesity messages that biomedicine and the health market have generalized as well. And this diet, which is a temporary initiative to achieve a particular end, becomes a state that determines their daily life.