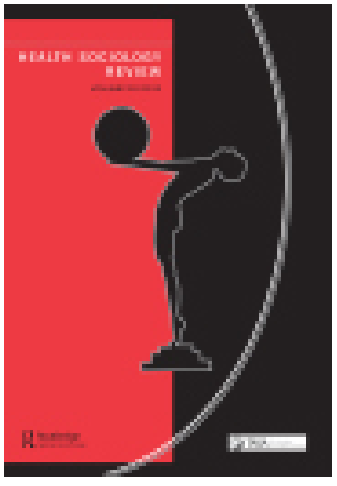

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"Obesities": Experiences and perspectives across weight trajectories

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"Obesities": Experiences and perspectives across weight trajectories

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Fatness or weight deemed excessive is pathologised as "obesity." "Obese" individuals are subject to stigma and exhorted to lose weight to improve health. Coping with supposedly excess weight, whether one prioritises self-acceptance or weight loss, is often a lifelong struggle; its effects on identity may persist regardless of (often transient) weight changes. This ethnographic study used participant-observation and repeated in-depth interviews (4) to explore health perceptions, lifestyles, and lived experiences of individuals self-identifying as obese or formerly obese ($n = 15$), over time and across different weight trajectories. A typology was constructed to categorise different types of "obesities" that emerged in the study: The Hopeful, the Despairing, the Resigned, and the Accepting. These types demonstrated characteristic approaches to weight loss, fears, hopes, and stigma experiences, but they were not static categories, and participants remained highly ambivalent regarding size and health. Based on alterations in circumstances and weight trajectories, individuals' subjectivities altered to best cope with changed weight and health statuses, life circumstances, and on-going, damaging stigma. Overall, participants were dedicated to health and wellbeing and had developed multifaceted coping mechanisms for dealing with stigma and societal misunderstandings of their lifestyles and priorities.

Keywords: obesity; weight change; weight trajectories; health perceptions; ethnography; lived experience

Introduction

Obesity stigma and medicalisation

In current biomedical discourse, fatness and "excess" weight is pathologised as "obesity" (Jutel, 2006). While excessive corpulence was always considered medically significant, the use of weight scales, statistical standards, and computer power helped introduce a new diagnostic focus solely on body weight. The significance of weight may now supersede other medical criteria, such as symptoms and medical history, in medical encounters and messaging (Davies, 1998; Guthman, 2011; Jutel, 2006). Obesity, having a Body Mass Index (BMI) in excess of 30, while ostensibly an objectively clinical category, is also a highly ideological construction (Gard & Wright, 2005). A simplistic energy balance model of weight control (calories in > calories out), characterises obese persons as lazy and gluttonous, and equivocal and nuanced findings about obesity and health risks are framed in alarmist and incontrovertible terms (Gard & Wright, 2005).

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This catastrophic depiction of obesity renders large bodies as visible confessions of apparent pathology; even in situations in which ill-health is not present (Davies, 1998; Jutel, 2006; Murray, 2009). Obese persons' non-normative appearances assign them discredited "spoiled identities" (Goffman, 1963). In a healthist context, in which maintaining healthiness is considered an individualist moral imperative and the duty of a responsible citizen, an obese person is further discredited as socially deviant (Crawford, 1980; Goffman, 1963). This moralistic construction of obesity compounds the pervasive and damaging stigma experienced by obese persons (Puhl & Heuer, 2010).

In the United States, 40% of people with a BMI > 35 reported experiencing discrimination in a multitude of settings, and obese persons are stereotyped as lazier, or less motivated than thinner people (Puhl, Andreyeva, & Brownell, 2008; Schwartz, Vartanian, Nosek, & Brownell, 2006). Importantly, obese persons may resist this discourse in their everyday lives; fat activism has been active for decades (Ellison, 2007; Schoenfielder & Wieser, 1983), and it now has a significant online presence (Dickins, Thomas, King, Lewis, & Holland, 2011). Among clinicians and patients, the Health-at-Every-Size (HAES) movement is growing, as are the multidisciplinary critical obesity and fat studies disciplines (Cooper, 2010). Nevertheless, dominant messaging asserts obese bodies should be normalised via weight loss (Murray, 2009). However, weight loss is rarely sustainable and is not without health risks (Aphramor, 2005; Gaesser, 2009).

Embodiment

Unlike the often static depiction of bodies in weight loss accounts (Levy-Navarro, 2009), wherein a fat body passes irrevocably to a thin state, material bodies are necessarily fluid (Longhurst, 2001). Individuals' embodiment may range from subjective and objective periods of various sizes, from thin to fat. Respecting embodiment in research involves treating individuals as "concerned about the management, maintenance and appearance of their bodies," given their practical recognition of their bodies' significance "as personal resources and as social symbols which give out messages about … self-identity. In this context, bodies become malleable entities which can be shaped and honed by the vigilance and hard work of their owners" (Shilling, 2003, pp. 4–5). A discursive environment rife with weight loss messages will therefore have profound effects on individuals' embodiments. Embodied weight histories and the passage of time likely alter understandings of health and bodies. Given omnipresent messaging on obesity and weight loss, insight into how obese individuals feel about their health and obesity over time and weight trajectories is necessary.

Obese persons' views on health and weight loss

Qualitative research shows obese persons have nuanced views on weight loss and obesity. They believe that weight loss may be beneficial; however, they also indicate exceptions to prevailing obesity messaging, criticise the BMI, and highlight other important aspects of health (Kwan, 2012, Lewis et al., 2010; Tischner & Malson, 2012). While valuable, these studies rely on single interviews and do not prioritise prospective understandings of change or weight alterations. A focus on change remains rare in studies on obesity, although some authors have described their experiences of weight loss attempts and fluctuations (e.g. Heyes, 2007; Longhurst, 2012; Murray, 2008). The larger study from which this article derived sought to examine change explicitly by using critical ethnography to explore obese individuals' perspectives on health and obesity and lived experienced across time and weight trajectories (Bombak, 2014). During analysis, a typology, i.e., a construction of categories based on participants' similarities, emerged that facilitated understanding participants' diverse perspectives and experiences concerning weight and health.

Weight-related typologies

Typologies of largeness tend to prioritise a "snapshot" view of a participant's bodily experience, focus on appearance concerns, or include only one gender. Martin (2002) conducted an ethnography utilising a gender and frame analysis of three what he termed "appearance organisations," a commercial weight loss support group, Overeaters Anonymous, and the National Association for the Advancement of Fat Americans. He analysed these organisations from a gender and frame alignment perspective and identified the frames deployed by the organisations, e.g. rationalisation, redemption, and injustice, and the "reselfing" identity transformations of members.

Psychologists Chambers and Swanson (2012) qualitatively investigated behavioural factors that differentiated weight loss maintainers, weight gainers, and lifelong "normal weight" individuals. Their intent was to identify predictors of lifelong weight maintenance. Likewise, Lindvall, Larsson, Weinehall, and Emmelin (2010) devised 11 ideal types of the Swedish middle-aged, non-obese, weight-stable population, according to their weight management approaches. While identifying weight-related types, these studies do not provide insight into how an obese body is experienced across time within a hostile context.

Honeycutt (1999) sought out women who had lost weight (Fat Busters), fat activists (Fat Boosters), and individuals seeking self-acceptance in an independent manner (Equivocators). She found a high level of ambivalence regarding their weight among all participants and that fatness, regardless of one's position on its pejorative status, could consume one's identity. Fat Busters remained scared of weight regain. Fat Boosters reacted defensively to claims concerning weight and remained hyper-aware of their and others' sizes. Equivocators sacrificed activities they enjoyed due to their size, tried to reconcile themselves to their present weight, or dreamed of a successful weight loss attempt (Honeycutt, 1999). Overall, participants did not differ greatly in their views of obesity, particularly with respect to its unattractiveness. Honeycutt's (1999) study demonstrated the ongoing struggle individuals encounter in achieving body acceptance in an environment hostile to bodily diversity.

Monaghan and Hardey (2011) applied an ideal-type typology in examining bodily sensibilities of their ethnographic sample of large U.K men. This typology highlighted the diverse ways in which obesity can be experienced and the fluctuations and ambivalences characteristic of an embodied state. The identified types included "the proud" (resistant to anti-fat discourse) and "the stigmatised" (internalised anti-fat discourse) among large participants, and "the wise" (resistant to anti-fat discourse) and "the prejudiced" (receptive to anti-fat discourse) among normative-sized participants.

While these typologies provide insight into the lived experiences of obesity, many do not conceptually focus on change, include both genders, or focus on participants' health perceptions. The present article addresses these gaps by presenting a Weberian (1949) ideal types model that emerged during ethnographic exploration of the following research questions: how do weight trajectories and experiences contribute to perceptions on obesity and health, and how do these perceptions change over time? Ideal types are hyperbolic constructions grounded in observations of the subject in question (Oakley, 1997). They can serve as a "conceptual instrument for comparison with and measurement of reality" (Weber, 1949, p. 97) that extends the use of a typology beyond a single dataset. The current typology can act as a framework for comparison and measurement for others exploring obesity as an often vilified and chronic, but not static or unidimensional, state.

This article presents this typology and the case studies that informed it. Participants' ambivalence concerning their own bodies, their negotiations of discourses, and their attempts to cope in a stigmatising environment are then discussed. For researchers, this typology may serve as a framework for comparing and measuring their own participants' different weight experiences and

attitudes. For clinicians and policy-makers, considering where patients may align with, and diverge from, this typology may allow for a greater focus on holistic health and patients' own priorities and lifestyles. This may help medical practice and messaging move beyond a narrow weight-centric focus that presupposes pathology and particular lifestyles among obese persons (Gard & Wright, 2005; Jutel, 2006; Murray, 2008).

Methodology

The study described in the present article involved one-year (2013–14) of ethnography and repeated in-depth interviews in a Canadian mid-size urban centre (Bombak, 2014). Ethics approval was granted by the researcher's institution. Names used are pseudonyms. Participants were male ($n = 2$) and female ($n = 13$) adults, ≥ 18 years of age. Participants were recruited via posters throughout the city at sites such as community centres, fitness centres, public libraries, and local clinics and electronic mailing lists that asked for obese or formerly obese participants. Maximum variation was sought in opinions regarding attitudes toward obesity, health, and weight loss. An effort was made to ensure the following participants were represented: participants attempting to lose weight; participants pursuing a self-identified healthy lifestyle, without prioritising weight loss; and participants prioritising body acceptance. While obesity is a contested term, connoting the medicalisation and stigmatiation of a population (Wann, 2009), this study sought to allow participants to discuss their views on the medicalisation of fatness. "Obesity" was used in study materials, to elicit participants' responses to this label. Participants often expressed relief at the opportunity to discuss obesity. For participants more interested in discussing obesity as a clinical phenomenon or their weight loss successes, alternate terminology may not have appealed; this would have affected the ability to examine a diverse range of opinions on obesity. For this article, I use the term obesity in scare quotes to acknowledge its contestation. For legibility's sake, I do not use scare quotes around obesity for the entire article. In summarising others' studies, in which other inclusion criteria (bigness, largeness, fat) may have been used, I use the term large or the authors' terminology.

Participants were asked about weight histories, priorities, lifestyles, and perspectives on health and weight. Following analysis of each phase of interviews, the next interview guide was assembled in order to capture emerging themes. In all interviews, participants were asked about changes in their perspectives, and emergent themes from prior interviews were addressed. Interviews were audio-taped, transcribed verbatim, and then analysed alongside field notes using thematic content analysis. Responses to research questions on how weight trajectories, time, and experiences influenced participants' health perceptions and related fieldnotes were considered for every participant and compared across all participants. Data from interviews are presented without seeking to "correct" participants' speech, as is common for research in this area (e.g. Monaghan, 2010a, 2010b; Norman, 2013). This privileges participant voices rather than reinforcing research-participant power relations.

Participants chose sites for participant observation they felt were most relevant to their lived experiences as obese persons. They were asked about sites at which they felt accepted or stigmatised, at which they pursued health, or were otherwise relevant to them as obese persons. Ethnography is a valuable tool in studying marginalised populations, as well as the "taken for granted" and everyday aspects of life that may need to be clarified to understand the lived experiences and emic perspectives of a group (Rabinow, Marcus, Faubion, & Rees, 2008). Being at relevant sites introduced new themes, facilitated recall, and clarified and deepened interpretation. Sites included fitness centres and classes, homes, restaurants, and grocery stores. At selected sites, formal and casual interviews were conducted, and I participated in relevant activities such as exercise and eating alongside participants. Field notes were recorded immediately after every encounter

with participants and included in the participant summaries of the overall analysis. Field notes sought to derive emic perspectives and concentrated on environments, participants, and interactions (Emerson, Fretz, & Shaw, 1995). Field notes were used to detect topics for future probing, pinpoint researcher bias, and identify issues of emotional salience. Ultimately, the participant-observation and field notes helped produced a focus on empathy, self-critique, and multivocality (Marcus, 1998, p. 193). Discrete and across-interview participant summaries were created from field notes and interview data, which informed the typology.

Rapport may have been affected by a number of factors. Obesity is a stigmatised condition, and my medium-sized body, Faculty of Medicine affiliation, and use of clinical terminology may have suggested pathologisation of participants. However, this may have appealed to participants who would not have responded to more "softened" or politicised terminology (Warin & Gunson, 2013). Some participants were interested in the medical aspects of obesity or were dubious concerning more fat-accepting stances. Furthermore, the long-term engagement and participant-observation may have eased strains between me and participants, and I sought to defer to participants' experiential knowledge.

Participants

Approximately 80% of participants identified as White, ages ranged from 30–60s, and a wide variety of socioeconomic and living conditions were evident. Due to one health-employee mailing list used in recruitment, many participants were current or previous healthcare employees. Some employment areas included healthcare providers, administration and finance, and sales. All 15 participants were interviewed at least once. A subset of participants ($n = 5$) were re-interviewed three times, on a seasonal basis, over one year. These individuals were selected based on the richness of their previous interviews and to maximise the range of weight trajectories and attitudes in the repeat interviews. Two of these individuals were hoping for weight loss, two were maintaining weight loss, and one participant had adopted a HAES perspective. One participant had lost weight for the first time following chronic obesity; all others were weight-cyclers. Like the overall sample, these participants identified as White, mostly female ($n = 4$), between the ages of 30+ and 50+, and they varied in living and socioeconomic conditions. All 15 initial interviews, the repeated interviews, and participant-observation were used in the data analysis.

Analytical approach: Ideal types

Weber (1949) developed ideal types to reconcile objectivity and subjectivity in the social sciences. Ideal types are theorist-derived constructions of individuals' subjective perceived realities (Aronovitch, 2012; Weber, 1949). Ideal-typical analysis is a tool to examine empirical data, aid in description, or develop hypotheses, while acknowledging they are abstractions from ever-fluctuating, multi-perceived social reality (Oakley, 1997; Torr, 2008; Weber, 1949). Typologies may label innately messy phenomena according to static stereotypes, averages, or value-laden laws (Al-Wagdani, 2010; Aronovitch, 2012; Torr, 2008; Weber, 1949). However, the advantage of such an analysis lies in probing differences between constructed ideal types and the empirical manifestations of the phenomenon studied (Al-Wagdani, 2010; Weber, 1949). Beyond categorising my own data, this extension of patterns identified among my participants may provide a tool for clinicians and researchers. It may allow them to think through the diversity of "obesities" in their studies and practices by providing a rubric for "measuring" and "comparing" reality (Weber, 1949, p. 51). Monaghan has valuably used ideal types to explore the bodily sensibilities of big men in the UK, obesity discourse entrepreneurs, and health professionals' attitudes regarding their own weight (Monaghan, 2010a, 2010b; Monaghan & Hardey, 2011; Monaghan, Hollands,

& Pritchard, 2010). This study advances this tradition by using Weberian ideal types to further explore the lived experience of obesity as a stigmatised phenomenon, with a greater focus on the effects of weight trajectories and time.

Results

During analysis, patterns emerged in participants' hopes, goals, histories, beliefs, fears, relationships to food, and social life. Data for all participants were assessed in these areas and congruence between categories was used to form prototypes of particular lived experiences of obesity. The following ideal types emerged: the hopeful ideal type (HIT), the despairing ideal type (DIT), the resigned ideal type (RIT), and the accepting ideal type (AIT). The types were spread across demographic and lifecourse categories; what most differentiated them was bodily trajectories. HITs and DITs were more likely to be thin or to have been thin. AITs and RITs were more likely to have been obese their entire lives.

Hopeful ideal type: description

The HIT epitomises those individuals engaging in the socially prescribed role of losing weight via dietary restriction and exercise. Their hope is that they will succeed in losing weight permanently by applying will power over their body. If they are successful, HITs may minimise the degree of stigma they experience and can serve as examples for others. By definition, such individuals are currently losing weight or maintaining a weight loss, and are the most publically accepted.

Examples

Many participants could be considered HIT examples. Todd and Harry had lost substantial amounts of weight years ago and not weight cycled. Todd stated he believed people could master their bodies. He hoped he could control his impulses to eat excessively and maintain his weight loss, although he was aware of the statistical unlikelihood of sustained weight loss. His self-esteem was intertwined with his weight loss, and he expressed scepticism over what he perceived as increased tolerance of obese bodies. HITs who had not weight cycled were less likely to condemn weight stigma. All examples of this type were highly conscious of weight regain, similar to the "Fat Busters" in Honeycutt's (1999) study:

> … I remember every time I used to lose a pound or even a half a pound I'd just be like oh yeah, like I can do this, I can beat this, and it was almost like a drug and like I can totally see how people get addicted to losing weight and get these crazy eating disorders. But with maintenance, you're just same weight, same weight. Like, you feel like you're striving for mediocrity almost (Todd).

Todd, however, was not necessarily the epitome of the HIT. He expressed frustration with the extent of dietary restraint required to maintain weight loss, suggesting some resistance toward simplistic weight loss messaging. HIT examples who had weight cycled but were currently pursuing weight loss, often expressed indignation over stigma, regardless of their belief in willpower leading to weight control. In accompanying Todd to a restaurant, he commented on the food, what he felt was the incongruence of slim servers, and placed onus for what he considered an "epidemic" on the fast food industry:

> … I still blame restaurants for a lot of the issues that overweight people have, like [relative] who's fairly overweight and he eats at McDonalds all the time and I'm just like, you know, yeah it's all

> about self-control, but disciplined willpower, but if this food wasn't so damn cheap and so accessible, and it's so good, we wouldn't have a lot of problems like that.

This is an externalising view that someone who had entirely adopted an individualistic, healthist perspective would not adopt (Crawford, 1980). Also in contrast to healthist imperatives, Todd worried less about health risks and more about appearance. Other HIT participants, particularly women and previous weight-cyclers, emphasised health factors beyond a narrow energy balance model, such as spirituality and enjoyment. Harry rejected some measurements of obesity that he felt did not accurately represent fitness. Therefore, while HIT participants prioritised weight loss, individual control, and the energy balance model, there was variability in views on stigma, industry culpability, and health and weight.

Despairing ideal type: description

DITs hope for relief from the socially vilified state of obesity. Similar to HITs, DITs consider themselves in violation of internalised healthist norms. They perceive themselves as blameworthy for their non-normative sizes, which they attribute to their lack of self-discipline concerning food and physical activity, reflective of standard obesity discourse. Such individuals are unlikely to have experienced permanent weight loss, and thus currently inhabit bodies subject to stigma. While chronically obese or perpetually weight cycling, such individuals perceive weight loss as a remote possibility reserved for persons who adhered to self-disciplining, healthist norms.

Examples

While slim in her early teens, middle-aged Daisy has since been a continual weight cycler. Eventually, she reached a weight she felt necessitated bariatric surgery. The surgery produced life-threatening complications, but Daisy eventually lost weight and was a marathon runner. An injury hindered her running, and Daisy had begun regaining weight. At a workplace eatery, she carefully controlled portions and caloric content of the meal, making special requests of servers. Still, she credited her weight regain to a lack of control in the presence of palatable food and unsustained motivation for exercise.

Similar descriptions of high levels of disrupted athleticism were present in other DIT narratives. Hannah had been a competitive high school athlete and weight lifter, and Paula was a gym member. All described relationships with food characterised by stress eating, coping, or feelings of insufficient control, which suggests uptake of an individualistic energy balance model. All DIT examples were also stymied by a lack of support in weight loss efforts or familial caregiving roles.

Less uniform among DIT examples were experiences with stigma. While Paula and Hannah could recount experiences that made them uncomfortable in public, Daisy was greatly affected by more overt stigma. She left a longstanding workplace to escape constant commentary on her food choices following her surgery. While Daisy spoke with anguish over her size and attributed it to her own actions, she felt the stigma she encountered was unjust and that her size was a consequence of psychosocial factors that should mitigate her stigmatisation:

> … You feel guilty if you eat because people are watching you because everybody knows you had the surgery and know you lost weight, but you want to eat like everybody else, and it's a birthday and somebody brought in cupcakes or you know something really good at [the cafeteria] that day or something but you know everybody watches and everybody comments and it's … I left the department I worked in for seven years because I knew that's what it would be like, and it didn't matter though because this is a small [workplace] everybody knows everybody talks, everybody watches because

> God forbid you don't know what you're eating yourself right, so it's a daily, it's a daily struggle it doesn't go away.

Daisy was less pre-occupied with achieving a normative BMI or altering her appearance than she was with being active, happy, and healthy again:

> I don't want to live my life sitting on the couch either; I want to do things with [relatives]. Like, when I first lost my weight and everything, I would go bike riding my [relatives] couldn't keep up with me … but you want to be able to do all those things … and enjoy life because how much fun do you have sitting at home, I spent a lot of time sitting at home, eating, being fat, doing nothing …

Daisy also referred to a colleague who was healthy despite being obese, in part due to social support. Indeed, a focus on mental and social wellbeing was present among all DIT examples. This suggests some resistance among all DIT examples to being potentially dismissed as unhealthy, by virtue of size alone.

Resigned ideal type: description

This type is characterised by less internalisation of standard obesity discourse compared to HITs and DITs. These individuals, chronically obese or perpetual weight cyclers, no longer believe that weight loss is possible for them, similar to "Equivocator" participants in Honeycutt's (1999) study. While not necessarily rejecting healthism or the dictates of self-regulated healthiness (Crawford, 1980), the specific goal of achieving weight loss has been abandoned. Alternate health goals may have been adopted, and potential benefits of weight loss are not necessarily rejected. Having encountered persistent stigma all their lives, these types fear further mistreatment, but compared to the despairing type, are more confident and indignant over such mistreatment.

Examples

Katrina is a middle-aged woman who remembered always having weight issues. Brief periods of weight loss were always followed by weight regain, and Katrina was sceptical over her capacity to lose weight permanently. Furthermore, Katrina did not appear to attribute this "failure" to her own actions but considered her current size immutable. She expressed frustration with doctors claiming she would die without inaccessible bariatric surgery, asserting that she "was not dead yet":

> … People are making millions of dollars on the suffering of people but I don't really see that there's a permanent solution, because I've lost lots and lots of weight over the years, gained it all back, lost, lost, lost … and gained it back, so clearly there is something that causes that to happen now, is that genetic … what is that?

Katrina believed weight loss could benefit her health but did not believe weight was the sole contributor to her health issues. She described a history of comfort eating, motivated by weight teasing, and familial heritability as contributors to her present size but also asserted high activity levels. Katrina was very concerned over another generation experiencing discrimination, which had impacted her occupational achievement, confidence, and social relationships. This oppression was something Katrina perceived as an issue that transcended any focus on lifestyle-shaming:

> … When I go on job interviews, I have an incredibly super crazy busy life … I need people to see that what a body looks like does not mean that I am stupid or I'm lazy or I don't know how to do it, or right

> … I do a lot, I'm … it's taken me a long, long time to recognize that I am not as dumb as people would like to believe that I am.

Thus, while internalising some standard weight-related discourse, Katrina was resistant to believing weight loss was possible for her. Her primary weight-related concern was addressing the effects stigma had had on her personal and professional life. Other participants shifted from HITs to RITs during data collection. Amelia and Christine had both experienced weight cycling and stigma, particularly in healthcare settings. Christine was especially frustrated at the lack of focus on the socioeconomic difficulties that impinged on her health behaviours. I accompanied them to their fitness centres. They were greeted by staff and fellow members, while smiling and gesticulating animatedly, and were familiar with group and personalised exercise regimes. At the end of data collection, Amelia described a not "negative" form of "surrender" with respect to accepting her stable weight, rather than seeking greater weight loss. Christine described a shift in focus from weight to health goals. While both believed weight loss might be health-beneficial, they also became more accepting of their weight and prioritised other goals.

Acceptor ideal type: description

Acceptors are the ideal type most resistant to dominant obesity discourse. These individuals renounce the view of obesity as necessarily unhealthy and adopt a Health-at-Every Size (HAES) position (Bacon, 2010). AITs may abandon moralistic imperatives of pursuing healthiness, but they may advocate for the elimination of discrimination based on size, weight, and presumed health behaviours. Discrimination is feared amongst AITs who have experienced its debilitating effects. Their diets could vary from the intuitive, healthful approach advocated by HAES practitioners, to one based solely on satisfying their varying hungers. While likely currently obese, these types could have various weight histories.

Examples

Clarissa is a middle-aged woman and like many of the other participants in this study who subscribed to a HAES view, she had overcome an eating disorder. Her stated goal was to be healthy without losing weight. Her lifestyle was characterised by a varied diet and a high level of activity. She led a fitness class for higher weight individuals; in the session I attended, she included messages of self-acceptance. She described stigmatising healthcare encounters that informed her resistance:

> When I go in and I tell you that my knees do not hurt, I'm not lying. When I go in and tell you that I do not have any of the issues that you want to have, I am not lying and when I tell you that I do yoga and increase my heart rate five hours a week, I am not lying. Just because I do not fit your mold, does not mean I am a liar.

All AIT examples expressed frustration with pervasive weight-related messaging and healthcare discrimination. To varying degrees, they rejected a moral imperative of health and the dictates of self-discipline. Matilda stated that she was as active as possible, given her family and work demands. She feared trying to lose weight would result in her resuming disordered eating. Melissa was trying to match her fitness activities to her embodied feelings, rather than engaging in daily vigorous activity, which she felt had been unhealthy. Therefore, all AIT participants were interested in pursuing health, they merely reconceptualised healthiness to not include a focus on weight.

Discussion

In this ethnographic study of obese individuals' experiences and perceptions of weight trajectories across time, participants could be assigned to a typology based on hopes, goals, histories, beliefs, fears, and lifestyles. However, participants' perspectives on their embodiment, others' bodies, and health were characterised by a high degree of ambivalence. This ambivalence was particularly evident with respect to views on their own bodies. Participants were aware of fluctuations in their self-acceptance and contacted me following interviews to further articulate perspectives on their bodies.

Discussing ambivalence is best done through considering participants' complicated negotiations of obesity messaging, embodied experiences, and stigmatising encounters. For example, Rachel was highly ambivalent respecting the impact of weight on her identity and health. As a child ballerina, she had an eating disorder. In adulthood, her weight, and attitude towards it, fluctuated greatly:

> … Whereas before I'd been like you know there's health at lots of different sizes, I'm healthy, you know there's a lot of things … I'm healthy, I'm extremely healthy cardiovascular wise … I'm extremely healthy, you know my blood pressure is awesome, my blood sugars are awesome, like everything else is really great, it's just the weight. But when it started to perhaps to be a potential factor for my muscular skeletal, endurance in my job …

Rachel condemned weight-related discrimination and advised "editing out" biased individuals from one's life. Having been introduced to the HAES movement, she accepted some of its tenets. However, she worried her weight would impede her ability to function in her vocation as she aged. She was concerned with being a healthy role model to her healthcare clients when advocating for a healthy lifestyle. She was professionally obligated to use the BMI but doubted its efficacy. While hoping for weight loss, she positioned it as a pleasant side effect of more holistic health aims. Her renewed health objectives stemmed from weight loss incurred during injury rehabilitation training. While she often maintained that it was possible to be healthy at a larger size, she was anxious for the wellbeing of very heavy clients.

Rachel's lifestyle habits varied across a size-accepting spectrum. She feared re-engaging in disordered eating and ceased weighing herself. She monitored her intake, censured herself regarding lapsed exercise, and was worried over using food as a numbing agent. However, she derived pleasure and delight in preparing and consuming food. I spent a day with Rachel, planning her weekly menu, grocery shopping, and baking bread. She discussed the health-based reasoning behind the effort she exerted concerning food. Rachel was impossible to neatly categorise, even within a single interview, as any particular "type" of obesity or as accepting or non-accepting of her size.

The fraught relationship with public and private embodiment and body satisfaction exists even among fat studies scholars (Heyes, 2007; Longhurst, 2012; Murray 2008, 2009; Throsby & Gimlin, 2010). For example, Murray (2008, 2009), a prominent fat studies scholar, has analysed in depth her embodied critique of fat activism and acceptance, "coming out as fat," and her own and others' reactions to her weight loss surgery. Heyes (2007), Longhurst (2012), Throsby and Gimlin (2010) explored the irreconcilability of their scholarly and politicised critique of bodily ideals and their personal body dissatisfaction and weight loss endeavours. Honeycutt (1999) identified ambivalence amongst the size-accepting "Equivocators" in her study. In this study, some participants became accepting of their weight over time and more embracing of non-weight-centric goals. This suggests a more complicated form of ambivalence than what may be implicit in some of the previously cited works, i.e. that only public fat acceptance is possible, and individuals will always long for a thin ideal.

In the present study, multiple factors contributed to participants' fluid weight perspectives and acceptance. Participants' fluctuations in self-acceptance and various weight-related perspectives may be a form of "agency play" (Battaglia, 1997) or "playing with reality" (Jackson, 1998). Battaglia (1997) described this as the use of agency in discourse, its strategic concealment, and its foregrounding, when actors ambiguate subject positions to elevate their positioning in particular contexts. This negotiation occurs in other embodied contexts, such as resistance to, and engagement with, treatment services and pro-anorexia websites among persons with anorexia nervosa (Lavis, 2011). Individuals of all sizes engage in this form of identity formation and protection when their credibility is threatened, and its usage does not connote insincerity. Participants were agentic actors who relied on multiple resources to understand their health and to resist stigmatising messages and encounters. In talking through these issues, they relied on numerous discourses in attempting to explore and explain themselves to others. Highlighting periods of embodied wellbeing was an example of resilience in what was an ongoing struggle to retain credibility in a fat-phobic and healthist environment. This is shown in other studies when the need for broader health definitions and less stringent "healthy weight" criteria is expressed (e.g. Kwan, 2012; Lewis et al., 2010; Monaghan & Hardey, 2011; Tischner & Malson, 2012).

Jackson (1998) discussed the human need to imagine oneself as able to exercise control in one's life. Pictured as a game, this may operate along a spectrum from observance of the game's rules to their outright rejection. During threatening periods, mastery play allows for the mental reconceptualisation of an individual's "*experience* of the situation" (Jackson, 1998, p. 30). This may be essential for understanding some participants' experiences with weight loss. Their weight loss efforts resulted in mental turmoil and physical deterioration as they slipped into unhealthy weight preoccupation and disordered eating. Their capacity to exert absolute control over their bodies was called into question, as it was for chronic weight cyclers. Ultimately, these participants maintained their perceived mastery by rewriting the game's rules and choosing to privilege a variety of alternate health outcomes over weight loss aims.

In joining in this "play" (Battaglia, 1997; Jackson, 1998), what is at stake for participants is their legitimacy as responsible health-seeking citizens. As such, they may seek to position themselves as healthy citizens who merely fall outside of societal approved sizes but not standards of health. If they have not recently been active, they may instead depict themselves as responsible citizens who are correcting any lapses in healthful behaviours (Crawford, 1980). If they do not engage in socially condoned health behaviours, they may consider how their lifestyles align with socially justifiable reasons for such recusal, for example, stress or psychological issues. Others may reconfigure the rules, by highlighting the injustice of stigma and the unfairness of the game itself. Participants who reject the standard weight loss/maintenance game (Jackson, 1998), may reimagine themselves as revolutionaries in designing a new game (Wann, 2009). This game's objective may shift from weight to health and self-acceptance. In the case of Clarissa's mastery play, the definition of what constitutes health (the game's objective) has been reconstrued. This allows fit and active Clarissa to advance herself as a worthy contender, regardless of her size, as she advocates for an inclusive, holistic definition of health and healthy lifestyles.

Murray (2008) discussed another form of ambivalence when critiquing what she sees as fat activism's proposal that fat persons can alter their bodily views and become fat accepting. She argued this is extraordinarily difficult given discursive influences on embodied subjective experiences and rampant, debilitating fat phobia. A fat person's experiences of being stigmatised have likely instilled, at the least, an ambiguous relation to one's body (Murray, 2008). Thus, in addition to strategic negotiations of agency, participants in my study likely shifted affectively with respect to body acceptance. For example, participants often stated that while they might view their appearances positively, this could alter with seeing their images in photographs or mirrors. Weight loss often produced a positive response, even in those doubtful of standard obesity

messaging. This positivity may have derived from personal affective embodiment and increased currency in a healthist environment. The relationship between size acceptance and weight loss amongst by participants was especially difficult to disentangle. Participants often stated they derived pleasure and value from activity, regardless of weight loss. However, they would often re-iterate that their ultimate activity goal remained weight loss.

In summary, participants' views on their bodies were inalienably tied to their embodied subjectivities and experiences. They had lived most of their lives in bodies treated as abject, stigmatised, and contemptible by a healthist, sizist community. Therefore, while some developed self-acceptance and opposed discrimination; for some, their lived experiences made it difficult to "simply *chang[e] [their] mind[s] about [their] bod[ies]*" (Murray, 2008, p. 109, Murray's emphasis) and they remained in ever-fluctuating states of body (dis)satisfaction.

Conclusions

Participants exhibited varied views on health and obesity, contingent on their current weight, previous weight histories, and social and discursive encounters and exposures. While no participant was an exact match, participants could be categorised according to a Weberian Ideal Typology (Weber, 1949). Types occupied a spectrum from aspiring to, and believing in their capacity for, permanent weight loss to advocating for fat acceptance. Such positioning was not static. Highlighting the fluidity of bodies (Longhurst, 2001) and the ambivalence of striving for body acceptance (Heyes, 2007; Longhurst, 2012; Murray, 2008, 2009; Throsby & Gimlin, 2010), participants' inner hopeful ideal types could re-emerge with weight loss or the re-sparking of their faith in the possibility of a normative size. Other participants, after enduring chronic weight loss struggles, chose to foreground health-centric goals and self-acceptance. The typology and examples provided can serve as a source of comparison and measurement for scholars examining embodied lived experiences and for policymakers and clinicians trying to treat patients and design effective, affirming public health programming. It broadens the view of obesity from a static, self-imposed, and pathological condition to a fluid and contingent state experienced by individuals, often dedicated to health, who must undertake ongoing identity negotiation to cope with pervasive fat phobia. This may help problematise existing views of obesity as pathology, brought on by sloth and gluttony (Gard & Wright, 2005), and open the way for more salutogenic, non-stigmatising approaches that privilege obese individuals' experiential knowledge, struggles, and priorities.

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