UNIVERSITY OF CALIFORNIA SAN DIEGO

Misdiagnosing Fat Oppression:
Weight Stigma and the Anti-Obesity Assemblage

A Dissertation submitted in partial satisfaction of the requirements
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Communication (Science Studies)

with a Specialization in Critical Gender Studies

by

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2024

The Dissertation of Rachel Fox is approved, and it is acceptable in quality and form for publication on microfilm and electronically.

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Dedication

This dissertation is dedicated to the people who need it.

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Abstract of the Dissertation

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Rachel Fox

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Professor Boatema Boateng, Co-Chair
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In the US, fatness is systematically devalued, and prejudice and discrimination against fat people is prevalent. Weight stigma researchers and advocates argue that defining and treating fatness as a disease reduces stigma against fat people, while fat-positive scholars argue it

exacerbates stigma. In this dissertation, I propose a new theoretical concept: the anti-obesity assemblage, defined as the network of human and non-human actors, technologies, practices, and discourses that enable and enact the elimination of obesity. I argue that the anti-obesity assemblage structures the oppression of fat people. I use this concept to investigate two main questions. First, how is the anti-obesity assemblage intertwined with weight stigma research and advocacy? Second, how does that entanglement restrict the capacity of weight stigma research and advocacy to meaningfully combat anti-fatness? To answer these questions, I use a variety of methods, including content analysis, discourse analysis, praxiography, and assemblage theory, to analyze what weight stigma researchers and advocates do and say in their stigma reduction efforts. Based on a random sample of 400 academic articles, I find that most (64%) weight stigma research prioritizes fighting obesity over investigating or reducing stigma. In my praxiography of weight stigma interventions with health professionals, I find that these interventions exercise what I call "afflictive power," defining fatness as a source of suffering and incompatible with a good life. Anti-obesity weight stigma interventions are stigmatizing in part because they depend on the exercise of afflictive power. Finally, my analysis of Novo Nordisk's weight stigma-focused media campaign shows that this campaign prioritizes obesity education and treatment and narrowly defines stigma in terms of shame and blame, yielding the overarching message that weight loss is the solution to fat oppression. Taken together, my findings demonstrate that anti-obesity efforts, including treating fatness as a disease, can never combat anti-fatness because they inevitably uphold the devaluation of fatness and direct attention and resources toward eliminating obesity, rather than toward social and political change that would improve the status of fat people. Fat studies scholars and activists must turn their focus to the role of the anti-obesity assemblage in upholding fat oppression.

Introduction

In the past decade, concern for weight stigma[1] has risen dramatically, with many professional and advocacy organizations putting out calls to combat this form of discrimination. In April 2020, a group of 36 internationally recognized obesity experts from the fields of medicine, public health, public policy, and patient advocacy published a "Joint International Consensus Statement for Ending Stigma of Obesity" in *Nature Medicine* (Rubino et al., 2020). 58 additional organizations, 15 scientific journals, 15 academic institutions, and one parliamentary group endorsed the statement and took the "pledge to eliminate weight bias and stigma of obesity." In January 2022, the Obesity Action Coalition, a US non-profit advocacy group, released their "Stop Weight Bias" public awareness campaign, partnering with pharmaceutical companies and other businesses to provide first-person testimonials about the harm of weight stigma, media guides, and a web form for individuals to report instances of weight bias in their lives (Obesity Action Coalition, 2022). In March 2024, Oprah Winfrey, (in)famous for sharing her weight journey with millions of viewers over three decades, appeared in "An Oprah Special: Shame, Blame and the Weight Loss Revolution" with the goal of "releasing the stigma and the shame and the judgment" around weight (Blum, 2024). Lately, even people in the most unexpected corners of medicine, public health, and mass media have reached a consensus about the harm fat[2] people face from weight-based discrimination.

[1] Throughout this dissertation, I will be using the term "weight stigma" to encompass a number of related concepts, including weight bias, obesity stigma, and obesity bias. These terms are all commonly used in the field of weight stigma research, as opposed to the phrases "fat stigma," "anti-fatness," or "fat oppression," which are used in fat studies (Pausé, 2021)

[2] Following the field of Fat Studies, I use the term "fat" as a neutral descriptor of size. As I explain in Chapter 1, the terms "overweight," "obese," and "obesity" are part of the architecture of fat oppression. I do not put them in quotes because they are part of my object of study, but the lack of quotes should not be taken as an endorsement of their use.

The actors in the examples above are linked by the common goal of producing a world without fat people, and by the belief that weight stigma impedes efforts towards this goal. For example, Rubino et al. argue that "weight stigma represents a major obstacle in efforts to effectively prevent and treat obesity," so "tackling stigma is not only a matter of human rights and social justice, but also a way to advance prevention and treatment of [this disease]" (2020, p. 491). Similarly, the home page of the "Stop Weight Bias" campaign website features a quote from one of the individual testimonials collected for the campaign: "All weight bias does is trap people in a spiral of shame and self-blame, neither of which works to address the very real, medical problem of obesity" (2022). Oprah echoes these messages in her special: "I come to this conversation with the hope that we can start releasing the stigma and the shame and the judgment, to stop shaming other people for being overweight or how they choose to lose – or not lose – weight" (2024). From these quotes, it is clear that these actors see addressing weight stigma and fighting obesity as not only compatible, but intertwined goals. In their view, reducing weight stigma benefits everyone by removing barriers to anti-obesity efforts.

In contrast, scholars in the field of fat studies, "an interdisciplinary field of scholarship marked by an aggressive, consistent, rigorous critique of the negative assumptions, stereotypes, and stigma placed on fat and the fat body," reject the idea that it is possible to reduce stigma and fight obesity simultaneously (Rothblum & Solovay, 2009, p. 2). For instance, Calogero et al assert: "It is difficult to understand how scholars and advocates can vilify weight stigma, yet in the same breath describe the people who belong to this stigmatized group as *diseased* and their bodies as the *problem*" (2016, p. 14, original emphasis). Similarly, Gingras and Stranz argue that treating fatness as a health problem is incompatible with weight stigma reduction: "We challenge the suggestion that the medicalization of fatness…can be pursued without stigmatizing

fat…when your mandate is to prevent and treat obesity, you are certainly not fat accepting" (2023, pp. 104–108). Longtime fat activist Marilynn Wann makes the same argument about the Rudd Center for Food Policy and Health. Of the Center's goals to "improve the world's diet, prevent obesity, and reduce weight stigma," she says: "With its first two goals, Rudd actually increases weight stigma, thereby undermining its third goal. There is no nice, unstigmatizing way to wish that fat people did not eat or exist" (2009, p. xvii). According to fat studies scholars, anti-obesity efforts inevitably *increase* the stigmatization of fat people, making them incompatible with stigma reduction.

In this dissertation, I take up the provocation issued by fat studies by asking: how does pursuing the goal of eliminating obesity interfere with the project of reducing weight stigma? I answer this question by examining the discourses and practices of weight stigma research and advocacy with a focus on how actors in these fields depict fat people, how they construct the problem of weight stigma, and what kinds of recommendations they make about how to ameliorate weight stigma. Said more simply, I examine what weight stigma researchers and advocates actually do and say in their attempts to simultaneously address weight stigma and fight obesity.

This dissertation focuses on three contexts: weight stigma research, weight stigma interventions with health professionals, and a weight stigma/obesity-themed public awareness campaign by pharmaceutical company Novo Nordisk. Across all three, I find that weight stigma researchers and advocates advance obesity elimination *at the expense* of addressing weight stigma. In order to argue that fat people need anti-obesity treatment, weight stigma actors must consistently depict fat people in stigmatizing ways. These depictions often reduce fat people's lives to one-dimensional narratives of disease and suffering. Additionally, weight stigma actors

narrow the definition of weight stigma to fit with an obesity elimination agenda. They ignore the role that medical discourses of pathology play in stigma and construct weight stigma as the systemic undertreatment of obesity resulting from ignorance about the nature of weight gain. By focusing on the ways that weight stigma can interfere with fat people seeking and undergoing medical treatment for obesity, weight stigma researchers and advocates ultimately portray medical interventions for obesity – and the subsequent weight loss spurred by such interventions – as the solution to anti-fatness. Thus, I argue that fighting obesity and fighting weight stigma are fundamentally incompatible pursuits. Fighting obesity necessarily entails reinforcing fat people's low social status and directing resources towards their medical treatment, rather than ameliorating their social mistreatment. By advancing anti-obesity efforts, weight stigma research and advocacy not only fail to reduce stigma, but intensify the very stigma they claim to combat.

In this introductory chapter, I begin by reviewing existing fat studies accounts of the role that medicine plays in stigmatizing fat people, highlighting how fat studies has yet to address the structural role that anti-obesity efforts play in anti-fatness. I argue that, without a concept that explains how anti-obesity efforts structure anti-fatness, fat studies has not been able to effectively critique weight stigma research and advocacy. Next, I outline my interdisciplinary theoretical approach. In order to address the limitations of existing fat studies analytics, I draw on feminist STS, Foucauldian theories of power, and Deleuze and Guattari's post-Foucauldian theory of assemblages to develop the concept of the *anti-obesity assemblage.* I use this concept to formulate novel research questions about weight stigma research and advocacy. Then, I discuss my decision to use several different methods to produce both broad snapshots and deep analyses of the discourses and practices of weight stigma actors, always attending to their likely impact. I end with an overview of the dissertation and summaries of the remaining chapters.

Literature Review: The Role of Medicine in Anti-Fatness

I use the term "anti-fatness" to describe the totality of the devaluation of fatness and the discrimination and prejudice against fat people that is linked to this devaluation. Anti-fatness is comprised of ideologies, practices, and systems that mark fatness as an undesirable, deviant, or inferior embodiment. Anti-fatness is prevalent in the US. This prevalence has been extensively studied and documented in academic literature. Despite improvements in population-level attitudes towards many other marginalized groups over the past 20 years, implicit attitudes towards fat people have remained consistently negative (Charlesworth & Banaji, 2022). Moreover, many people hold both implicit and explicit anti-fat attitudes; such attitudes have been documented in children, parents, teachers, romantic partners, employers, and health professionals (Baker et al., 2017; Bernard et al., 2014; Brochu & Morrison, 2007; Crandall et al., 2001; Daníelsdóttir et al., 2010; Elran-Barak & Bar-Anan, 2018; Fontana et al., 2013; Jayawickrama et al., 2023; Lydecker et al., 2018; K. S. O'Brien et al., 2007; Phelan et al., 2014; Philip et al., 2023; Sabin et al., 2012; Teachman & Brownell, 2001). In addition, mass media depictions of fat people are relentlessly negative. News broadcasts frequently portray fat people from behind and/or from the neck down, engaging in stereotypical "fat" behaviors (Cooper, 2007; Heuer et al., 2011; McClure et al., 2011; Puhl, Luedicke, et al., 2013). Such negative depictions have been shown to worsen anti-fat attitudes (Saguy & Almeling, 2008). Fat people are often presented as the butt of jokes in television shows, and reality TV shows exploit fat people's suffering for entertainment, as in shows like *The Biggest Loser* or *My 600 Pound Life* (Cameron, 2022; Ingraham, 2022; Justin, 2021; Raisborough, 2016; Zimdars, 2019). On a structural level, fat people are often excluded from social life by a built environment not designed to accommodate their bodies (B. Evans et al., 2021; Huff, 2009; Owen, 2012; Solovay, 2012). Fat people often

struggle to find clothing, and this problem grows exponentially worse as size increases (C. Evans, 2020). Fat people are also often neglected in the design and development of medical technologies and treatments (Brown & Ellis-Ordway, 2021; Goss et al., 2020; A. H. Gupta & Blum, 2022).

Research indicates that the vast majority of fat people will experience weight-based stigma at some point in their life, and that the likelihood of experiencing weight stigma increases dramatically as one's size increases (Andreyeva et al., 2008; Gerend et al., 2022; Puhl et al., 2021; Puhl & Brownell, 2006; Spahlholz et al., 2016; Vartanian et al., 2018). Fat people frequently internalize negative attitudes and beliefs about themselves (Durso & Latner, 2008; Pearl & Puhl, 2018) but also experience prejudice in interpersonal relationships with parents, spouses, friends, coworkers, teachers, classmates, and health professionals (Côté & Bégin, 2020; Fikkan & Rothblum, 2012; J. Mensinger et al., 2018; Puhl, Peterson, et al., 2013; Puhl et al., 2016; Puhl & Heuer, 2009, 2010; Puhl & Lessard, 2020; Schmidt et al., 2023; I. Thompson et al., 2020). Fat people, especially fat women, face penalties in hiring and compensation because of their weight (Caliendo & Gehrsitz, 2016; Flint et al., 2016; Giel et al., 2010; Pearl, 2018; Rudolph et al., 2009; Swami et al., 2010). Fat people also face discrimination in legal settings. Body size is not a protected class in the US outside the state of Michigan, so fat people do not have legal recourse for experiencing discrimination (Kirkland, 2008; Meadows et al., 2020; Solovay, 2012). Fat women who experience sexual assault are less likely to be believed and fat people are more likely to be treated as responsible for experiencing a crime (Carels et al., 2022; A. Clarke & Stermac, 2011; Schvey et al., 2013; D. E. White et al., 2014; Yamawaki et al., 2018; Zidenberg et al., 2021). Within healthcare, fat people frequently experience diagnostic overshadowing, in which their ailments are blamed on their weight rather than treated (Kinzel,

2014; Paine, 2021). Fat people may also be denied medical procedures, such as joint replacement surgeries, gender affirming care, and fertility treatments, based on their weight (Boots et al., 2024; Brownstone et al., 2021; Chrisler & Barney, 2017).

Among fat studies scholars and fat activists, there is an implicit recognition that efforts to produce a world without fat people contribute to anti-fatness. When making this claim explicit, however, most authors pinpoint the beginning of the process of producing a world without fat people – medicalization – as the source of anti-fatness (McHugh & Kasardo, 2015). For instance, Marilyn Wann asserts:

> Calling fat people "obese" medicalizes human diversity. Medicalizing diversity inspires a misplaced search for a "cure" for naturally occurring difference. Far from generating sympathy for fat people, medicalization of weight fuels anti-fat prejudice and discrimination in all areas of society. (2009, p. xiii; see also LeBesco, 2009)

Although Wann identifies that the medicalization of fatness fuels anti-fatness, her explanation of *how* this occurs is quite vague. Miller similarly argues that "the logics of the obesity epidemic perpetuate…damaging anti-fat stigma" but does not elaborate on how this occurs (2019, p. 81). This assertion is echoed by Prohaska and Gailey: "The classification of 'obesity' as 'epidemic' in medicine and as a disease by the American Medical Association resulted in the labeling of fat as a social problem and pathological condition that needs to be remedied" (2018, pp. 2–3). Fat studies scholars generally provide two explanations for how the medicalization of fatness contributes to anti-fat prejudice: by proliferating inaccurate claims or by making fat people responsible for their weight.

Scholars often claim that the medicalization of fatness is illegitimate because it is based on exaggerated, incomplete, or otherwise biased data about the relationship between higher weight and poorer health. In other words, researchers studying anti-fatness often critique pathologizing claims about fat bodies as harmful because they are *false*. Much of this literature

focuses on debunking anti-obesity claims. For example, in 2001, the US Surgeon General announced that 300,000 excess deaths in the US were related to obesity and in 2004, a team of CDC epidemiologists upped this claim to 400,000 excess deaths per year (cited in Guthman, 2013). Although this claim was immediately refuted by another group of CDC researchers (Flegal et al., 2005), dozens of articles and books within fat studies and related fields have devoted time to debunking it (Bacon, 2010; Brown, 2016; Campos, 2004; Flegal, 2021; Gard, 2010; Gordon, 2020; Guthman, 2013; Harrison, 2021; Manne, 2024; Mehl, 2023; Monaghan et al., 2013; Nath, 2019; J. E. Oliver, 2006; C. O'Reilly & Sixsmith, 2012; Rogers, 2018; Saguy, 2013; Saguy & Almeling, 2008; Stoll, 2019; Wann, 2009). A similar amount of ink has been spilled over the Body Mass Index (BMI). Critical scholars have critiqued the BMI on the grounds that it was never meant to be used as an individual diagnostic tool (for diagnosing "overweight" and "obesity) and that it was developed on a non-representative population, meaning that it does not accurately predict individual health (Anderson, 2012; B. Evans & Colls, 2009; Flegal, 2023; Fletcher, 2014; Gordon, 2020; Gutin, 2018, 2021; J. E. Oliver, 2006; Prillaman, 2023; Rasmussen, 2019a; Strings, 2019, 2023; Strings & Bell, 2024). One of the most popular topics to debunk is the idea that obesity is an "epidemic" at all. In this critique, scholars typically assert that the "obesity epidemic" is a "moral panic" based on a misleading exaggeration of the harms of higher weight using an epidemiological metaphor that inaccurately implies higher weight is contagious (Boero, 2009a; Bombak, 2014; Fletcher, 2014; Gard, 2010; Greenhalgh, 2015; Gutin, 2018; Harrison, 2021; Herndon, 2014; LeBesco, 2011; Lupton, 2018; Moffat, 2010; Nicholls, 2013; J. E. Oliver, 2006; Saguy, 2013). Other "fat myths" that are frequently targeted for debunking are: eating less and exercising more can produce long term weight loss, losing weight improves health outcomes in the long term, and weight is a good

predictor of morbidity and mortality. Though claims about the falsity of anti-obesity discourse imply that portraying fatness as an urgent public health problem somehow contributes to anti-fatness, the focus of this scholarship is on contesting the accuracy of these claims and identifying the biased motivations underlying their production. Thus, the precise mechanisms by which such claims contribute to anti-fatness are left mostly unstudied and untheorized.

In addition to debunking, critical scholars frequently claim that medicalizing fatness positions fat people as responsible for their weight, leading to inappropriate blame and condemnation. The arguments in this literature follow four steps. First, authors point to the social-structural forces or factors that make certain populations already facing marginalization more likely to be fat. These forces include the stress of racism and poverty, obesogenic environments (lack of green space for exercise, easy access to fast food and barriers to accessing more nutrient dense food), and disparate exposure to pollution. Second, authors assert that, although fatness is produced through structural forces, neoliberalism has turned fatness into a public health crisis that individuals must manage on their own through lifestyle change. Under neoliberalism, the social-structural factors that drive fatness remain unaddressed, which these authors portray as unjust (Guthman, 2009; Harjunen, 2016; King-White et al., 2013; LeBesco, 2011; Rose Spratt, 2021; Scambler, 2018; Schorb, 2022). In the third step of this argument, authors argue that the war on obesity unjustly blames marginalized people for being fat and makes them responsible for losing weight, even though they are not to blame. Many authors end their arguments at this step, leaving readers with the message that anti-obesity efforts are harmful because they do not address the root causes of weight gain and disproportionately target people who are more likely to be fat because of pre-existing inequalities (Brewis, 2010, 2014; Firth, 2013; Greenhalgh & Carney, 2014; J. E. Oliver, 2006; Strings, 2015; Tomiyama et al., 2018;

Yoshizawa, 2012). Other arguments contain a fourth step that makes the harms of anti-obesity efforts more explicit. In the fourth step of this argument, authors assert that marginalized people are harmed by being blamed for fatness, as such blame leads to increased surveillance of these groups, villainization of their lifestyles, and an intensified effort to force them to lose weight (Boero, 2009b; R. Cain, 2013; Dame-Griff, 2020; Dickman, 2022; B. Evans & Colls, 2011; Friedman, 2015; Herndon, 2005, 2014; Kirkland, 2011; Maher et al., 2010; Mollow, 2015; Parker, 2014; Rice, 2015; Warin et al., 2012). While this scholarship does accurately identify how the medicalization of fatness can negatively impact fat people, it primarily focuses on who is made responsible for the existence of fat bodies and who should be blamed, rather than focusing on how efforts to combat obesity *per se* contribute to anti-fatness.

The scholarship I have identified above is focused on either the literal production or social construction of obesity. Studying these phenomena is different from studying how anti-fatness is structured. Scholarship that focuses on disproving the factual basis for anti-obesity efforts may undermine certain claims about the relationship between weight and health. But by claiming that biased data is what makes anti-obesity efforts illegitimate, this scholarship implies that anti-fatness *would be legitimate* if based on accurate data. Conversely, these claims also imply that anti-obesity efforts can only contribute to anti-fatness *if they are false*. Said differently, in this scholarship, the injustice of the medicalization of fatness hinges on this medicalization being inaccurate. However, the issue of whether a claim is stigmatizing is orthogonal to its accuracy – whether a claim is true does not determine its consequences. The social construction of obesity as explored in existing research is largely separate from the question of anti-fatness.

Similarly, scholarship that condemns the medicalization of fatness for blaming fat people implies that a war on obesity that avoids blaming fat people will not contribute to anti-fatness. Indeed, this has been the contention of many progressive thinkers. Scholars in this camp use the most critical social scientific theories to argue that structural changes to decrease obesity rates will be far less problematic than current, individualizing anti-obesity efforts (see, for example, Fullagar et al., 2021; K. Gupta, 2019; Land, 2018; Landecker, 2013; Warin, 2015, who draw on feminist new materialist theories to argue for this point). In this scholarship, the injustice of the medicalization of fatness hinges on this medicalization directing attention away from the structural causes of "disease," i.e., of obesity. Anti-fatness is constructed as the failure to treat society, rather than individual behavior, as the real cause of obesity. However, challenging blame leaves intact the devaluation of fatness, reinforcing the idea that the existence of fat people is a problem to be dealt with. After all, identifying who should be blamed is only necessary if the existence of fat people is a problem for which someone must be held responsible. As such, this approach is not sufficient for explaining the role of medicalization in anti-fatness.

The insufficiency of these approaches becomes even more pronounced in fat-positive critiques of weight stigma research and advocacy. As I will show, weight stigma research and advocacy are united by the common belief that weight is fundamentally outside of an individual's control: nearly every actor within these endeavors would agree that it is inappropriate to blame fat people for being fat. In fact, much of weight stigma advocacy focuses on intervening in attributions of blame. Thus, the critique that medicalization leads to blaming fat people for their bodies is more difficult to levy against weight stigma research. This leaves fat positive scholars with only the strategy of debunking claims about obesity. In their article on "Scientific Weightism," Calogero et al. state that weight stigma research perpetuates a

"recognizable weight narrative" that "fat is bad, obesity is a disease, we are in the midst of an 'obesity epidemic,' obesity causes increased morbidity and mortality," etc. (2016, p. 13). They refute these claims, arguing that they are "fallacious" and urging weight stigma researchers to "steer clear of the exaggerated warnings of the 'obesity epidemic'" (2016, pp. 13–14). Schmidt and Brochu assert that many weight stigma interventions are based on a "dominant, weight-normative paradigm" that "likely limit[s] the effectiveness of the interventions" by perpetuating obesity myths (2021, p. 155). To increase the efficacy of such interventions, they suggest that interventions should "address misconceptions regarding weight and health, debunk stereotypes of fat people, and raise awareness of weight bias…by providing information on critical weight science and weight-inclusive models of health" (2021, p. 155). Similarly, Brochu and Amirniroumand recommend that interventions debunk "the assumptions underlying the dominant weight-normative perspective on health" so that "stigmatizing assumptions about weight and health can be rigorously challenged" (2021, p. 165). Gingras and Stranz make a similar recourse to debunking in their criticism of Obesity Canada. They argue that "anti-fat experts," even those who claim to be fighting weight stigma, "show disregard for the enormous body of literature that demonstrates the fragile association between people's weight and their health" (2023, p. 105). However, as I have just articulated, asserting that a claim is false is different from asserting that it stigmatizes; whether a claim is stigmatizing depends on its impact rather than its veracity. Consequently, accusing weight stigma researchers and advocates of perpetuating debunked claims is not the same as demonstrating that their materials or actions stigmatize fat people.

In addition, these fat positive critics of weight stigma research and advocacy have struggled to explain how anyone could believe that it is possible to fight obesity and weight

stigma at the same time. This struggle often appears in the rhetorical flourishes employed by these authors. Calogero et al. imply that the contradiction between fighting obesity and reducing weight stigma is self-evident, but they do not explain this contradiction, stating, "[I]t is difficult to understand how scholars and advocates can vilify weight stigma, yet in the same breath describe the people who belong to this stigmatized group as *diseased*" (2016, p. 14). Brochu and Amirniroumand assert that many weight stigma interventions "are weight-loss centered, focus on the prevalence and consequences of fatness, or frame fatness as a disease." According to these authors, this focus means that "even though these interventions intend to reduce weight bias, they reinforce a negative cultural value of fatness" which "limits the ability of these interventions to effectively reduce weight bias, as they are situated within a social context that stigmatizes weight" (2021, p. 165). In this assertion, it is clear that Brochu and Amirniroumand see interventions that frame fatness as a disease as a hindrance to weight stigma reduction, but the question of *how* such medicalizing statements perpetuate anti-fatness is unclear. Gingras and Stranz accuse Obesity Canada of engaging in "magical thinking" when they try to combat obesity and reduce weight stigma simultaneously. However, "magical thinking" is not a social mechanism, it is a psychological explanation for the individual behavior of believing two contradictory ideas. As such, this concept does not explain why these two endeavors are incompatible, but merely reasserts that they are. These authors claim that "it is obvious that the medicalization and the subsequent pathologizing of the fat body form the predicates for fat stigma," but do not detail how this "obvious" process works (2023, p. 104).

There are two gaps in the fat positive literature on weight stigma research and advocacy. First, this literature does not provide an explanation for how weight stigma researchers and advocates work to make fighting obesity and fighting weight stigma compatible. If these

endeavors are not compatible (and I agree that they are not), how do weight stigma researchers and advocates consistently claim not only that fighting obesity and fighting weight stigma *are* compatible but that such endeavors must be pursued simultaneously? Second, and more importantly, the fat positive literature on weight stigma does not explain *how fighting obesity contributes to anti-fatness*. Even Marilyn Wann's pithy assertion that "there is no nice, unstigmatizing way to wish that fat people did not eat or exist" is not substantiated with explanations of how "wishing that people did not exist" contributes to their systemic oppression. It is not possible to levy a substantive critique of anti-obesity weight stigma research and advocacy without this explanation.

In this dissertation, I investigate how weight stigma research and advocacy uphold and contribute to anti-fatness through their focus on fighting obesity. A significant amount of weight stigma research is done by social psychologists. The critiques of this research mostly come from social psychologists as well. As such, these critiques are generally concerned with the extent to which specific claims are stigmatizing at the individual level, i.e., how much a particular claim leads individuals to develop stigmatizing attitudes and beliefs. As a critical, qualitative social scientist grounded in the fields of Communication, Science and Technology Studies, and Feminist Studies, I am interested in providing an explanation that goes beyond individual psychology and instead provides a structural perspective on how these endeavors perpetuate anti-fatness.

Theoretical Framework

The field of science and technology studies (STS) provides both precedent and a set of tools for studying a field of scientific research. A fundamental tenet of STS is the idea that all scientific knowledge is socially produced. STS scholars typically reject the assumption that only

false or flawed scientific research is socially constructed, as well as the assumption that true, objective research is free from social influence. STS scholars have shown that the goals, interests, and values of researchers shape the knowledge that is produced. For example, the social goals of researchers shape how they define their concepts, which research questions they ask, and what outcomes they measure. Thus, when a group of researchers share a goal, this can produce systematic gaps in their research, even if the data they have gathered is accurate (Fleck, 2012). STS scholars also investigate research practices, tracing the social arrangements and subjectivities that are formed through the process of knowledge production itself (Callon, 1984; Latour & Woolgar, 1986). For instance, feminist STS scholars studying psychology have investigated the materials and experimental setups created in the practice of research as themselves cultural products (Haraway, 1990). Here, once again, STS scholars are not limited to questions regarding whether a given set of research practices produce flawed or misleading results. Finally, STS scholars study the societal impact of technoscience. In particular, STS scholars have shown how networks of expertise remake the world in their image (Hacking, 1998; T. Mitchell, 2005). Rather than simply "applying" their findings, networks of expertise, made of human and non-human actors, produce new social and material arrangements as they expand: per Law, "technoscience practices are shaped by but also shape the social. They help to format the world" (Law, 2017, p. 39; see also Eyal, 2013).

I am particularly influenced by work within feminist STS that disavows the demand for a detached, impartial, and seemingly "objective" approach to scholarship. As Haraway and other standpoint theorists explain, all scholarship advances an agenda. Therefore, while some approaches to research may appear to be devoid of a political goal, this is only because the power and agenda embedded in some approaches to research has been hidden, while others appear

"political" or "biased" because they diverge from the conventions of objectivity (Haraway, 1988). A feminist STS approach to research means that I readily acknowledge the assumptions and goals that I bring to my scholarship and see them as a valuable part of the research endeavor. I am interested in studying anti-fatness and do not pretend otherwise. Accounting for this goal has led me to select methods that, as I will discuss shortly, enable me to trace and document anti-fat sentiments and practices in a way that is not predetermined by existing categories of analysis nor limited to only one part of the phenomenon that I study.

Feminist STS and critical gender studies share a commitment to producing scholarship that is in service of liberation—bringing about a freer and more equitable world. This means that my scholarship has both a descriptive and a prescriptive dimension. I do not sacrifice the rigor of carefully documenting weight stigma research and advocacy, but, in the words of Fujimura, I do "take sides" and "take stands" (1991). If, as Latour (1993) quipped, "science is politics by other means," then my inquiry is meant to illuminate those politics within weight stigma research and advocacy, highlighting not only what they do but also what they hide or make more difficult. Law asserts that the true purpose of STS research is to reveal that "things never have to be the way they are" (2017, p. 49). When we recognize that the systems in which we live are contingent, we can work to "open up and enact alternative and better possibilities" (Law, 2017, p. 49). My approach is informed by a lineage of feminist scholarship that assesses the world as it is in order to imagine how it could be and how we can act to bring about a different future. Rather than seeing such speculations as bias or naivety, they are instead a useful way to diagnose what is harmful about the status quo.

To account for the workings of power within scientific and medical research, I situate my work within Foucauldian theory. For Foucault, medicoscientific discourses operate within a

regime of "power-knowledge-pleasure" wherein seemingly-objective or "true" medical claims about people are "put into discourse" – they are talked about – in a way that exerts control over a population (1990, p. 11). In analyzing such discourses, Foucault's aim is:

> not…to determine whether these discursive productions and these effects of power lead one to formulate the truth…or on the contrary falsehoods designed to conceal that truth, but rather to bring out the 'will to knowledge' that serves as both their support and their instrument. (1990, pp. 11–12)

As I explained in my literature review, many fat studies scholars have criticized obesity science for promulgating false or exaggerated claims about fat people and the relationship between weight and health. These efforts, concerned with truth as they are, exist firmly *within* the very regime that Foucauldian analysis is meant to interrogate; they do not address the "will to knowledge" that drives the production of such claims. At best, the work to debunk obesity discourses is meant to interfere with how these discourses are used in biopolitical exercises of population regulation. In Foucault's theory of biopower, the state engages in techniques of identification, differentiation, and normalization to shape its constituency towards particular ends; under capitalism, this end is usually maximized productivity of "healthy" citizens and an appropriate amount of population growth through reproduction (Foucault, 1990, 2003b; Shim, 2014). Fat studies scholars argue that the US uses the epidemiological construct of the "obesity epidemic" to frame fat people as failed citizens and drive them to attempt to achieve thinness (e.g., Greenhalgh & Carney, 2014; Jette et al., 2016; Murray, 2008a). In theory, debunking the epidemiological claims on which such biopolitical efforts depend should undermine them. In practice, this has not occurred, nor has revealing the biopolitical workings of the state changed its approach to obesity.

Some fat studies scholarship has focused on the other pole of biopower, anatamopolitics and the exercise of discipline. They have used this focus to illustrate how medical discourses that

equate health with thinness compel individuals to attempt to bring their bodies into alignment with, or maintain their achievement of, the norm of thinness (Bordo, 1993; Heyes, 2006; Strings, 2019; Throsby, 2012; Welsh, 2011). These accounts have succeeded in raising awareness that the norm of feminine thinness is not purely medical but also aesthetic, such that women discipline themselves for beauty rather than health (Chernin, 1994; Donaghue & Clemitshaw, 2012; Wolf, 1991). They have also, as I described in my literature review, drawn attention to the unjust expectation that everyone disciplines themselves to meet a single standard when individual bodies vary in myriad ways and individual material circumstances are unequal. However, from a Foucauldian perspective, these critiques do not undermine the regime of obesity, but rather contribute to the will to knowledge regarding fat bodies as they posit more and more complex causal theories of obesity. Like debunking, the majority of these critiques operate *within*, rather than against, the obesity regime. Moreover, as several feminist scholars have pointed out, raising individual awareness that we are subject to disciplinary power in the pursuit of thinness challenges neither the pleasure inherent in conforming with disciplinary imperatives nor the systems that demand thinness from us, whether we agree with its pursuit or not (Cahill, 2010; Coleman, 2010; Fox, 2018; Heyes, 2006). Uncovering disciplinary power is not sufficient for explaining or combatting anti-fatness.

Operating within the will to knowledge *about obesity* has limited the utility of Foucauldian approaches within fat studies. I address the limitations of these approaches in two ways. First, I work with Foucauldian conceptions of power to develop a novel theory meant to complement the concepts of biopower and disciplinary power. As I explore in Chapter 3, Foucault's concept of "productive" power, i.e., power that shapes lives rather than taking them, depends on expert determination of what kind of life is bad and what kind of life is good.

Medical actors often *explicitly* delineate normal or desirable ways of being from pathological or undesirable ones. I call the ability to define a way of being as a threat or source of suffering "afflictive power." In essence, afflictive power is a Foucauldian conception of stigma. However, the primary way I address the limitations of existing Foucauldian approaches to anti-fatness is by turning to the work of Deleuze and Guattari – in particular, their concept of *assemblage* (see Chapter 1). Deleuze and Guattari explicitly framed their theoretical work as both incorporating and moving beyond Foucauldian concepts and ideas, and therefore their theoretical approach represents a valuable path for building on existing fat studies scholarship without falling into the traps I identified above (Deleuze, 1992, 2006; Morar, 2016). The concept of *assemblage* (1987) allows me to talk about how biopower, disciplinary power, and afflictive power are interwoven in the context of anti-obesity efforts, forming a whole network that is greater than the sum of its parts.

Whereas existing fat studies scholarship has focused on individual cases of anti-fatness, I use assemblage theory to synthesize this research. I link together the numerous instances of anti-fatness documented in fat studies to reveal the sprawling, flexible structure constituted by anti-obesity efforts: the *anti-obesity assemblage*. Instead of explaining the historical roots of anti-fatness or how obesity and the obesity epidemic have been constructed, the concept of the anti-obesity assemblage provides a way to study the material-discursive structure of anti-fatness in the present. The anti-obesity assemblage is an *eliminationist* assemblage: while medicalization literature typically focuses on the ways in which medicine creates differences and targets specific bodily states/life phases for optimization, the concept of eliminationist assemblages draws attention to efforts by medicine and public health to eliminate a *way of being* from the world. An eliminationist assemblage is composed of anything that contributes to bringing about a world

without a particular way of being, including standards, human and non-human actors, technologies, practices, representations, and discourses. As a specific eliminationist assemblage, the anti-obesity assemblage (AOA) is comprised of anything that works to *enable* or *enact* the elimination of obesity. It is constituted by all the people, technologies, institutions, and discourses that participate in, or are part of, anti-obesity efforts, regardless of intention. Obesity elimination is enabled by the transformation of fatness into obesity, the construction of obesity as an eliminable threat, and the production of new knowledge about obesity. Obesity elimination is enacted by fat people on their own bodies using the disciplinary techniques and technologies produced by the AOA. Obesity elimination is also enacted by health professionals who draw on medical standards and technologies to intervene in fat bodies. The concept of the AOA provides a way of talking about the war on obesity that goes beyond specific weight loss practices, the social construction of the BMI, or the production of anti-obesity public health campaigns. In other words, the first step to understanding how the fight against obesity contributes to anti-fatness involves (re)conceptualizing what anti-obesity efforts *are*.

Research Questions

Bringing the concept of the anti-obesity assemblage to bear on the fields of weight stigma research and advocacy enables me to ask new questions about how these endeavors perpetuate anti-fatness. In Chapter 1, I begin with two questions. First, how does the anti-obesity assemblage (AOA) produce anti-fatness? And second, based on existing research, what are the oppressive consequences of the AOA? After outlining how anti-obesity efforts produce anti-fatness, I turn my attention to weight stigma research and advocacy. In Chapters 2 – 4, I use the concept of the AOA to guide my analysis of three cases: the field of weight stigma research, weight stigma interventions performed with health professionals, and a weight stigma/obesity

awareness campaign by pharmaceutical company Novo Nordisk. For each case, I ask three questions. First, I ask: how is this research or advocacy intertwined with the anti-obesity assemblage? Second, I investigate the question: how is weight stigma research and advocacy's capacity to meaningfully fight stigma constrained by being part of the anti-obesity assemblage? Third, as referenced above, fat positive scholars have puzzled over how weight stigma researchers are able to justify their rhetoric. To address this puzzle, I ask: how do weight stigma researchers and advocates portray fighting obesity and fighting stigma as compatible goals?

Methods

I apply qualitative and quantitative social scientific methods opportunistically throughout my chapters in order to produce both broad and deep analyses of the ways in which weight stigma research and advocacy perpetuate anti-fatness. I draw on discourse analysis, content analysis, praxiography, and assemblage analysis to produce accounts of what weight stigma researchers and advocates say and do, and to highlight the consequences of these discourses and practices.

I use numerous forms of discourse analysis across my chapters to reveal the common meanings present in a group of texts or media artifacts. Discourse analysis "entails an examination of how and why things appear the way they do, and how certain actions become possible" (Dunn & Neumann, 2016, p. 4). According to Foucault, discourse itself *constructs* its object, meaning that what we think and know about a given topic – what is even *thinkable* about it – is bound by the set of conversations about it (Foucault, 1971). Given that discourse "governs the way that a topic can be meaningfully talked about," analyzing the discourses about a specific object can help to uncover tacit meanings and assumptions built into the very concepts that describe that object (Hall, 1997). By analyzing discourse, an analyst can reveal not only

prominent themes in what is being said but also what is taken for granted within a given set of statements. Such an analysis can reveal the workings of power in and through discourse, providing insight into how, for example, the marginalization of a particular population is upheld or the authority of a dominant group is naturalized. In my second chapter, I use a thematic analysis of discourses within weight stigma research to examine how weight stigma researchers focus on some problems at the expense of others. In Chapter 3, I analyze the educational materials shared with health professionals in weight stigma interventions for what they teach these professionals about fat people and how to treat them. In each of these cases, discourse analysis reveals how weight stigma researchers and advocates construct fat people as afflicted and weight stigma as a problem that can and should be addressed with intensified anti-obesity efforts.

I use content analysis to make quantitative claims about the field of weight stigma research as a whole. Content analysis involves producing a systematic and, often, quantitative description of the content of a group of texts (broadly construed). Unlike the gradual revelation of latent meanings in discourse analysis, content analysis is deductive: it begins with a theory and hypothesis about the content which is then used to develop a coding scheme that is applied to every text (Potter & Levine-Donnerstein, 1999). Because it is so circumscribed, content analysis is useful for producing claims about the "big picture" of a given corpus – analyzing content can reveal a large-scale trend across hundreds or thousands of artifacts. In Chapter 2, I use the anti-obesity assemblage to develop a coding scheme that assesses, based on an article's abstract, introduction, discussion, and conclusion, whether the article enables obesity elimination and therefore contributes to the AOA and anti-fatness. I use these criteria to code a random sample of articles generated from a corpus of academic research on weight stigma.

Systematically coding this corpus enables me to quantify what percentage of weight stigma research contains anti-obesity claims or otherwise prioritizes obesity elimination (e.g., by setting weight loss as the positive outcome of the study). I use the findings from this analysis to show that the majority of weight stigma research contains anti-obesity claims or is motivated/justified by anti-obesity goals.

Praxiography is the study of practices and how they enact particular realities. In *The Body Multiple* (2002), Mol engages in a praxiographic study of the enactment of atherosclerosis – she follows doctors, histology technicians, medical staff, and other actors through the various practices they undertake to diagnose, visualize, or otherwise assess what is typically considered an objective disease. By tracing *how* a given configuration of people, ideas, and objects enable the production of evidence for the presence of atherosclerosis, Mol argues that the disease does not exist "out there" regardless of human observation, but that it is *done* (or brought into being) in different settings by different actors. A praxiographic approach provides a way around using a given thought collective's (Fleck, 2012) conventions for assessing their object (e.g., how doctors measure disease) without limiting the scope of social scientific inquiry to the "social" dimensions of a phenomenon (e.g., how patients experience disease). In the case of weight stigma interventions, performing a praxiography of these interventions – following the practices of those who perform the interventions to see how they *enact* weight stigma – lets me analyze what kinds of experiences these researchers are creating for the health professionals who participate in their interventions. I can then, using the reported results of the intervention, connect these experiences to their effects on the intervention participants. A praxiographic inquiry provides an assessment of weight stigma interventions that is not limited to whether the interventions "worked" to reduce stigma per the measures employed by the researchers, or

whether they are fatphobic per the standards of fat studies. I use the materials and methods sections of each intervention to reconstitute its performance to the best of my ability. Although this is not the same as witnessing each intervention in person, Mol herself suggests that this method is a valuable way to perform praxiography; it enabled me to analyze the practices across dozens of interventions rather than limiting me to studying only the ones I could attend in person (2002, p. 158; see also Mak, 2006).

In Chapter 4, I analyze how the anti-obesity assemblage is transforming weight stigma advocacy through resources provided by pharmaceutical company Novo Nordisk. Specifically, I analyze one axis of the anti-obesity assemblage, the assemblage of enunciation, by attending to what Deleuze and Guattari call a "regime of signs" (1987, p. 90). A regime of signs is not reducible to the idea of language or ideology, but rather draws attention to the ways in which signs "express organizations of power" (1987, p. 68). As such, analyzing a regime of signs focuses on the interrelationship between the material and the semiotic elements of the anti-obesity assemblage as it grapples with weight stigma. Unlike a more traditional discourse analysis, analyzing a regime of signs goes beyond looking at how particular concepts are defined and instead looking at how the *links* between different statements produce meaning that *transcends* the relationship between any specific signifier and signified. This examination necessarily involves attending to the ways in which human and non-human actors also shape this network of meaning. Additionally, this analysis attends not just to what kinds of things are linked together through signification, but also which things are excluded from this network of meaning. For this chapter, I used an unconventional and opportunistic approach to compile a corpus of audiovisual media funded directly or indirectly by Novo Nordisk. From this corpus, and its corresponding network, I found that this media network entirely subsumes weight stigma to the

anti-obesity assemblage, communicating the message that obesity elimination is the solution to fat people's oppression.

Plan of the Dissertation

The first chapter of this dissertation proposes the theoretical concept of "eliminationist assemblages" as an alternative to other related concepts typically used to conceptualize efforts to eliminate a way of being, such as medicalization, eugenics, and the normal. I lay out Deleuze and Guattari's theory of assemblages (1987) before defining eliminationist assemblages as a type of assemblage comprised of anything that enables or enacts the elimination of a particular way of being. I then trace the components of one example that I call the *anti-obesity assemblage*: the structure constituted by and through the many people, institutions, discourses, standards, technologies, and practices that work together to produce a world without fat people. Within the anti-obesity assemblage, obesity elimination is enabled by transforming fatness into obesity, constructing obesity as an eliminable threat, and producing new knowledge about obesity. Fat people enact obesity elimination by using disciplinary techniques and technologies generated by the anti-obesity assemblage to intervene on their own bodies. Health professionals also draw on anti-obesity standards and procedures to intervene on fat bodies. Drawing on existing research, I argue that the anti-obesity assemblage has a range of oppressive consequences for fat people, such as dehumanization through the elevation of the disease of obesity over fat personhood.

Chapters 2, 3, and 4 each examine three dimensions of the relationship between anti-fatness and weight stigma research and advocacy: how this research/advocacy contributes to and changes the anti-obesity assemblage, how researchers and advocates attempt to make fighting obesity and fighting stigma compatible, and how stigma reduction efforts are undermined by anti-obesity efforts. Chapter 2 provides a broad look at the field of weight stigma research and its

relationship to obesity elimination. A historical analysis of early publications in the field reveals that since the field's inception, weight stigma has been treated as a problem secondary to the problem of obesity. Based on a content analysis of a random sample of 400 articles discussing weight stigma, I show that nearly two-thirds of the research about weight stigma contains claims or focuses on topics that enable obesity elimination. Additionally, weight stigma research that enables obesity elimination is cited significantly more often than research that does not, and almost half of weight stigma research is published in medical journals. The field's investment in obesity elimination has shaped weight stigma research through its disproportionate focus on populations such as bariatric patients, its focus on internalized stigma, and its heavy use of attribution theory to guide interventions. Weight stigma research erases the social origins of weight stigma and portrays stigma as a property of obesity, enabling researchers to propose that increasing the medicalization of fatness will reduce stigma.

In Chapter 3, I show how weight stigma interventions with health professionals contribute to the anti-obesity assemblage as well as how the ability of weight stigma researchers to reduce stigma is limited by their entanglement in the anti-obesity assemblage. I show that weight stigma researchers exercise *afflictive power* during these interventions. Afflictive power is the capacity to define a way of being as a threat and source of suffering. Weight stigma researchers enact affliction with health professionals by putting them in fat suits, wherein health professionals experience discomfort, incapacity, and suffering (both physical and social). Health professionals associate these negative experiences with fatness and use them to imagine that all fat people live miserable lives. Researchers also exercise afflictive power by exposing health professionals to afflictive representations of fat people, leading health professionals to associate fatness with a lack of physical capacity, freedom, agency, and joy. When afflictive

representations of fat people suffering from weight stigma are presented without explaining anti-fatness as a system of oppression, intervention participants receive the message that fat people suffer from physical *and social* anguish that can only be cured by *changing their bodies*. I also show that weight stigma interventions often explicitly train health professionals to fight obesity and *provide them tools to do so*; these interventions *enable* obesity elimination by training health professionals to *enact* it. Weight stigma researchers' investment in obesity elimination constrains their ability to reduce stigma because eliminating obesity necessarily involves stigmatizing fat people.

In Chapter 4, I investigate the regime of signification being produced by a particular part of the anti-obesity assemblage: Novo Nordisk's media network. I analyze how Novo Nordisk's weight stigma advocacy network is working to make fighting obesity and fighting weight stigma seem like compatible goals. I show how, both through what they say and what they do not say, the links they make and the links they downplay, Novo Nordisk's media network weaves together the problems of weight stigma and obesity. Overall, this media network portrays obesity education and treatment as the solution to the prejudice and discrimination that fat people face. They achieve this by defining weight stigma narrowly, as a matter of blaming and shaming fat people for being fat and believing that weight is individually controllable, rather than as the systematic devaluation of fatness itself. Unfortunately, the blame/shame/controllability conception of stigma is also prevalent in fat activism and fat studies scholarship, and my analysis shows that the existing frameworks for understanding anti-fatness are easily co-optable.

In the conclusion, I consider what weight stigma research and advocacy are doing – and not doing – for the cause of fat liberation. Because anti-obesity efforts structure the oppression of fat people, the path towards fat liberation involves reducing these efforts and dismantling the

anti-obesity assemblage. I use the concepts of deterritorialization and reterritorialization to show that weight stigma research and advocacy are doing the opposite: they are helping to grow the anti-obesity assemblage by enrolling new actors and discourses while simultaneously curtailing fat activist discourses that could function as lines of flight out of the assemblage. I argue that the increasing presence of weight stigma within the anti-obesity assemblage is ushering in a "new face of the war on obesity": no longer a war, but an empathetic, socially aware, reflexive, and scientific effort to produce a world without fat people.

This dissertation ends with guidance for fat studies scholarship and fat activism. The study of our oppression has been co-opted by people who think the world would be better off without us. Hence, I call for a renewed focus on *studying anti-fatness and fat oppression*, rather than studying "fat," the "fat body," "fat identity," etc. We need to stop centering the truth of fat bodies and weight loss and start focusing on our own oppression. Without an analysis of the concrete structural sources of our oppression, we cannot resist it effectively. In the absence of an analysis of our oppression, we are forced to ask and answer other people's questions about health, about weight loss, about fat – rather than actually fighting for liberation. If fat studies scholarship and fat activism are to survive the Ozempic era, we need to address the central role of anti-obesity efforts in fat oppression. It is high time for fat activists to join the war on obesity – on the side of fat people, against the war itself.

Chapter 1
The Anti-Obesity Assemblage: A Structural Model of Anti-Fatness

In her foreword to the *Fat Studies Reader*, fat activist Marilyn Wann quips that "there is no nice, unstigmatizing way to wish that fat people did not eat or exist" (2009, p. xvii). Fat activists and fat studies scholars have long recognized that the desire for a world without fat people – a desire produced and endorsed by US medicine and public health – plays a substantial role in prejudice and discrimination against fat people. Despite this recognition, however, fat studies scholars have not provided a comprehensive account of obesity elimination efforts nor connected such efforts to anti-fatness. As I discussed in the introduction to this dissertation, the vast majority of fat studies scholarship concerned with anti-obesity efforts critiques them by asserting that these efforts are based on inaccurate knowledge. Such critiques do not attend to the many people and institutions behind these efforts. The few accounts that do attend to these actors tend to focus too narrowly or too broadly. For example, Mundy (2010) and Harrison (2021) each attend to the profit-seeking dimension of anti-obesity efforts through their concepts of "Obesity Inc." and the "Diet-Industrial Complex," but they do not describe anti-obesity efforts beyond the capitalist realm. In contrast, Morgan (2011) focuses on "systemic fat hatred" to conceptualize a "Fat Apparatus" that includes virtually all elements of society as contributors to anti-fatness, including obesity elimination. Yet this concept is limited both by its focus on hatred and by its lack of specificity.

Fat studies scholarship has not produced a complete account of anti-obesity efforts and their role in anti-fatness. However, this problem is not limited to fat studies scholarship. In this chapter, I argue that the social sciences writ large do not have a way to conceptualize the

phenomenon of medicine and public health targeting a way of being[3] for elimination. Drawing on Deleuze and Guattari's theory of assemblages, I put forth such a concept, which I term *eliminationist assemblages*. Eliminationist assemblages are constituted by the sprawling efforts to enable and enact the elimination of a way of being from the world. This concept encompasses insights from scholarship on eugenics, medicalization, and the construction of norms, but is not limited to these ideas. I argue that efforts to produce a world without fat people constitute an eliminationist assemblage that I call the *anti-obesity assemblage.* The workings of the anti-obesity assemblage structure anti-fatness and produce specific oppressive consequences for fat people. The concept of the anti-obesity assemblage provides a precise way for fat studies scholars to discuss the structure and anti-fat consequences of the "war on obesity."

This chapter begins with a review of critical social scientific theories of medical elimination. I argue that none of the existing frameworks adequately capture how elimination efforts work in the 21st century. I turn to Deleuze and Guattari to lay out the concept of eliminationist assemblages, highlighting how this concept encompasses the insights of existing theories without being limited to them. In particular, the theory of eliminationist assemblages accounts for the rhizomatic character of the network constituted by medical and public health imperatives for elimination, including discourses, standards, experts, research practices, technologies, individual disciplinary techniques, institutions, and more. Importantly, none of these elements are essential components of an eliminationist assemblage, meaning these assemblages are extremely flexible and adapt easily to the rapidly changing circumstances of the present. After I lay out eliminationist assemblages in general, I turn to the anti-obesity assemblage (AOA). I explore three ways that obesity elimination is enabled: transforming

[3] A way of being is an ongoing characteristic, behavior, or bodily state.

fatness into obesity, transforming obesity into an eliminable threat, and producing new knowledge about obesity. I also explore how obesity elimination is enacted by myriad actors using means provided by the AOA (technologies, pharmaceuticals, disciplinary techniques, etc.). Using the fat studies literature, I outline some of the ways that enabling and enacting obesity elimination can harm fat people. I conclude with a discussion of how the concept of the anti-obesity assemblage can be used in fat studies scholarship and fat activism.

Literature Review: Theorizing Elimination

In this section, I review the ways that critical social scientists have made sense of medical and public health efforts to eliminate specific ways of being from the world. I argue that the frameworks of eugenics, medicalization/biomedicalization, and the construction of the normal each capture an important part of elimination efforts, but none are sufficient for discussing the entirety of the structure that is constituted through these efforts. I provide a brief summary of the central ideas and mechanisms of each framework as well as the kinds of solutions implied by each framework. I then discuss the limitations of each framework for theorizing elimination and justify the turn to eliminationist assemblages.

The term "eugenics" provides a way of talking about medicoscientific efforts to eliminate different ways of being during specific historical periods as well as a particular logic and set of interventions that center on the control of reproduction. From the late 1800s to the mid-1900s, the US eugenics movement sought to "improve" the genetic quality of the US population through specific productive and repressive practices based on white supremacist ideas of population fitness, anthropometry, and teleological progress through evolution (Duster, 2004; Gould, 1996; Hacking, 1990; Schuller, 2018; Sekula, 1986). The sciences of phrenology and anthropometry provided a paradigm in which bodily characteristics were seen as indicative of some essential

quality of the person, meaning that visible differences became grounds to make claims about a person, group, or race as inferior (Gould, 1996; Sekula, 1986; S. M. Smith, 1998). Eugenic actors attempted to systematically prevent deviant individuals and groups from reproducing through practices such as institutionalization, sterilization, birth control, and neglect, so that their "inferior" genes would eventually leave the human gene pool (Black, 2003; L. J. Davis, 1995; Ladd-Taylor, 2017; Ordover, 2003). Conversely, "fit" (i.e., white, wealthy, able, Christian, etc.) individuals and populations were incentivized to procreate at scale to "improve" the genetics of the US population (Dorey, 1999; LeBesco, 2009; Strings, 2019). Although eugenic ideas were most prominently enacted through the early and mid-1900s, they have never disappeared from the US (Duster, 2004; Samuels, 2014). However, the term "eugenics" specifically refers to efforts to eliminate inferior groups from the world through the *control of reproduction*.

Scholars have also conceptualized medicine's attempts to eliminate ways of being through the term medicalization. Medicalization is the process by which a form of human variation is defined as a medical problem and brought under the realm of medical jurisdiction (Conrad, 2007). For a way of being to be medicalized, it must first be devalued: defining something as a disease or disorder necessarily involves treating it as undesirable, harmful, or threatening (Canguilhem, 2012; Conrad & Schneider, 1992; Freidson, 1988; Jutel, 2011). Once a way of being is seen as diseased, medicine and public health then engage in efforts to treat and prevent it, developing an infrastructure for elimination (Armstrong, 1995; Bowker & Star, 1999). As a concept, medicalization provides a more flexible way to talk about efforts to eliminate a way of being than eugenics, as it is not limited to any particular causal theory (e.g., heritability) or intervention (e.g., reproductive control). However, medicalization has been criticized for focusing too narrowly on medical authority and failing to recognize how professional jurisdiction

and boundaries have become more fluid and distributed in the 21st century (A. Clarke et al., 2003, 2010; Epstein & Timmermans, 2021; Eyal, 2013). The concept of biomedicalization addresses many of the limitations of medicalization by recognizing the "increasingly complex, multisited, multidirectional processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine" (2003, p. 162). In focusing so much on the new subjectivities constituted by biomedicine, the increasing medical jurisdiction of medicine over health in addition to illness, and the stratifying dynamics of biomedicalization, though, this work shifts the focus away from elimination.

Scholars in disability studies have identified the medicoscientific construction of "the normal," and, by extension, the "abnormal," "pathological," or "deviant," as a fundamental basis for the elimination of deviant ways of being (Canguilhem, 2012; Cryle & Stephens, 2017; L. J. Davis, 1995; Foucault, 1990; Thomson, 1997). The creation of statistical normalcy by eugenicists and the uptake of the desire to classify individuals as normal or pathological in healthcare and public health has enabled medicine to function as a means of social control, targeting those who exist outside the norm for discipline and intervention (K. Gupta, 2019; Jutel, 2006; Lupton, 2018; Zola, 1972). Clare argues that the goal of "cure" at the center of the US medical-industrial complex functions as a "widespread ideology centered on eradication" that "rides on the back of *normal* and *natural*" (2017, pp. 14, 28, original emphasis). The concepts of "the normal" and the ideology of cure capture an important aspect of the medical efforts to eliminate deviant ways of being, but they do not capture the entirety of these efforts. Classification and ideology are not the only sources of harm faced by people who are marked as medically undesirable. Moreover, a focus on the construction of the normal orients us towards a

critique of normalcy itself, emphasizing the similarities and underlying historical roots of different efforts to eliminate certain ways of being while downplaying their differences and specificities.

Each of these frameworks provides partial insight into medical efforts to eliminate a way of being, but they are each insufficient for understanding such efforts as a whole. This insufficiency results from each framework treating some element, logic, or mechanism as *essential* to making sense of elimination efforts. The framework of eugenics depends on the presence of a specific set of theories and interventions: for an elimination effort to be eugenic, it must be centered on a way of being that is seen as heritable and possible to eradicate through changes in population-level reproduction. Thus, the term eugenics does not accurately describe many current elimination efforts. Additionally, the imprecise use of the term "eugenics" to describe non-genetic elimination efforts can appear hyperbolic or appropriative, given the history of these practices. The framework of medicalization does not depend on a specific set of practices, yet because of its focus on medical jurisdiction, it implies that the most important part of elimination efforts is that they are *medical* rather than that they are *harmful*. Biomedicalization is less focused on medical jurisdiction, but as a framework, it focuses more on the productive aspects of medical power – how medicine makes people live –than the repressive consequences of elimination efforts. The disability studies framework about the tyranny of the normal accurately captures that the basis for elimination efforts extends beyond medicine into other realms of life. However, this framework also implies that the construction of normalcy *fundamentally structures* elimination efforts: norms are treated as the essential component that must be destabilized to undermine elimination efforts. Yet the boundary between the normal and the abnormal is always in flux and elimination efforts may even attempt to increase the

proportion of people considered abnormal as part of their workings. Thus, the norm cannot be treated as foundational to elimination efforts.

To address the shortcomings of existing frameworks, I turn to assemblage theory as a way to conceptualize elimination efforts. As I will explain in more detail below, treating elimination efforts as an assemblage involves identifying them based on *their effects in the world*, rather than some pre-existing idea about their constitutive parts. In other words, the existence of an *eliminationist assemblage* does not depend on any particular causal theory of deviancy nor any particular method or mechanism of elimination. Moreover, there is no one part of the assemblage that cannot be lost or swapped out for another. Rather, any discourse, standard, person, technology, or thing can be considered part of an eliminationist assemblage if that element contributes in some way to the efforts to eliminate a way of being from the world.

Assemblage Theory

The theory of assemblages comes from French theorists Gilles Deleuze and Félix Guattari and is most thoroughly outlined in their text *A Thousand Plateaus*. As many have noted since the release of this text, "assemblage" is a (mis)translation of the French term *agencement*, meaning "a construction, an arrangement, or a layout" (DeLanda, 2016, p. 1; Nail, 2017, p. 22; Puar, 2020, p. 57). The significance of this mistranslation is both temporal and agential: while the idea of assembling, as in "bringing things together" implies a process over time, an actor capable of assembling things, and things fitting together into a united whole, the French *agencer,* to arrange or piece together, implies something quite different. As Nail explains, an assemblage is not defined by its unity or a common goal (what it is), but rather by what it *does*. Thus, the elements of an assemblage, as I will describe below, are linked by their effect in the world, rather than the intention of each individual part. Said differently by Buchanan, "while it is true

assemblages are contingent, their outputs are not…as Deleuze and Guattari say, given a certain effect, what kind of machine (assemblage) is capable of producing it?" (2017, p. 461).

Assemblages are composed of three interrelated features: their "abstract machine," their "concrete assemblage," and their "personae" (Nail, 2017, p. 24). The abstract machine, essentially the relations between the elements, and the concrete assemblage, the elements themselves, are "mutually transformative": as the things in the assemblage change, so do the relations between them.[4] This is significant because it gives assemblages incredible flexibility; elements can be added and removed without destroying the assemblage because it is defined only by elements being in relation to each other. The relations between elements – what Puar describes as "relations of force, connection, resonance, and patterning" – shift according to the presence and absence of various material and discursive elements (Puar, 2020, p. 57). This flexibility allows assemblages to do different things at different times as elements and relations between them shift. The "personae," the "immanent agents or mobile positions, roles, or figures of the assemblage," are also mutually constituted with the abstract machine and the concrete assemblage, in that they are not personae without the assemblage itself, yet the assemblage cannot exist without agents that *arrange* its elements (Nail, 2017, p. 27). However, the fact that the personae do not control the assemblage nor define its essence again gives assemblages a powerful flexibility. If actors can be linked by things other than common goals, then actors with divergent, or even contradictory, goals can still end up having similar effects in the world through an assemblage.

[4] This is strikingly similar to Barad's concept of *relata* outlined in "Posthumanist Performativity": "relata do not preexist relations; rather, relata-within-phenomena emerge through specific intra-actions…relations are not secondarily derived from independently existing "relata," but rather the mutual ontological dependence of "relata"—the relation—is the ontological primitive…relata only exist *within* phenomena as a result of specific intra-actions (i.e., there are no independent relata, only relata-within-relations)" (2003, p. 813).

Assemblages are sprawling, churning, and, by definition, able to integrate actors and objects (both human and non-human) on micro and macro levels. Yet while they are in flux, they also retain "a logic, an operational sense…that can be mapped – one always knows what is possible and what is not possible within a given assemblage" (Buchanan, 2017, p. 463). Despite their flexibility, assemblages are "structured and structuring," meaning they can have large-scale, durable effects on the world over time (Buchanan, 2017, p. 463).[5] In *Habeas Viscus,* Weheliye explains this durability using Stuart Hall's phrase "tendential combinations," meaning relations that tend to appear and remain over time, although not determined by the assemblage itself; they are "preferred articulations" that "insert historically sedimented power imbalances and ideological interests, which are crucial to understanding mobile structures of dominance…into the modus operandi of assemblages" (2014, p. 49). In other words, assemblages are always flexible and perpetually in motion, but some of their components – and effects – are not necessarily arbitrary. Changes in the assemblage over time can still be traced, which is useful for observing which parts of it remain more stable and which do not. However, for analytical purposes, it cannot be assumed that any one element is *inherent or essential to* the assemblage (any element could be excluded from the assemblage in the future). All of these characteristics make assemblage a useful concept for trying to grapple with the scale, complexity, and contingency of US anti-obesity regimes.

Eliminationist Assemblages

Assemblage theory provides a novel and generative way to conceptualize medical and public health efforts to eliminate a way of being from the world. Using assemblage theory, any actor, element, or relation that enables or enacts the elimination of a particular way of being can

[5] The structured and structuring nature of assemblages is what differentiates them from Barad's *relata* and agential realism. Barad's theories help explain local situations but are less applicable to large scale systems over time.

be considered part of an *eliminationist assemblage*. Eliminationist assemblages are comprised of discourses, representations, standards, experts, research practices, technologies, disciplinary techniques, institutions, organizations, and more. Despite the breadth and flexibility of this definition, however, eliminationist assemblages are identifiable through their orientation towards (eliminating) a particular way of being. Typically, an eliminationist assemblage simultaneously produces the way of being it targets, provides the cultural justification and imperative for eliminating that way of being, and directs resources or enrolls new actors, institutions, and technologies towards that end. We may, for instance, claim that an anti-homosexuality assemblage came into being in the US during the middle of the 20th century as psychiatrists constructed homosexuality as a particular way of being, circulated claims that gay people were a threat to society based on their pathological sexuality, and performed conversion therapy (Bayer, 1987). We can also conceive of current efforts to produce a society without people with Down Syndrome as an anti-Down assemblage and efforts to "cure" and prevent autism as an anti-autism assemblage.

Conceptualizing elimination efforts as an assemblage means that an analyst's purview is not limited to a specific set of interventions (eugenics), professional jurisdiction (medicalization), or analytic (norms and cure). However, the concept of eliminationist assemblages is compatible with these approaches and is intended to augment them, not supplant them. 19th and 20th century[6] eugenic efforts can be treated as an eliminationist assemblage, albeit one that did not target one specific way of being. Rather, the eliminationist assemblage of eugenics operated by collapsing many forms of difference together into one broader problem of the "unfit" and provided a shared solution for all of these ways of being: reproductive control. In

[6] Eugenic efforts are also ongoing today through various genetic and reproductive technologies (Duster, 2004).

my conceptualization, most (or perhaps all) eugenic efforts lead to the constitution of an eliminationist assemblage, but not all eliminationist assemblages are eugenic.[7] For example, the anti-Down assemblage can be considered eugenic because it often works through selective abortion, but the anti-obesity assemblage largely does not operate this way.

The expansion of eliminationist assemblages often involves medicalization, but eliminationist assemblages transcend medicine and the dimensions of medicine that are frequently contested in the medicalization literature. For instance, while much of the medicalization literature focuses on contesting the etiology of a specific way of being as a way to challenge the legitimacy of medicine (e.g., mental illnesses are social constructs, not "really biological (Szasz, 1960)), the concept of eliminationist assemblages does not depend on medicine using a particular etiological theory. Any causal theory for a way of being can be part of an eliminationist assemblage but eliminationist assemblages do not require causal theories to exist. Similarly, other medicalization literature attempts to delegitimize medicine by contesting the use of particular interventions on the grounds that they are dangerous or ineffective (Dumit, 2012). But eliminationist assemblages do not depend on one kind of intervention being used, nor do their interventions need to be effective for the assemblage to exist. Moreover, while medical expertise and authority often play important roles within eliminationist assemblages, even these elements are not *required* for an eliminationist assemblage. Norms are also not an essential element of eliminationist assemblages: these assemblages often draw distinctions between normal and abnormal, but these are only one part of a broader network. The existence of an eliminationist assemblage never hinges on some fundamental actor or object.

[7] Similarly, some eliminationist assemblages may operate through genocide (i.e., murder as the technique of elimination), as the assemblage constituted by the Holocaust did, but not all eliminationist assemblages are genocidal.

How to Analyze an Assemblage

To analyze an assemblage, Deleuze and Guattari instruct the analyst to ask: "What is the territoriality of the assemblage, what is the regime of signs and the pragmatic system?" (1987, p. 505). Or, more simply, "Given a certain effect, what machine is capable of producing it?" (1983, p. 3). Each assemblage is "simultaneously and inseparably a machinic assemblage and an assemblage of enunciation," meaning "it is necessary to ascertain both what is said and what is done" (1987, p. 504). In other words, to analyze an assemblage, one must ask where and how it is working, with the "how" encompassing practices, actions, and objects (the machinic assemblage) but also discourses, the linguistic and semiotic limits on what is thinkable (the assemblage of enunciation). Tracing an eliminationist assemblage (the "machine") involves identifying the elements and linkages that produce the "effects" of enabling and enacting the elimination of a particular way of being.

This dissertation investigates a specific eliminationist assemblage I call the *anti-obesity assemblage*. The anti-obesity assemblage (AOA) enables and enacts the elimination of obesity. In the following section, I provide a schematic of the anti-obesity assemblage generated by synthesizing fat studies scholarship on the extensive harms fat people face from anti-fatness with scholarship that discusses anti-obesity efforts without focusing on their harms. Linking together this scholarship reveals a network of standards, human and non-human actors, technologies, practices, representations, and discourses that together enable and enact obesity elimination. I find that obesity elimination is *enabled* by the anti-obesity assemblage through the transformation of fatness into obesity, the transformation of obesity into an eliminable threat, and the production of obesity knowledge. Obesity elimination is *enacted* by the anti-obesity assemblage through disciplinary weight loss practices that are imposed onto fat people by

themselves and others. After outlining the anti-obesity assemblage, I discuss some of the oppressive consequences fat people face from obesity elimination efforts.

The Anti-Obesity Assemblage

Enabling Obesity Elimination

Transforming Fatness into "Obesity"

Through a network of standards, classifications, and quantification practices, the anti-obesity assemblage creates "obesity" as a pathological condition and obese people as a problem in need of intervention. In other words, the anti-obesity assemblage enables obesity elimination by creating its own target. The Body Mass Index is a height to weight ratio (kg/m^2) that, once calculated, is used to slot individuals into one of several weight classifications: "underweight," "normal weight," "overweight," or "obese." From their creation, these categories were intended to dictate what action an individual should take regarding their weight—gain, maintain, or lose—and thereby act as both diagnosis and prescription despite signifying only a particular height-weight ratio (NIH Consensus Statement, 1985). BMI is easily calculated; height and weight are regularly collected in schools, healthcare settings, and epidemiological research. As a result, the BMI is also used to generate "obesity" as a population-level phenomenon. Any individual whose BMI is calculated as 30 or above becomes a member of the "obese" category and is thereby transformed into a target of the anti-obesity assemblage.[8]

The widespread use of the BMI in the anti-obesity assemblage performatively constitutes obesity as a BMI of 30 or above (Gutin, 2018, 2021; Nicholls, 2013). Most components of the anti-obesity assemblage are linked through the use of the BMI, from federal research institutions to smart scale manufacturers to gym teachers. Individuals use online calculators and weight

[8] Individuals with a BMI between 25 and 29 are classified as "overweight" and are also often targeted by the anti-obesity assemblage, although sometimes to a lesser extent than individuals classified as obese.

charts to monitor their own BMI. Electronic health records automatically calculate a patient's BMI when their height and weight are recorded, directing healthcare providers to certain kinds of advice and procedures. Media outlets regularly use the BMI in obesity-related news and entertainment, and scientists use the BMI in research. The BMI is even used as an immigration criterion (Pausé, 2019). The anti-obesity assemblage exists in its present, ubiquitous form largely through the BMI. Moreover, quantifying and classifying bodies using the BMI and its weight categories has enabled our present ability to imagine a world without fat people.

Transforming Obesity into an Eliminable Threat

The US media ecosystem makes up a large portion of the anti-obesity assemblage. Media analyses have found that anti-obesity stories appear in media across the political spectrum (P. Cain et al., 2017; Rinaldi et al., 2020), and the number of news stories about obesity has increased dramatically since the 1990s (Gearhart et al., 2012). US media enable anti-obesity practices by depicting fatness almost exclusively as a threat that can and should be eliminated. (I discuss this further in Chapter 3 using the concept of afflictive power.) News coverage of obesity and the obesity epidemic has portrayed fat people as threats to their own health, the health of others, and the health of the nation. For instance, a recent machine learning study of over 100,000 *New York Times* articles found that this media presented fatness as such a threat to individual health that the terms "'obese,' 'overweight,' and 'morbidly obese' connote[d] unhealthiness almost as strongly as… terms about eating disorders" (Arseniev-Koehler & Foster, 2022, p. 1511). In other words, if one learned about fatness from reading the *New York Times* for 30 years, one would think fatness was as dangerous and threatening as conditions *with one of the highest lethality rates in current biomedicine* (Castellini et al., 2023). US media depict fat people as interpersonal threats by framing their mere existence as harmful to their friends, family, and

other associates. Since 2007, news media have extensively covered a controversial set of academic studies that claim obesity can "spread" through social networks (Christakis & Fowler, 2007; TED, 2010). Using headlines such as "If Your Best Friend Becomes Obese, You Have A 57% Chance of Becoming Obese, Too" (Baer, 2014) and "Is Obesity Contagious?" (Khamsi, 2007), this media discourages readers from maintaining relationships with fat people due to the threat of "contracting" their pathological state.

The most ubiquitous portrayal of fat people as a threat can be found in news coverage of the "obesity epidemic." Such biomediatized[9] representations of fat people often employ metaphors of warfare to frame fatness as a risk to national security (Boero, 2012; Saguy, 2013). For example, in 2001, US Surgeon General Richard Carmona called obesity "the terror within," warning that "unless we do something about it, the magnitude of the dilemma will dwarf 9/11 or any other terrorist attempt," and a 2002 op-ed claimed that body fat was "every bit as much a bioterrorist threat as anything Saddam might lob over" (Biltekoff, 2007, pp. 29, 33). Fat people are also represented as a threat to human advancement through depictions of "devolution," where iconic "march of progress" images are modified with fat people and/or animals at their endpoints to show how obesity and other hallmarks of the "failure of modernity" such as fast food are causing humanity's regression back into animality (F. R. White, 2013; see also Kersbergen & Robinson, 2019). Additionally, fat people are cast as a threat to US economic prosperity through apocalyptic headlines about how obesity costs the nation billions every year and will bankrupt an already overburdened healthcare system (Brookes, 2022; Gillborn et al., 2020; Saguy & Almeling, 2008). In sum, this media transforms fatness into an enemy that must be eradicated.

[9] Biomediatization posits that media and biomedical entities co-create biomedical phenomena, rather than imagining the media as merely reproducing already-made biomedical information (Briggs & Hallin, 2016)

Alongside these portrayals of fatness as worth eliminating, US media also enables obesity elimination by portraying fatness as *eliminable* through anti-obesity practices. News publications, magazines, and websites feature myriad stories about weight loss diets, exercise regimes, drugs, and surgeries. Messages about the necessity and feasibility of weight loss can also be found in many forms of media such as public health campaigns (Hardy, 2022; Lupton, 2015; MacKay, 2017). Reality TV shows such as *The Biggest Loser* and *My 600 Pound Life* explicitly show fat people undergoing extreme weight loss interventions at great personal cost (Cameron, 2022; Raisborough, 2016). These kinds of media complement the journalistic construction of fatness as a threat: news stories portray fatness as an epidemic in need of elimination while weight loss media spreads ideas about how that elimination takes place.

Producing Obesity Knowledge

The anti-obesity assemblage expands itself through knowledge production about obesity. This continual expansion enables and increases ongoing efforts to eliminate obesity. For instance, researchers producing claims about the harms of obesity link it with other social problems and the constituencies who care about them, as in the recent spate of research linking obesity with climate change (see Guthman, 2011). Relatedly, some obesity researchers take up the tools of different fields to study the causes of obesity. In so doing, they make obesity a problem of interest to researchers in those fields, which in turn opens up research into new types of solutions. For example, research that draws on media effects scholarship to link youth-focused food advertisements to childhood obesity makes childhood obesity a relevant topic to anyone studying the role of advertisements in consumer behavior and/or advocating for policy changes to restrict what products corporations may promote to children (UConn Rudd Center for Food Policy and Health, 2020).

Researchers producing claims about solutions to obesity also enroll additional actors into the anti-obesity assemblage. This trend is readily apparent in feminist and other critical social scientific research that employs nuanced, cutting-edge theories of racial capitalism, intersectionality, and new materialisms to argue, almost invariably, that the existence of obesity is an injustice that could be mitigated through structural reform (Berlant, 2007; K. Davis, 2010; Fullagar et al., 2021; K. Gupta, 2019; Land, 2018; Landecker, 2013; Probyn, 2008; Strings, 2015; Valdez, 2021; Warin, 2015; Yancey et al., 2006). Portraying obesity in this way implicates *everyone* in the project of fighting it, not just doctors or public health officials. This scholarship thus attempts to enroll a much wider range of expertise and actors at all levels of society to fight obesity. Moreover, this scholarship provides the anti-obesity assemblage with the cultural capital and appropriate rhetoric to frame obesity elimination as a social justice effort. For instance, Aaron and Stanford (2022) claim that weight stigma and structural racism work together to cause disproportionately high rates of obesity in Black people in the US while unjustly limiting Black people's access to obesity medications. From this framing, they claim that structural racism and weight stigma can be mitigated through legislation that would expand access to anti-obesity treatments under Medicare.

Enacting Obesity Elimination

There are very few resources dedicated to helping fat people thrive in the world without changing their bodies. In contrast, thousands of people, billions of dollars, and innumerable groups, institutions, technologies, and drugs are dedicated to producing a world without obesity. The variety of anti-obesity interventions – the number ways that obesity elimination can be enacted – is staggering. Individuals employ numerous tools supplied by the AOA to manage their own bodies. For instance, weight loss supplements and "diet foods" meant to alter appetite,

digestion, and metabolism can be found in nearly every supermarket and pharmacy, on TV, and hawked by celebrities on social media (Gordon & Hobbes, 2021; Rijo, 2019). Intimate technologies such as scales, calorie-counting apps, and biometric trackers help fat people quantify and surveil their food intake, exercise expenditures, weight, and body composition (Jutel, 2006; Lupton, 2018). "Somatic experts," the wide range of professionals who now deal with health and wellness, may themselves intervene in fat bodies (e.g., bariatric surgeons), enact obesity elimination with a patient/client (e.g., personal trainers, weight watchers leaders), or coerce weight loss by gatekeeping other procedures or making dire warnings about a fat patient's health. Weight loss technologies such as pharmaceuticals also enact obesity elimination. The GLP-1 agonist molecules in a Wegovy injection act against obesity in concert with the person injecting the drug, the somatic expert who prescribed it, and the pharmaceutical company that manufactured it. Any and all attempts to make an "obese" body thinner constitute obesity elimination. Attempts to prevent the existence of obesity by, for example, pre-emptively dieting against weight gain can also be enactments of obesity elimination.

Highlighting how different methods of enacting obesity elimination are analytically similar represents a departure from existing approaches that focus on slicing and dicing "legitimate" anti-obesity efforts from "illegitimate" ones. "Fad diets" enact obesity elimination as much as "medically-supervised behavioral modification programs"; individual intention does not impact whether an elimination effort is part of the AOA (Cardel et al., 2022). Similarly, the efficacy of an intervention also does not dictate whether it enacts obesity elimination; the act of intervening itself is what makes an intervention part of the anti-obesity assemblage. The same is true of intervention risk profile. The variety of anti-obesity interventions is vast and textured. For

the purposes of the anti-obesity assemblage, however, it is this vastness and texture that matters, rather than any individual intervention.

The Anti-Obesity Assemblage Structures Fat Oppression

The concept of the anti-obesity assemblage provides a way to link two disparate branches of fat studies scholarship. One branch of fat studies scholarship describes obesity elimination efforts but does not link those efforts to their consequences because the authors focus almost exclusively on debunking the social construction of obesity and the obesity epidemic. A separate branch of scholarship, often employing interviews or survey-based methodologies, focuses on fat people's oppression in different realms of life such as healthcare, intimate relationships, or employment. This scholarship, though it details the consequences of anti-obesity efforts, does not make the link between these efforts and the material circumstances of fat people's lives. In other words, because fat studies scholars have not had the concept of the anti-obesity assemblage, it has not been possible to demonstrate the ways that obesity elimination efforts structure anti-fatness. As I explored in the introduction to this dissertation, the invisibility of this link (despite an intuitive sense among many that it exists) has thwarted attempts to decry or resist the injustice of targeting fat people for elimination. Instead, attempts to resist anti-fatness have been funneled into contesting the veracity of obesity/the obesity epidemic or relied on attempting to prove fat people's blamelessness.

The following sections are a preliminary attempt to remedy the decades of stagnation and futility in fat activism and fat studies scholarship by connecting anti-obesity efforts to fat oppression via the anti-obesity assemblage and its effects of enabling and enacting obesity elimination. However, much of this section is speculative, based on hypotheses regarding the mechanisms underlying fat oppression, because research demonstrating these links *has yet to be*

undertaken. As I will outline in the discussion of this chapter and the conclusion of this dissertation, the amount of research on anti-fatness that needs to be done is staggering. In spite of these missing links, I have endeavored to synthesize the myriad studies documenting the oppressive consequences of anti-fatness and connect some of these consequences to specific ways in which obesity elimination is enabled and enacted within the anti-obesity assemblage. I suggest that enabling obesity elimination leads to the devaluation of fat people, the widespread belief that being fat is incompatible with living a good life, and the distribution and uptake of a clinical sensibility towards fatness among the public, including a feeling of "knowingness" about how fat people should undertake weight loss. I draw on a more well-established set of research to connect enacting obesity elimination to fat people's physical and mental suffering.

Fat Oppressive Consequences of Enabling Obesity Elimination

Enabling obesity elimination contributes to widespread devaluation of, and discrimination against, fat people. On a basic level, consistent media portrayals of fat people as threats – to themselves, to others, and to society – create associations between fatness and moral badness, i.e., harm, suffering, waste, and backwardness (Crawford, 2017; Kersbergen & Robinson, 2019; F. R. White, 2013). In addition, anti-obesity media never portray fat people as flourishing or even as having the possibility to flourish without weight loss. In doing so, they diminish many people's ability to even *imagine* living a good life while being fat.

Fat people are also dehumanized by the efforts to render them eliminable (Kyrölä & Harjunen, 2017). "Obesity" is itself a pathologized, medicalized category. When laypeople are trained to see fat people through the lens of "obesity," it – and the medical information linked to it, such as its causes and harms – can become the *defining characteristic* of a fat person (Fox et al., 2023; Greenhalgh, 2015). The omnipresence of medical categories like obesity and clinical

tools such as the BMI has spread a clinical sensibility towards fatness throughout US society, training laypeople to see fat people *through a dehumanizing clinical gaze* (Foucault, 1994). Fat people are dehumanized when their lives become *defined by* the message that their bodies are killing them and harming the nation (Fox, 2018; Saguy, 2013).

Fat people are devalued through the expectation that they should be constantly attempting to lose weight. The category of "obesity" literally contains a prescription to lose weight, so classifying people as "obese" imposes that prescription onto them. This renders fat bodies inherently liminal, excluding the possibility that fat people can merely exist without engaging in weight loss (Kyrölä & Harjunen, 2017). Moreover, reality TV shows and other forms of anti-obesity media routinely put forth fat suffering as a spectacle for popular entertainment, making fat people's quality of life irrelevant in the calculus of weight loss endeavors (Cameron, 2022; Ingraham, 2022; Justin, 2021; Zimdars, 2019). Consistent portrayals of weight loss in media may train audiences to think about the mechanisms of weight loss first when they see fat people. People exposed to weight loss media can develop not only the expectation that fat people engage in weight loss, but a sense that they know how to lose weight and how much discomfort fat people should tolerate toward that end (Frederick et al., 2016; Saguy et al., 2014). The ubiquity of weight loss media thus leads to a common sense understanding that fat people cannot, or do not deserve to, exist peacefully in their fat bodies. Through the anti-obesity assemblage, access to a self-determined life is stripped from fat people.

Fat people also face discrimination because of the ways the anti-obesity assemblage works to make them eliminable. Portraying fat people as health threats to themselves and others may lead individuals to avoid or even feel repulsed by them. Fat people have reported being avoided or facing hostility in crowded spaces, such as on airplanes or public transportation (B.

Evans et al., 2021; Owen, 2012). The imagined liminality of fat embodiment can lead individuals to see structural accommodations for fat bodies as a waste of time and resources; in this logic, if fat people wish to access particular spaces or resources, they should just lose weight. Research on healthcare encounters has shown that providers are less likely to physically examine their fat patients (Schvey, 2010). An individual who sees fat people as threatening, diseased, or liminal may also discriminate against them in hiring situations. In a review of employment discrimination against fat women, Fikkan and Rothblum found that fat women face disparate treatment in "hiring, promotion, performance evaluation, and compensation" (2012, p. 576).

The oppressive consequences of the anti-obesity assemblage's efforts to enable obesity elimination create an untenable world for fat people. Mass hostility and derision push them to spend their time and resources attempting to shrink their bodies in search of the shreds of humanity they have been denied. Deep belief in obesity as a threat to the world leads many others to intervene in fat bodies or develop spaces and standards to facilitate interventions.

Fat Oppressive Consequences of Enacting Obesity Elimination

The negative impacts of attempting weight loss are well documented. Fat people suffer through experiences of starvation, self-deprivation, weight cycling, and side effects ranging from unpleasant to deadly as they engage in projects of undoing their own bodies. Fat people's physical and mental suffering can be considered an oppressive consequence of the anti-obesity assemblage and its efforts to eliminate obesity. As feminist scholars have long recognized, weight loss practices, though promised as a way to happiness, often preclude this very happiness. Dieters suffer hunger, bodily aches and chills, lightheadedness, obsessive thoughts about food, and mood swings as they deprive their bodies of necessary nutrients (Chernin, 1994). Fat dieters endure these ailments plus the added psychological burden of being repeatedly told that if they

do not lose weight, they will die (Levy-Navarro, 2012). Many fat dieters perceive weight loss as a life and death struggle, with each pound lost a path to humanity and each pound regained a signal of impending doom (Fox, 2018; Rodier, 2015). Moreover, research has shown that weight loss, and especially weight cycling (repeatedly losing and regaining weight) can *cause* significant health problems. Such cycling is the most common outcome of weight loss dieting, as the vast majority of dieters regain the weight they lose within five years (Bacon & Aphramor, 2011; O'Hara & Taylor, 2018). Fat studies scholars have also documented many of the adverse side effects of weight loss medications, supplements, and procedures (Boero, 2012; Herndon, 2014). For example, the weight loss drug fen-phen was used by millions of people in the US in the 1990s before it was withdrawn from the market for causing pulmonary hypertension and heart valve problems (Mundy, 2010).

In healthcare, the imperative to eliminate fatness can override typical clinical or caretaking logics, leading healthcare providers to ignore a fat patient's presenting ailment in favor of blaming their condition on their weight. In 2014, fat activist Lesley Kinzel encouraged fat people to use the hashtag #DiagnosisFat to document their experiences with clinicians who mistreated or misdiagnosed them because of their weight (2014). The hashtag now links hundreds of stories of fat people left to suffer and incur the physical, mental, and financial toll of attempting to heal themselves or seek out another provider. This practice may also lead to a fat person's death, although the prevalence of this phenomenon has yet to be measured (Russo, 2019; Strapagiel, 2018). As mentioned above, fat people may crash diet, seek out weight loss surgery, or pursue other means of weight loss so that a doctor will take their symptoms seriously.

Outside of fat activist spaces, the suffering created by the pursuit of obesity elimination is almost always attributed to fatness itself (Mercedes & Kriete, 2023). As such, the consequences

of the anti-obesity assemblage are also self-reinforcing: engaging in weight loss produces suffering and poor health which, through the assemblage's mechanisms of enabling obesity elimination, increases the devaluation of fat people and bolsters their portrayal as inherently pathological. Yet the only way for fat people to escape this devaluation – to scramble for their humanity, to gain minute amounts of bodily capital, and often to access medical care – is to continue to engage in disciplinary weight loss techniques. The anti-obesity assemblage creates a world where it is virtually impossible for fat people to opt out of the pursuit of thinness, even as such a pursuit slowly destroys them.

Using the Anti-Obesity Assemblage to Study Anti-Fatness

In this chapter, I have posited that fat people's lives are constrained by the efforts to eliminate them. Using Deleuze and Guattari's theory of assemblage, I have conceptualized anti-obesity efforts as an eliminationist assemblage that structures fat oppression. The anti-obesity assemblage is a diffuse, material-discursive structure that enables and enacts the elimination of fat people from the world. Any standard, human or non-human actor, technology, practice, representation, or discourse that contributes to obesity elimination can be considered part of the anti-obesity assemblage. Using literature from the field of fat studies, I have outlined three mechanisms by which obesity elimination is enabled: the transformation of fatness into "obesity," the transformation of obesity into an eliminable threat, and the generation of new knowledge about obesity. I have also identified that the anti-obesity assemblage provides a seemingly endless number of ways for individuals to enact obesity elimination. The mechanisms of enabling and enacting obesity elimination I have identified here are prominent in the US, but this is not an exhaustive overview of the anti-obesity assemblage. Obesity elimination is also enabled and enacted by elements that I have not discussed here, such as the interpellation of

healthcare providers into obesity elimination via medical education and the funding networks established by US anti-obesity advocacy organizations.

Using the concept of the anti-obesity assemblage, I have suggested numerous ways that anti-obesity efforts may lead to oppressive consequences for fat people. The ways that obesity elimination is enabled lead to fat people being dehumanized, with their pathology elevated over their personhood. They also lead to the widespread expectation that fat people engage in weight loss, regardless of the cost of weight loss efforts. These ideas may also provoke interpersonal discrimination against fat people. The ways that obesity elimination is enacted also lead to specific oppressive consequences for fat people. Weight loss endeavors have well-documented negative physical and mental repercussions, such as constant hunger and obsessive thoughts about food. Disciplinary standards such as the weight-first treatment paradigm in healthcare have resulted in fat people's medical neglect and suffering. Obesity elimination efforts often leave fat people suffering and miserable, which is in turn attributed to obesity itself because of the anti-obesity assemblage. As such, the oppressive consequences of obesity elimination feed back into the devaluation of fat people.

The concept of the anti-obesity assemblage fundamentally reorients the task of fat studies scholarship. Rather than focusing genealogically on the historical roots of anti-fatness, the social construction of obesity and the obesity epidemic, or who is "truly to blame" for fat bodies, the anti-obesity assemblage draws our attention to the present, material reality of the US anti-obesity regime and its anti-fat consequences. Said more simply, the concept of the anti-obesity assemblage shifts our focus from *why* to *what is happening*. It is a schematic for *how the project of obesity elimination is working in the present moment*. The concept of the anti-obesity assemblage provides a way to analyze anti-fatness that does not reduce anti-fatness to some other

form of oppression (e.g., sexism, capitalism) and does not depend on the motivations of a given actor or the history or accuracy of a particular standard. Anti-obesity efforts do not need to be false or corrupt to harm fat people. Instead, fat studies scholars can ask of any discourse, practice, or policy about fatness: "does this expand or otherwise legitimize the effort to produce a world without fat people?" If the answer to this question is yes, then the matter in question will perpetuate fat oppression. The project then becomes to show the connections between anti-obesity efforts and their oppressive consequences.

More importantly, the concept of the anti-obesity assemblage provides a way for fat studies scholars to assert that efforts to eliminate obesity will *always and inevitably* increase fat oppression. Contributing to one part of the anti-obesity assemblage strengthens, and potentially expands, the entire structure. Just as a new obesity treatment leads to more attention on obesity elimination, producing new reasons to eliminate obesity (such as linking it with other social justice issues) leads to increased investment in anti-obesity interventions. The anti-obesity assemblage grows by assimilating any new actor, practice, or discourse invested in producing a world without fat people. This holds as true for Ozempic prescriptions as it does for public policy targeted at "obesogenic environments," Instagram posts about trauma as a source of weight gain, and medical research into the relationship between weight and health.

Employing the concept of the anti-obesity assemblage can also help scholars more precisely articulate the ways in which anti-fatness intersects with other structural forms of oppression (Collins, 2019). For example, Dame-Griff (2020) argues that US Latina/o/x populations are marginalized and targeted for intervention through the racialized and medicalized construction of "Latina/o/x obesity." However, the concept of medicalization does not fully describe the phenomena she details in her article, such as the construction of Latina/o/x

people as an economic threat to the US via their pathological bodies. Using the concept of the anti-obesity assemblage, we could more precisely articulate that the public health focus on eliminating "Latina/o/x obesity" merges ongoing racist, neoliberal, and anti-immigration attitudes towards Latina/o/x populations with the resources of the anti-obesity assemblage. When Latina/o/x populations are constituted through these many simultaneous logics, they become more intensively targeted for anti-obesity interventions in the interest of keeping them "healthy enough to continue to labor" while minimizing their "drain on the economy and the healthcare industry" (2020, p. 223). Conceptualizing fat oppression as *structured* by anti-obesity efforts enables fat studies scholars to consider obesity elimination in their analyses of the intersecting power relations that produce social inequalities and shape individual and group experiences.

What Eliminationist Assemblages Bring to the Social Study of Medicine

The anti-obesity assemblage can also be understood as one of many eliminationist assemblages that operate in the 21st century. I define eliminationist assemblages as networks of people, discourses, practices, and other elements that enable and enact the production of a world without a particular way of being. While other concepts, such as eugenics and the normal, have been useful in critical scholarship on the social impact of medicine, they gain critical leverage from concerns about the historical power of particular eliminationist practices and discourses. In contrast, by focusing our attention on efforts to eliminate specific forms of human variation *per se*, the concept of eliminationist assemblages zooms out, encompassing the full range of eliminationist practices and discourses as they manifest in the present. In so doing, studying eliminationist assemblages allows us to trace a broader set of social consequences produced by medicalized efforts to shape human variation, without centering medicine as the sole locus of power.

As the case of the anti-obesity assemblage demonstrates, the presence of an eliminationist assemblage can have devastating consequences for the people whose way of being is targeted for elimination. Just as the anti-obesity assemblage structures the oppression of fat people, it seems likely that other groups are similarly oppressed by efforts to eliminate their way of being. For example, some scholars have argued that efforts to produce a world without autistic people (what I would call the anti-autism assemblage) have harmful effects on a structural level (A. Mitchell, 2022). However, even if the effects of an eliminationist assemblage do not rise to the level of constituting a structure of oppression, they still likely have certain negative consequences for their targets. The case of the anti-obesity assemblage suggests two primary ways that these consequences are patterned. On the one hand, eliminationist assemblages devalue a way of being culturally through efforts to enable its elimination. On the other hand, eliminationist assemblages direct resources toward elimination efforts and away from other possible ways of interacting with a particular way of being. The following chapters will demonstrate how these consequences manifest even in anti-weight stigma efforts so long as they prioritize obesity elimination.

The concept of eliminationist assemblages diverges from existing frameworks for discussing elimination by removing the need for the analyst to hold the epistemic high ground over the people or phenomenon they are discussing. First, employing this concept does not depend on the claims of an eliminationist assemblage being "wrong" or "biased." For example, critiques of medicalization often depend on an implicit claim that some conditions just do not need to be treated, casting their medicalization as wrong because it is false or unnecessary. While this may indeed be the case, the "truth" about a way of being, i.e., whether it "truly" should be targeted for elimination, does not determine whether an eliminationist assemblage is present or how it harms the people whose way of being it seeks to eliminate. Second, the calculus of

whether an elimination campaign "works" does not determine whether it falls under the concept of eliminationist assemblages. Analysts can employ the concept of eliminationist assemblages regardless of how that assemblage impacts the way of being it targets. Third, the concept of eliminationist assemblages does not depend on an analyst uncovering the hidden motivations or consequences of an elimination effort. Many actors involved in enabling and enacting the elimination of a way of being openly recognize this as their goal. In fact, myriad organizations explicitly use the goal of elimination as their *raison d'etre* and fundraise on the promise that they will eliminate a way of being (e.g., the Alzheimer's Association, who describe themselves as "lead[ing] the way to end Alzheimer's and all other dementia" (*Home | Alzheimer's Association*, n.d.). Using the concept of eliminationist assemblages depends not on an epistemic evaluation, but a material one: are there efforts being made to eliminate a particular way of being?

Additionally, the concept of eliminationist assemblages opens space for *evaluating the existence of these assemblages*. Without this concept, neither experts nor the public can weigh in on whether a particular way of being should be targeted for elimination or debate the relative prioritization of elimination over other ways of interacting with that way of being. This is, in part, because the concept of an eliminationist assemblage does not have an intrinsically negative connotation. Labeling something an eliminationist assemblage is not itself a critique; as stated above, there are many experts and advocates who reflexively understand themselves as engaging in an effort to eliminate a way of being. (In contrast, because it is widely understood as pejorative, debates over eugenics frequently come down to the meaning of the term.) I do not assume that, in a just world, eliminationist assemblages would no longer exist. At the same time, however, the concept does allow us to study and trace certain negative consequences that are obscured by other concepts. Some eliminationist assemblages constitute structures of oppression,

but this is not an intrinsic property that they all share. It is not an intrinsically abolitionist concept; there is no assumption that all eliminationist assemblages should be ended. In some cases, such as the case of Alzheimer's mentioned above, we might agree that elimination is a valuable goal but still critique the relative prioritization and resources given to efforts to prevent or treat it over efforts to care for those affected.

Conclusion

This chapter initiates a broader scholarly project: investigating the societal consequences of efforts to eliminate specific forms of human variation. The concept of eliminationist assemblages creates space for radical solidarity across different struggles against what has been previously conceptualized as "medicalization" or "normalization." However, my primary goal is to understand how efforts to produce a world without obesity oppress fat people. The anti-obesity assemblage is a valuable case for understanding the consequences of eliminationist assemblages more generally, but ultimately my focus remains on studying structural anti-fatness and its links with anti-obesity efforts. As I discuss further in the final chapter of this dissertation, studying the oppressive consequences of the anti-obesity assemblage provides new avenues for fat activists to understand and thus combat fat oppression. In particular, I argue that combating fat oppression requires dismantling the anti-obesity assemblage.

In the next several chapters, I put the claim that the anti-obesity assemblage structures fat oppression to a "risky test" (Popper, 2014) by examining if this relationship holds even within weight stigma research and advocacy. Said differently, I investigate whether combating obesity stigmatizes fat people even when it is intertwined with efforts to combat weight stigma. In Chapter 2, I use a content analysis of weight stigma research to show that this field is deeply intertwined with the anti-obesity assemblage in a way that deprioritizes the goal of fighting

stigma. Chapter 3 is a praxiography of weight stigma interventions with healthcare professionals and trainees, demonstrating how these interventions produce stigmatizing experiences and representations of fat people in order to expand the anti-obesity assemblage. In Chapter 4, I use the concept of the anti-obesity assemblage to guide my analysis of a weight stigma/obesity awareness campaign funded by Novo Nordisk. I find that weight stigma advocacy efforts funded by Novo Nordisk make fighting weight stigma and fighting obesity compatible by defining obesity treatment as the solution to weight stigma.

Chapter 2
Fighting Weight Stigma to Fight Obesity: Weight Stigma Research, 1960-2024

"Tackling stigma is not only a matter of human rights and social justice but also a way to advance prevention and treatment of obesity and associated metabolic diseases" (Rubino, 2024)

In 1963, Lenore Monello and Jean Mayer, obesity researchers from the Harvard School of Public Health, published an article with an unexpected title: "Obese Adolescent Girls: An Unrecognized 'Minority' Group?" The article was unexpected, they explained, because their research was initially "aimed at discovering personality traits of possible etiologic significance in obese adolescent girls," especially "traits associated with lessened physical activity" (1963, p. 35). They soon discovered, however, that the physical differences between the "obese" and "nonobese" girls in their sample had little to do with any inherent personality characteristics. Instead, the differences between girls of different weights were better explained by the "social and psychologic pressures on obese persons in our society." In fact, they argued, the "obese" girls in their study showed "personality characteristics strikingly similar to the traits of ethnic and racial minorities recognized by Allport and others to be due to their status as victims of prejudice." This led the authors to conclude that any negative characteristics shared by the "obese" girls were more likely the *result* of their "obesity" rather than its cause (1963, p. 38). After this study and its surprising findings, however, both Monello and Mayer returned to conducting research on the causes of obesity.

I begin this chapter on the field of weight stigma research with this article for two reasons. First, the date of publication: while many people assume that concern for prejudice and discrimination against fat people is a recent invention, scholarship on this topic dates back to the 1960s. Second, the article exemplifies a number of trends within the academic literature

concerning weight stigma that have been present since this scholarship began and which continue through to today: it was published in a medically-oriented journal (the *American Journal of Clinical Nutrition*), its concern for weight stigma is predicated on concern for obesity, and the findings are portrayed as significant because they have implications for reducing obesity rates. Said more simply, this article demonstrates the *anti-obesity orientation* shared by the vast majority of the academic literature on the mistreatment of fat people.

In this chapter, I build the argument that academic research on weight stigma is, and has been for the duration of its existence, deeply intwined with the anti-obesity assemblage. As I will show, despite its ostensible focus on the mistreatment of fat people, the majority of weight stigma research enables obesity elimination and therefore also drives fat oppression. A focus on weight stigma itself does not preclude researchers from participating in the effort to produce a world without obesity. In fact, weight stigma research has pursued this end since its inception, and this goal has come to dominate weight stigma research in the decades since it began. While some fat studies scholars have made claims about the presence of anti-fat assumptions in specific parts of weight stigma research, this chapter is the first comprehensive empirical analysis of the extent to which much this field supports obesity elimination efforts.

Following the research questions outlined in the introduction to this dissertation, I build up my argument about the anti-fat nature of weight stigma research in three ways. First, I use content analysis to quantify the extent to which weight stigma research is intertwined with the anti-obesity assemblage. In this section, I operationalize the concept of the anti-obesity assemblage into a set of criteria for evaluating whether an article enables obesity elimination based on its abstract, introduction, discussion, and conclusion. I apply these criteria to a random sample of articles generated from a corpus of academic research on weight stigma, revealing that

nearly two-thirds of weight stigma research enables obesity elimination in some capacity. Second, I examine how weight stigma researchers have come to see fighting obesity as compatible with fighting weight stigma. Using genealogy, I show that weight stigma research has consistently treated weight stigma as important only insofar as it drives weight gain and inhibits obesity elimination efforts. In the final section of this chapter, I employ discourse analysis to identify the prominent themes within this research, showing how the field disproportionately focuses on topics that enable obesity elimination. As part of this analysis, I show how entangling weight stigma research with the anti-obesity assemblage hinders its ability to understand and combat weight stigma.

Literature Review

As mentioned above, several scholars have noted that weight stigma research is linked to anti-obesity efforts in some capacity. However, these scholars have used specific manifestations of this link as evidence of the broader nature of the field, rather than engaging in any comprehensive review of the research. Saguy, for example, uses the Rudd Center's dual goals of studying weight stigma and fighting obesity to assert that weight stigma research blends a "public health crisis" approach to obesity with a "fat rights" approach towards fat people (2013, pp. 67–68). Bombak et al. (2022) similarly assert that the research and advocacy organization *Obesity Canada* is undermining its own efforts to study weight stigma by accepting large sums of money from anti-obesity pharmaceutical companies. While these examples are illustrative, they do not provide evidence of weight stigma research's systematic entanglement with anti-obesity efforts. Without a concept that accounts for anti-obesity efforts in a structural sense, these scholars have not been able to fully describe what they saw in these examples and have instead latched onto limited manifestations of the anti-obesity orientation of weight stigma research.

In a similar vein, some scholars have criticized weight stigma research as upholding anti-fatness, often by pointing generally to its incorporation of certain claims about obesity. For example, Calogero et al. (2016) argue that weight stigma research perpetuates "scientific weightism" by relying on, and promulgating, claims about obesity as a disease and epidemic. However, they do not explain how such claims uphold anti-fatness beyond asserting their fallaciousness, and they deliberately do not provide examples of specific anti-fat claims in published research because they do not want to "critique any one research group" or "assume any malicious intentions or motivations on the part of weight stigma scholars" (2016, p. 10). Schmidt and Brochu make a parallel claim about weight stigma intervention research, arguing that this research is "influenced by the dominant, weight-normative paradigm that inherently stigmatizes fatness by viewing it as a disease" (2021, pp. 154–155). Yet, as I discussed previously, these authors struggle to explain how claims about fatness as a disease uphold anti-fatness, taking for granted that readers agree with this proposition.

Explaining how weight stigma research upholds anti-fatness requires addressing more than localized instances of anti-fat rhetoric, researchers taking money from pharmaceutical companies, and the repetition of fallacious claims about weight and health. It involves a systematic inquiry into the many manifestations of anti-fatness in research across the field. Said differently, it requires examining the extent to which weight stigma research is intertwined with the anti-obesity assemblage – a phenomenon that can be *measured*. This involves going beyond noting the mere presence of specific anti-obesity assumptions or claims within this literature, and instead measuring what proportion of published weight stigma research broadly *prioritizes obesity elimination as a primary goal*. Without a systematic inquiry, it is easy to write off individual articles as unfortunate missteps in a field with good intentions. Moreover, it is easy to

dismiss or ignore critiques that depend on vague generalizations, such as the accusation by Calogero et al. that all research using the term "obesity" is perpetuating "scientific weightism." Thus, my methodology in this chapter is an attempt to rectify the piecemeal approach of existing scholarship through the analytic leverage afforded by the concept of the anti-obesity assemblage.

In this chapter, I turn to content analysis to *quantify* what percentage of academic articles on weight stigma enable obesity elimination. As a deductive method, content analysis begins with a theory-driven hypothesis about a group of texts, which is then used to develop a coding scheme that can be applied to each text (Potter & Levine-Donnerstein, 1999). The coding criteria can be applied to analyze the content systematically, producing a quantitative description of a group of texts. Said differently, because the criteria for analysis are so circumscribed, content analysis is useful for producing claims about the "big picture" of a given corpus, such as, in this case, what percentage of articles on weight stigma contain anti-obesity claims or otherwise prioritize obesity elimination. I also quantify the entanglement between weight stigma research and the anti-obesity assemblage in two other ways: by identifying the percentage of weight stigma research published in medical journals, and by comparing the citation rates of weight stigma research that prioritizes obesity elimination with weight stigma research that does not. This yields the following three research questions:

> Research Question 1: What proportion of weight stigma research centers obesity elimination in its abstract, introduction, discussion, and/or conclusion?
>
> Research Question 2: Is weight stigma research that centers obesity elimination cited more frequently than weight stigma research that does not?
>
> Research Question 3: What kinds of journals publish research on weight stigma most frequently?

While the method of content analysis is well suited to producing a systematic account of how weight stigma research is intertwined with the anti-obesity assemblage, it is less helpful for explaining how the entanglement of weight stigma research within the anti-obesity assemblage upholds anti-fatness. In other words, it is a quantification of a particular phenomenon, rather than an explanation of consequences. The task of explaining *how* the entanglement of weight stigma research with the anti-obesity assemblage upholds anti-fatness is discussed primarily in the next two chapters. However, I touch on this point in a limited capacity in this chapter by analyzing how the prioritization of obesity elimination produces important absences within weight stigma research, limiting its usefulness in efforts to fight anti-fatness.

Operationalizing the Anti-Obesity Assemblage

As detailed in Chapter 1, the concept of the anti-obesity assemblage refers to the network of standards, human and non-human actors, technologies, practices, representations, and discourses that enable and enact obesity elimination. Because academic articles on weight stigma cannot literally be enactments of obesity elimination, they can only be part of the anti-obesity assemblage if they enable obesity elimination. Thus, quantifying the percentage of academic articles on weight stigma that are part of the anti-obesity assemblage requires operationalizing what it means for an article to "enable obesity elimination." In the previous chapter, I discussed three mechanisms by which obesity elimination is enabled: the transformation of fatness into "obesity," the transformation of obesity into an eliminable threat, and the production of obesity knowledge. In operationalizing this concept, I chose to focus on the latter two mechanisms. Rather than simply classifying an article as enabling obesity elimination if it uses the word "obesity" to refer to fatness, I sought to capture the ways that weight stigma research enables obesity elimination that can be most directly connected to anti-fatness.

One way that articles on weight stigma can enable obesity elimination is by portraying fatness as a threat. Portraying fatness as a threat increases its salience as a problem to be eliminated and motivates people to address it, ultimately providing discursive "fuel" for the anti-obesity assemblage. (I discuss this aspect of the anti-obesity assemblage in more detail in Chapter 3.) For example, describing obesity as a disease, an epidemic, or a public health crisis all emphasize its status as a threat. Similarly, discussing the harmful effects of obesity enables obesity elimination by encouraging readers to take the problem seriously. In my coding scheme, this included: a) portrayals of obesity as burdensome in any capacity, b) discussions of higher weight as harmful to health without identifying stigma as a mediator in this relationship, and c) portrayals of weight stigma as an effect of obesity, rather than a social force.

Another way that articles on weight stigma can enable obesity elimination is by producing knowledge about obesity. Producing knowledge about obesity primarily enables obesity elimination by identifying its causes, investigating the most effective ways to enact its elimination, and identifying the barriers to its elimination. In other words, knowledge production about obesity enables obesity elimination by honing efforts to enact it. I operationalized this mechanism in several ways. I included research that portrays weight stigma as a driver of, or risk factor for, higher weight in my criteria because such research enables obesity elimination by putting forth a new cause of obesity, creating new targets for anti-obesity efforts. Similarly, articles on weight stigma that discuss barriers to weight loss or anti-obesity efforts more broadly (such as weight stigma itself) enable obesity elimination by guiding future anti-obesity efforts. Finally, studies that measure weight gain or loss as an outcome enable obesity elimination by producing evidence for evaluating either causes of or solutions to obesity. However, I excluded from my coding scheme claims about the causes of obesity more generally, because many

scholars believe that such claims can be destigmatizing, and, as mentioned, I wanted to focus on the forms of enabling obesity elimination that are most plausibly connected to anti-fatness.

The other mechanism of enabling obesity elimination found in articles on weight stigma is explicitly calling for more resources to be directed to anti-obesity efforts. Calling for more resources to be dedicated to fighting obesity enables obesity elimination in the most straightforward sense: it helps to increase the resources that are connected to the anti-obesity assemblage. In my coding scheme, this included articles calling for more anti-obesity education or research, as well as research recommending anti-obesity interventions.

Materials and Methods

Corpus

My goal in compiling a corpus was to capture, as comprehensively as possible, the set of academic conversations about weight stigma appearing in published literature. In alignment with this goal, I chose to include texts that made claims about weight stigma in their titles or abstracts. This is because many articles about obesity make claims about weight stigma, but that focus often does not appear in the title. For example, the second most highly cited article in this corpus is titled "Health Consequences of Obesity in Youth: Childhood Predictors of Adult Disease" (Dietz, 1998). This title does not include a claim about stigma, but the second sentence of the abstract is "Discrimination against overweight children begins early in childhood and becomes progressively institutionalized" and the first section of the article is titled "Effect of Body Size on Socialization," which indicates that this article is clearly part of the academic construction of weight stigma despite its title.

Also in the interest of comprehensiveness, I attempted to capture the wide variety of terms that are used to discuss weight stigma. While a full list of terms I searched for can be

found in Appendix A, in general, the term "weight stigma" also encompasses weight bias, weight-based prejudice, obesity stigma/bias/prejudice, fat stigma, anti-fat bias, etc.[10] The point of combining research that uses different terms for discussing the marginalization of fat people is not to homogenize this research, but rather to recognize that the terms researchers use when they write about this phenomenon help constitute it. In my writing, I generally use the term "weight stigma" to stand in for this diverse terminology.

I chose to use Web of Science as the database from which to generate my corpus because it reliably indexes journals across all fields (unlike PubMed, which primarily indexes medical journals) and reliably contains a high percentage of academic publications (unlike Google Scholar, which indexes magazines and other forms of media) (Falagas et al., 2008).

After performing my initial search, which yielded 3840 items, I cleaned my corpus by excluding articles written in a language other than English and removing non-article materials, such as editorials, book reviews, and meeting abstracts. Next, I excluded articles I identified as using the search terms in semantically different ways, such as computer science articles that use the term "weight bias" to refer to bias in weighting algorithmic variables. I also excluded articles that exclusively discussed the stigma of another condition, e.g. HIV or schizophrenia, and articles that focused on the secondary stigmatizing effects of being the parent or partner to a fat person. Finally, I excluded articles that focused exclusively on the stigma of bariatric surgery, binge eating disorder (BED), or other disparaged/pathologized behaviors. The final corpus contains 2502 items.

[10] I did not include research about "body image" specifically in my corpus because this theoretical construct reflects how an individual feels about their own body rather than about a devalued group.

Coding Scheme

As described above, the goal of this content analysis was to quantify what proportion of weight stigma research enables obesity elimination in ways that are most plausibly connected to anti-fatness. To make coding more efficient, I decided to code only the abstract, introduction, discussion, and conclusion (or the first and final section) for statements that enable obesity elimination. This approach to coding is based on the idea that these sections of the article capture the priorities of the researchers and how they articulate the significance or contribution of the article. I developed a binary coding scheme to classify articles as either "enabling obesity elimination" or "not enabling obesity elimination" (the full codebook can be found in Appendix A). In line with the operationalization described above, I created a detailed set of criteria for what constituted "enabling obesity elimination."

During coding, I assumed that texts were "not enabling obesity elimination" until proven otherwise. For each article, I first attempted to code the abstract for the presence of claims that met the criteria for "enabling obesity elimination." If I did not find anything that would be coded "enabling" in the abstract, I moved on to the introduction, discussion, and conclusion (or first and final section, depending on how the sections were labeled). For some kinds of statements (such as calls for more anti-obesity education), the presence of even one instance in any of these sections was enough for the article to be coded as "enabling." The rationale for this approach is that some kinds of statements more blatantly and directly enable obesity elimination. Other kinds of statements, such as the assertion that weight stigma drives obesity, only led an article to be classified as enabling obesity elimination if it met additional criteria. To count as "enabling," such statements had to either a) appear in the first two paragraphs, b) appear in the conclusion or

last paragraph, or c) appear in three sentences total across the introduction, discussion, or conclusion.

Journal Classification

To determine how many articles were published in medical journals, I used the Web of Science research areas classification system. From my original corpus, I excluded any articles published in journals that were classified in an area other than "Life Sciences & Biomedicine" (Arts & Humanities, Physical Sciences, Social Sciences, or Technology). These research area classifications are not mutually exclusive; for example, the journal *Social Science and Medicine* is tagged as both "Public, Environmental & Occupational Health" (part of the Life Sciences & Biomedicine research area) and "Biomedical Social Sciences" (part of the Social Sciences research area). However, by excluding articles tagged with anything other than a Life Sciences & Biomedicine category, I created a group of articles that were solely classified as medical. I also used analytical tools included in Web of Science to find the number of articles published in each journal.

Sample

After assembling the complete corpus, I randomly selected 400 articles to code, which comprised approximately 15 percent of the corpus. In addition to coding these 400 articles, I also used analytic tools available through Web of Science to explore specific dimensions of the entire corpus, such as which journals published the largest number of articles (Figure 1) the most highly cited articles (Figure 2), and the most prolific authors (Figure 3).

Data Analysis

Most of the data gathered is reported as frequencies and proportions. However, I did run one statistical test to compare the difference between the number of times cited for articles coded as

enabling obesity elimination and those that were not: the Mann-Whitney U Test. The Mann-Whitney U test is used to assess whether there is a difference between two samples that are not normally distributed. I used this test because the number of times each article was cited does not form a normal distribution (as most articles are cited only 0-2 times).

Results

Article Content

To determine what proportion of weight stigma research advances anti-obesity efforts, I coded a random sample of 400 articles from the corpus of weight stigma research articles, representing 15% of the corpus. Of the 400 articles selected for coding, **257 (64%)** were coded as "enabling obesity elimination" and **143 (36%)** were coded as "not enabling obesity elimination." Although I hypothesized that a significant portion of this research would demonstrate an anti-obesity orientation, this proportion was much higher than I expected, at nearly two-thirds of the articles.

Many articles coded as "enabling obesity elimination" were largely focused on obesity as a problem, with stigma as a secondary or subordinate concern. For example, a large number of articles examined health professionals' (HP) attitudes, beliefs, and clinical experiences regarding fat patients. One subgroup of these articles focused on HPs' subjective experiences of weight loss counseling and the barriers they faced in doing so, often framing their anti-fat bias and/or fear of stigmatizing their patients as two such barriers (Agaronnik et al., 2021; Agarwal & Nadolsky, 2022; Christenson et al., 2018; Fontana et al., 2013; Glenister et al., 2020; Jung et al., 2016; Schwenke et al., 2020; Serban et al., 2021). These articles were frequently identifiable based on abstract alone. For example, the abstract of the article "What Barriers and Facilitators Do School Nurses Experience When Implementing an Obesity Intervention?" described "concerns about

obesity stigma" as a barrier to school nurses implementing an anti-obesity intervention (Schroeder & Smaldone, 2017). Another genre of article that regularly appeared in this category was obesity treatment guidelines or treatment recommendations (Bejciy-Spring, 2008; Durrer Schutz et al., 2019; Gallagher et al., 2021; Gaskin et al., 2024; Nadolsky et al., 2023; Neil & Roberson, 2015; Orjuela-Grimm et al., 2021; Sharma & Ramos Salas, 2018). Similar to research on stigma as a barrier to anti-obesity efforts, these articles often contained guidance on how health professionals can "address" or "reduce" weight stigma in their anti-obesity practice. In their abstract, Durrer Schutz et al. state that general practitioners are typically the "first contact for patients with obesity for any medical treatment" so their article "aims to provide obesity management guidelines specifically tailored to GPs…[that] highlight the importance of avoiding stigmatization, something frequently seen in different health care settings" (2019).

In addition to literature related to providers, another subset of "enabling obesity elimination" articles focused on fat patients, especially patients engaging in weight loss. For instance, many studies surveyed and/or interviewed bariatric surgery candidates; a number of these studies also focused on external or internalized stigma as a barrier to treatment-seeking and/or predictor of weight regain post-surgery (Drew, 2011; Fabrig et al., 2024; Feig et al., 2022; Hoffmann et al., 2022; Liu et al., 2022; Meneguzzo et al., 2021; Owen-Smith et al., 2018; Rand & Macgregor, 1990; Zahra-Zeitoun et al., 2024).

However, not all articles coded as "enabling obesity elimination" were so explicit in their orientation. Less explicitly anti-obesity articles often did not include anti-obesity statements in their abstracts but rather within the first three paragraphs of the article. For example, Asgeirsdottir begins an article on how body weight and gender shape Iceland's work force with a

set of claims about obesity as burdensome despite the remainder of the article focusing on how discrimination against fat women negatively impacts their employment rates:

> As obesity rates in Western countries rise, researchers examine the possible consequences of this trend for the labor market. Governments provide a wide variety of tax-funded social-welfare programs intended to aid the unemployed and the unemployable; if obesity is not only on the rise but also negatively correlated with an individual's capacity to find employment, it threatens to become an increasing burden for the entire tax-paying public. (2011, p. 148; see Campos-Vazquez & Gonzalez, 2020 for a similar example)

Articles with anti-obesity claims in the first three paragraphs were coded as "enabling obesity elimination" even when the rest of the article did not contain these claims. One article that drew on the problem of obesity as its rationale but otherwise focused on stigma is Brochu and Morrison's "Implicit and Explicit Prejudice Toward Overweight and Average-Weight Men and Women" (2007). This article investigated a crucial dimension of stigma: how reliably stigmatizing attitudes lead to discriminatory behavioral intentions. Yet the third sentence reads "Puhl and Brownell (2001) claimed that weight bias is one of the remaining acceptable forms of prejudice, a sentiment that is particularly troubling given the obesity epidemic facing much of Western society" (2007, p. 681). This line alone is enough to change the meaning of the subsequent research because it indicates that these *stigma researchers*, despite their concern for stigma, considered obesity so pressing a threat that it warranted mentioning *in the first paragraph*.

The 36% of articles coded as "not enabling obesity elimination" were more likely than the "enabling obesity elimination" group to report on basic psychological or social psychological research on stigma, including its prevalence, nature, and mechanisms of action (e.g., Krendl et al., 2006). Echoing Richardson et al.'s 1961 study of elementary school children, multiple studies in this corpus subset investigated stigmatizing attitudes and beliefs, including how these attitudes

and beliefs emerge, how they function, and their consequences, among children and adolescents (Beltrán Garrayo et al., 2023; Cave, 2009; Chen et al., 2023; K. E. Darling et al., 2024; Gmeiner & Warschburger, 2020; Israel & Ivanova, 2002; Peretz-Lange & Kibbe, 2024; Rancaño et al., 2024; Sobal et al., 1995; Turnbull et al., 2000). Other studies focused on weight bias internalization, including how specific groups come to hold devaluing beliefs about themselves based on their size, what factors influence this internalization, how this internalized bias can lead to detrimental consequences, how to measure it, and how it can be best excised (Aimé et al., 2020; Argyrides et al., 2022; Bevan et al., 2023; Carels et al., 2024; Cunning et al., 2022; Damiano et al., 2015; Durso & Latner, 2008; Endo et al., 2022; Hilbert et al., 2014; Lucibello et al., 2021; Martin-Wagar et al., 2023; J. L. Mensinger & Meadows, 2017; Pearl et al., 2023; Ratcliffe & Ellison, 2015).

Several articles in this category drew explicitly on weight neutral, fat positive, or Health at Every Size®[11] frameworks, all of which reject the goal of obesity elimination at the individual level. Articles drawing on these frameworks were less likely to test an empirical hypothesis or utilize quantitative research methods; in general, they were interpretive, featuring reviews or analyses from humanistic social scientific traditions such as feminist studies, ethnic studies, disability studies, and/or fat studies. However, some articles in this genre did provide their own set of guidelines to improve the treatment of fat people in healthcare and other spaces, mirroring some of the anti-obesity guidelines found in the "enabling obesity elimination" category (Barry, 2019; Brownstone et al., 2023; Crawshaw, 2020; Dark, 2019; Fahs, 2020; Foos, 2024; Friedman, 2017; Jones & Pausé, 2023; Kinavey & Cool, 2019; Pausé, 2019; Pickett & Cunningham, 2017; Rauchwerk et al., 2020; Sorensen & Krings, 2023; Souza & Ebbeck, 2018; Tylka et al., 2014;

[11] Health at Every Size® is a health promotion movement that focuses on changing individual health behaviors rather than weight loss (Gibson, 2022).

Webb et al., 2022). Interestingly, despite fat positive articles using the same terms as the other articles in my corpus (weight stigma, anti-fat attitudes, etc.), these articles were far more likely to use these terms interchangeably, without definition, and/or without operationalization. In contrast to the "enabling obesity elimination" articles, which largely contained specific, narrow definitions for weight stigma based on attribution theory (discussed below), fat positive articles tended to use these terms expansively to capture a structural form of prejudice. They often treated weight stigma not merely as a matter of individual attitudes or beliefs, but as a broad form of injustice. Kinavey and Cool, for example, start their abstract with the statement "Anti-fat bias is a persistent and widespread barrier to body liberation that psychotherapists are ethically bound to do something about" and offer therapists "ten ways to shift your therapeutic lens," including "interrogat[ing] your intentional or unintentional promotion of diet culture" and "consider[ing] the link between emotional health and a fat-oppressive culture" (2019, p. 116). These constructions of weight-based oppression are broad, structural, and grounded in social justice conceptions of oppression – a far cry from the more common definition of bias as individual misattributions of obesity causality, as I will discuss in the next section.

Citation Rates

In addition to comprising nearly two-thirds of articles in my corpus, articles coded as enabling obesity elimination were also cited far more than articles coded as not enabling obesity elimination, further indicating the dominance of anti-obesity efforts in weight stigma research. Articles coded as enabling obesity elimination were on average **cited 37.8 times**, while articles coded as not enabling obesity elimination were on average **cited 23.5 times**. Similarly, the median number of times cited for an article coded as enabling obesity elimination was **10**, while the median number of times cited for an article coded as not enabling obesity elimination was **4**.

Using a Mann-Whitney U Test to compare the two groups of articles showed that the articles coded as enabling obesity elimination were cited significantly more frequently than articles coded as not enabling obesity elimination, $p < 0.001$. To depict the size of this difference in a more intuitive way, I used the median number of citations across the whole corpus (8) to divide the articles into two groups: articles cited 8 times or fewer, and articles cited more than 8 times. While **54%** of articles coded as enabling obesity elimination were cited more than 8 times, only **38%** of articles coded as not enabling obesity elimination were cited more than 8 times (Table 1).

Table 1: Differential Citation Rates Between Articles

	Enabling Obesity Elimination Articles	Not Enabling Obesity Elimination Articles
Cited 8 times or fewer	118/257 (46%)	89/143 (62%)
Cited more than 8 times	139/257 (54%)	54/143 (38%)

Where Weight Stigma Research is Published

Another indicator of the anti-obesity orientation of weight stigma research is where it is published. Different academic journals are intended to reach different audiences and advance specific goals, per the aims and scope of each journal. The journal *Obesity*, for example, describes itself as "the premier source of information for increasing knowledge, fostering translational research from basic to population science, and promoting better treatment for people with obesity" while *Fat Studies* publishes "scholarship that critically examines theory, research, practices, and programs related to body weight and appearance" (*Fat Studies Aims and Scope*, n.d.; *Overview - Obesity*, n.d.). In other words, although these journals publish material

on similar topics, their goals and audiences[12] differ. Quantifying the percentage of weight stigma research published in journals like *Obesity*, compared to the percentage published in journals like *Fat Studies*, serves as a proxy measure for how much weight stigma is intertwined with the anti-obesity assemblage. However, the mere proportion of publication in medical journals alone is not sufficient for this estimate, since journals like *Social Science and Medicine* publish both anti-obesity and critical research. As such, I will present the results of this publication analysis in multiple ways.

Almost half (1193/2502, **48%**) of all weight stigma research is published in medical journals. Additionally, similar to the disparity in citation quantity between articles that enable obesity elimination compared to articles that do not, articles published in medical journals were cited more than articles published in non-medical journals. Articles published in medical journals were cited an average of **40.3** times with a median of **11** citations, while those published in non-medical journals were cited only an average of **26** times with a median of **9** citations.

A more intuitive depiction of the anti-obesity orientation of weight stigma research can be seen in the titles of the journals in which weight stigma research is most frequently published. As shown in Figure 1, out of the top five journals that have published the largest number of articles on weight stigma, **four** (80%) have "obesity" in the title and the journal *Obesity* has published the largest number of articles on weight stigma (90). Of the top 20 journals, **eight** (40%) have "obesity" in the title and 11 (55%) are classified in the research area of Biomedicine and Life Sciences per Web of Science.

[12] *Obesity* describes its readership as "Endocrinologists, cardiologists, gastroenterologists, nutritionists, dietitians, paediatricians, obstetricians, rheumatologists, general practitioners, surgeons, bariatric surgeons, funding bodies and policy makers with interests in obesity."

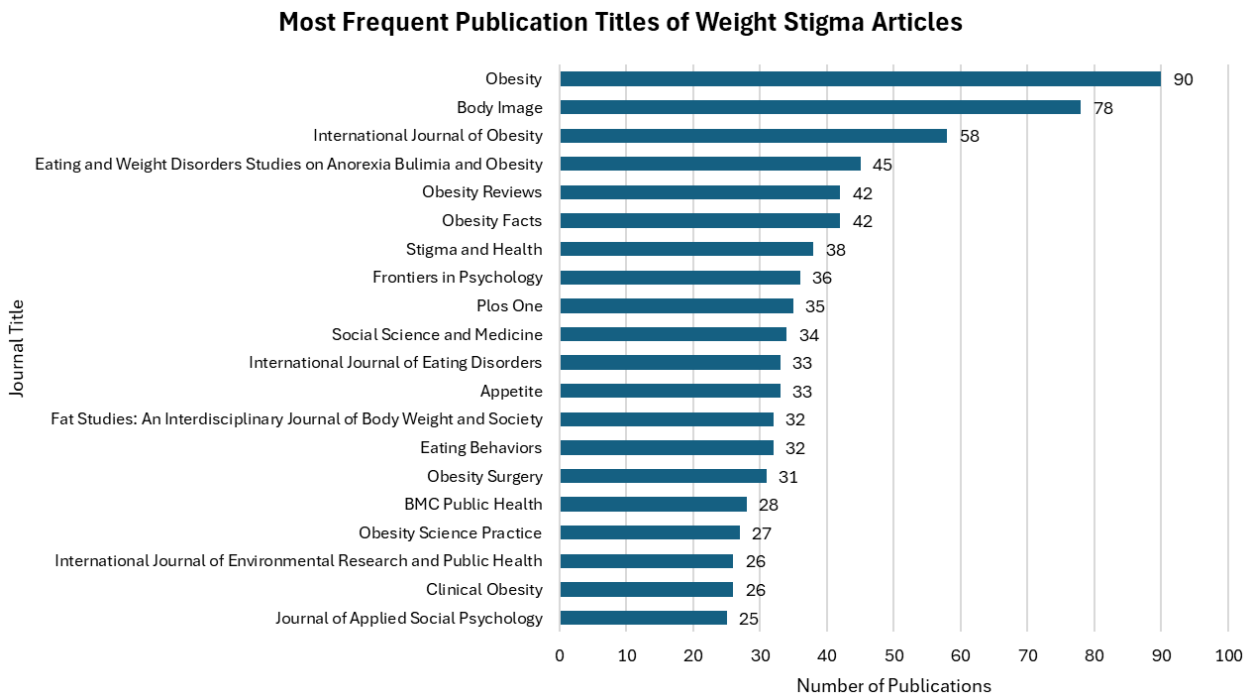

Figure 1: The 20 journals which have published the largest number of articles on weight stigma.

In total, my content analysis of academic research on weight stigma reveals that the majority of the scholarship in this field is deeply medicalized and contributes to the devaluation of fat people by supporting the goal of eliminating obesity. Almost two-thirds of this literature uses the threat of obesity to justify the study of weight stigma or connects the study of weight stigma directly to anti-obesity goals. Moreover, articles that contain anti-obesity claims and advance anti-obesity goals are cited significantly more than articles that do not, which indicates that anti-obesity conceptions of weight stigma are more influential and have a greater reach than conceptions of weight stigma that do not depend on or advance anti-obesity ends. Finally, this analysis revealed that nearly half of weight stigma research is published in medical journals, which also indicates how concern for weight stigma is intertwined with concern for treating and preventing obesity.

Weight stigma research's present entanglement with the anti-obesity assemblage yields another question: has it always been this way? Have weight stigma researchers always seen

fighting obesity and fighting weight stigma as compatible endeavors? And, if not, how did the field come to be this way? The following section provides an overview of the history of weight stigma research.

A Brief History of Weight Stigma Research

As mentioned in the introduction to this chapter, research dedicated to the mistreatment of fat people began in the 1960s. Even in this early decade, however, research into weight stigma was largely focused on anti-obesity ends. For instance, sociological and social psychological research – research that ostensibly did not need to focus on health, healthcare, or weight loss – frequently included anti-obesity claims. One example of this phenomenon is Cahnman's seminal article "The Stigma of Obesity," published in *The Sociological Quarterly* in 1968. While this article begins by calling the lack of consideration for obesity stigma in the sociological literature an "amazing" omission and contains an entire section debunking claims about the relationship between higher weight and poorer health, Cahnman ends the article with the claim that ameliorating the stigma of obesity will lead to weight loss:

> The stigma cannot be removed except by moral treatment whose primary objective is to consider the patient as a potentially normal human being who is as capable of the healthy exercise of all his faculties as anybody…If this outcome can be secured and if complementary conditions are favorable, weight reduction is likely to follow in due course, through metabolic processes or otherwise. (1968, pp. 298–299)

In this passage, Cahnman asserts that raising the self-confidence of a fat person generally leads to weight loss. He goes on to state that in cases where raising a fat person's self-confidence does not cause weight loss, "the answer is tolerance... [and] mutual respect for the common humanity of each and every one of us." In other words, weight loss is still portrayed as the baseline goal.

Another example of this phenomenon can be seen in the work of Natalie Allon, a sociologist and early member of the advisory board of the National Association to Aid Fat

Americans (NAAFA, now called the National Association to Advance Fat Acceptance) (Robinson, 2014, p. 113). Allon brought many of the tenets of fat activism to a hostile anti-obesity space when she presented "The Stigma of Overweight in Everyday Life" at the 1973 "Obesity in Perspective" meeting from the NIH's Fogarty International Series in Preventive Medicine (Allon, 1973; Sobal, 1984). Yet in a later report of interviews with fat adolescents, she asserted that her insights into weight stigma among this population should be "incorporated into treatment programs, focused on the goal of weight-losing" (Allon, 1979, p. 478). Clearly, taking sociological or social psychological approaches to the study of stigma did not preclude an anti-obesity orientation.

Moreover, sociological and psychological research made up only one half of the research into weight stigma.[13] The other half of this early research explored weight stigma as a specifically *medical* concern, focusing explicitly on stigma as a barrier to weight loss counseling among health professionals and, by extension, as a barrier to weight loss efforts among fat people. In an article also titled "The Stigma of Obesity," professor of nursing Beatrice J. Kalisch wrote that physicians largely believed that "obesity was either incurable or only slightly amenable to help," such that "one cannot help but wonder if the reported low success rate in the treatment of these individuals is related to the expectations of failure by physicians, nurses, and other helpers" (1972, p. 1126). Similarly, in a 1969 report of the medical management of fat patients in an outpatient clinic, Maddox and Liederman reported that the "disvalue of fatness" and physicians' "experience of failure in weight management" provided a "poor context for learning how to manage the overweight patient when such management is indicated" (1969, p. 220). These quotes demonstrate how concern for weight stigma emerged from a primary concern

[13] Of the 48 articles on weight stigma published prior to 2000, 52% (25/48) were published in medical and clinical journals.

for anti-obesity efforts, meaning that for these researchers, the goals of fighting weight stigma and fighting obesity were never separate.

In the 1980s, much of weight stigma research began to consolidate around a novel social psychological theory of the role of *causal attributions* on individual attitudes (Weiner et al., 1988). The idea that fat people were stigmatized because many people viewed fatness as the outcome of condemnable behaviors (e.g., gluttony, laziness) had been present in the weight stigma literature from its origins. But the commonsense wisdom that stigma is related to holding someone personally responsible for their misfortunes was legitimated through this new "attribution theory." Though attribution theory encompasses a broader set of ideas, its application to stigma focused on beliefs about the controllability of a way of being; according to this approach, a way of being seen as caused by something controllable was viewed more negatively than one seen as caused by something uncontrollable. Attribution theory helped to solidify the anti-obesity orientation of weight stigma research by framing increased knowledge about obesity as a way to reduce stigma. For example, in 1980, DeJong published an intervention showing that high school girls rated a hypothetical obese classmate slightly more favorably when her weight was attributed to an uncontrollable thyroid condition than when her weight was unexplained. This led DeJong to conclude that the "derogation of the obese results from the presumption that such persons are responsible for their physical deviance," and, by extension, that this derogation could be mitigated by communicating that "obesity is a complicated disorder… the naive theory that overeating and lack of exercise are the sole causes of obesity must be replaced by one that recognizes its complex etiology" (1980, p. 85). While much of weight stigma research was already intertwined with anti-obesity efforts, the adoption of attribution theory intensified this orientation and largely homogenized the field. The consolidation of weight stigma research

around attribution theory has helped to naturalize the idea that fighting obesity and fighting weight stigma are compatible endeavors.

The dominance of attribution theory – and the anti-obesity orientation of weight stigma research – was further solidified in the 1990s with the development of formal measures to assess weight stigma in individuals. Allison et al.'s 1991 pair of scales, the Attitudes Toward Obese Persons (ATOP) Scale and the Beliefs About Obese Persons (BAOP) Scale were based on the idea that "attitudes toward obese persons are influenced by the extent to which the obesity is perceived as controllable by the individual" (1991, p. 601). The BAOP exclusively measures "the extent that one believes obesity is under the control of the obese person," with beliefs that obesity is uncontrollable indicating lower levels of stigma (1991, p. 602). Allison et al. assert that "people have more positive attitudes toward obese persons when they believe that obesity is largely beyond the obese persons control," and, much like DeJong, recommend education to ameliorate negative attitudes:

> Educating people to the difficulties in controlling body weight might improve attitudes toward obese persons. Similarly, cognitive modification might be used to increase self-acceptance and instill positive self-concepts in obese persons. The focus would be on altering the obese person's beliefs about the causes of their obesity, and viewing ideas of personal responsibility for body size as maladaptive beliefs. (1991, p. 606)

The ATOP and BAOP are still frequently used today and have been translated into numerous other languages (de Souza et al., 2024; Dedeli et al., 2014; Kim et al., 2010; Pipová et al., 2024; Styk et al., 2022; Wang et al., 2016; Zagaria et al., 2022).

By the late 1990s, weight stigma research had successfully documented the presence of stigma in many realms of life including education (Canning & Mayer, 1966; Crandall, 1991; Klesges et al., 1992; Latner & Stunkard, 2001, 2003), employment (Klesges et al., 1990; Larkin & Pines, 1979; Pingitore et al., 1994; Rothblum, 1992; Rothblum et al., 1988), romantic

relationships (C. T. Miller et al., 1995; Sobal et al., 1995), familial relationships (Crandall, 1995), and healthcare (Blumberg & Mellis, 1985; Kaplan, 1982; Maiman et al., 1979; Maroney & Golub, 1992; Packer, 1990; J. H. Price et al., 1987; Wiese et al., 1992). Moreover, thanks to second wave feminist concerns about the impact of media that idealizes thinness on rates of eating disorders and bodily dissatisfaction among women (e.g., Bordo, 1993; Chernin, 1994; Orbach, 1978; Wolf, 1991), weight stigma research had also documented the disproportionate impact of anti-fat bias on women and girls (Monello & Mayer, 1963; Schoenfielder & Wieser, 1983; O. W. Wooley et al., 1979; S. C. Wooley & Wooley, 1979). However, even the influence of feminist concern for body image and eating disorder rates among women did not diminish the anti-obesity orientation of weight stigma research. In fact, beginning in the late 1990s, recourse to weight stigma (and the idea that stigma is constituted by a belief in the controllability of body weight) became a useful strategy in the "War on Obesity." For example, Boero argues that the American Obesity Association,[14] a non-profit dedicated to increasing obesity treatment, "set itself apart from the public health establishment" by arguing that "the public health mainstream reinforce[d] negative stereotypes about fat people by approaching obesity as primarily a consequence of poor lifestyle choices" (Boero, 2012, pp. 31–32). The American Obesity Association used the concept of weight stigma to lobby for federal funding for obesity research and Medicare and Medicaid coverage of weight loss surgeries.

Nowhere is the intertwining of weight stigma research and the anti-obesity assemblage more clear than in the 2005 founding of the Rudd Center for Food Policy and Obesity at Yale

[14] The American Obesity Association and the North American Association for the Study of Obesity (NAASO) merged in 2007 to become the Obesity Society (Boero, 2012, p. 148). The NAASO established a "Weight Discrimination Task Force" in 2003.

University. [15] The center was the result of a collaboration between Leslie Rudd (a wealthy California food and wine entrepreneur) and Kelly Brownell, then a professor of psychology and epidemiology at Yale. Rudd's motivation for the center, as a publication from the time described it, was that Rudd "struggled with his weight, and with the resulting stigma, for much of his life" and therefore wanted the Center to "represent a fresh start in the fight against obesity and against the discrimination faced by overweight and obese individuals" (Medicine@Yale, 2006). Brownell, meanwhile, was an outspoken critic of the US food industry and its obesogenic effects. The success of his 2003 book *Food Fight: The Inside Story of The Food Industry, America's Obesity Crisis, and What We Can Do About It* and his frequent media appearances turned him into a notable public intellectual in the early 2000s, leading *Time Magazine* to name him one of "The World's 100 Most Influential People" in 2006 (Huckabee, 2006; Weaver, 1995). His message lined up with other anti-obesity weight stigma rhetoric at the time: both Brownell and the media considered his argument about an obesogenic food environment "destigmatizing" because it reduced individual culpability for higher body weight. Simultaneously, the threat of rising obesity rates provided the urgency and justification for his work and the founding of the Center. Brownell's goal of policy reform – taxing "junk" food – aligned with Rudd's goal of jointly fighting obesity and weight stigma by targeting a structural source of higher body weight. Alongside two other researchers at the intersection of fighting obesity and fighting stigma, Rebecca Puhl[16] and Marlene Schwartz,[17] Rudd and Brownell successfully used the impetus of the "obesity epidemic" to jumpstart a fundamentally anti-obesity research program into weight stigma.

[15] In 2015, the Rudd Center moved from Yale University to the University of Connecticut (Schwarz, 2014). In 2021, the center changed its name to the Rudd Center for Food Policy and Health.
[16] Per her bio in the book, Puhl was a clinician at the Johns Hopkins Weight Management Center.
[17] Per her bio in the book, Schwartz was Co-chair of the NAASO's Weight Bias Task Force.

As the Rudd Center was founded, its researchers quickly made their anti-obesity/anti-stigma position clear in a number of prominent publications. In 2005, coinciding with the opening of the Center, Rudd, Brownell, Puhl, and Schwartz published the edited volume *Weight Bias: Nature, Consequences, and Remedies*. Their introduction to the text plainly stated their view about not only the compatibility of fighting obesity and reducing stigma, but the necessity of doing so. In the section "Separating the Person from the Condition," they argue:

> One can accept obesity as an undesirable and dangerous condition without despising the person with it. Having empathy for the obese person is not inconsistent with fighting obesity as a condition. This is an important conceptual point that must be made time and again if social progress is to be made. Questions of personal responsibility are central in this context and are key to framing the obesity issue in a constructive way. (2005, p. 6)

In this quote, the Rudd Center researchers advance the idea that one must *both* "fight obesity" and "have empathy for the obese person" in order to make social progress. The only caveat they provide in the fight against obesity is that one must attend to "questions of personal responsibility" in order to remain "constructive" in these efforts. This framing demonstrates the total naturalization of fighting obesity and fighting stigma as compatible endeavors. To this day, the Rudd Center remains, as Saguy noted, one of the most visible examples of how weight stigma research is intertwined with the anti-obesity assemblage.

As the only academic research center even partially dedicated to the study of weight-based discrimination, the Rudd Center's anti-obesity approach has dominated weight stigma research since the early 2000s. Researchers from the Rudd Center have authored or co-authored half of the top-cited articles on weight stigma, including the most cited article in the field (Figure 2). Rebecca Puhl alone has authored or co-authored more than twice as many articles related to weight stigma as any other researcher in the field. Her articles make up five percent of all research published on this topic (Figure 3). With the resources of the Center, Puhl and colleagues

have published in dozens of academic venues and participated in hundreds of media appearances, growing the network of people and organizations connected to their particular version of fighting obesity/weight stigma.

In many ways, the research and discourses emerging from the Rudd Center function as an obligatory passage point (Callon, 1984) for scholars, journalists, and policy-makers looking to produce work about weight-based discrimination, spreading the entanglement of weight stigma and the anti-obesity assemblage. Puhl and her interlocutors are some of the only researchers with the resources and network to produce large-scale, quantitative research about rates of weight-based discrimination across the globe. Puhl has a long-standing collaboration with WW International (formerly Weight Watchers), providing her access to a larger and more diverse population of research subjects than any other stigma researcher (Puhl et al., 2021). As a result, anyone looking to make claims about the prevalence and consequences of weight stigma, especially outside the US, must cite research from the Rudd Center, which then increases the reach and legitimacy of the Center. Journalists and policy-makers beholden to the professional standard of seeking out experts for commentary in their work also consult the Rudd Center's researchers and media resources, thus also increasing its status. All of these citations amplify the Rudd Center's particular construction of weight stigma and related anti-obesity goals, naturalizing the connection between fighting stigma and fighting obesity.

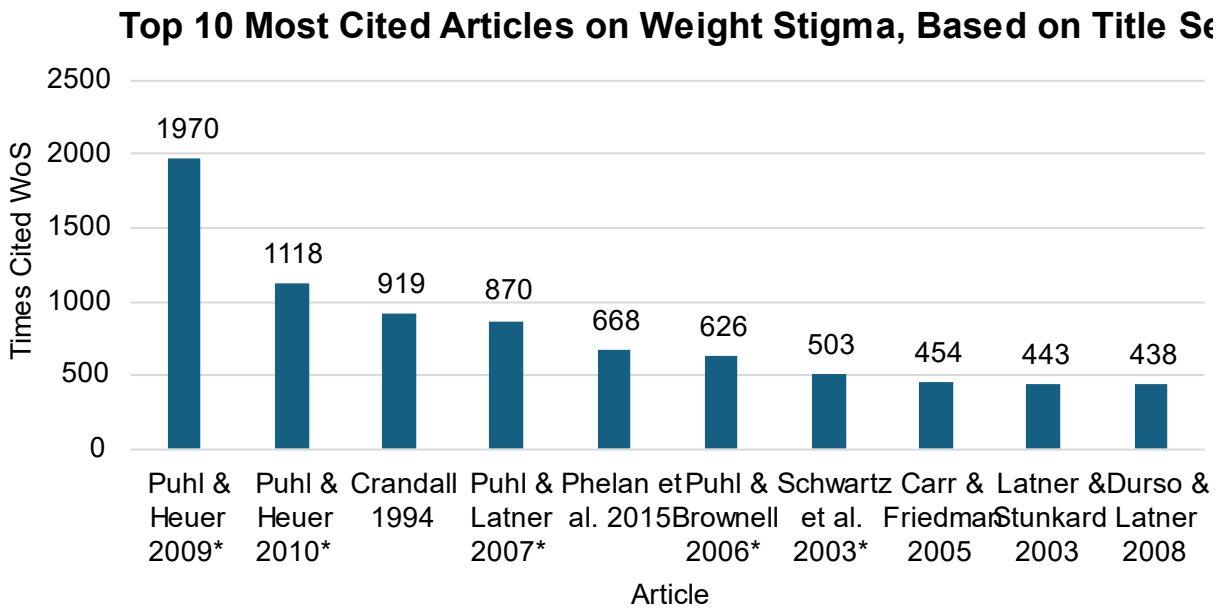

Figure 2: The top 10 most cited articles in weight stigma research, based on a search of titles related to weight stigma, as of 2024.
* indicates authors affiliated with the Rudd Center

In sum, examining the history of research into weight stigma reveals a consistent anti-obesity focus. The prevalence of attribution theory in weight stigma research has framed an entanglement with the anti-obesity assemblage as both necessary and beneficial for addressing stigma. The large amount of research focused on healthcare, as well as the significant proportion of research authored by practicing health professionals, has constructed weight stigma as a distinctly *medical* concern, even amongst researchers who framed fat people as a group deserving of civil rights (Flanagan, 1996). The idea that fighting weight stigma necessarily entails fighting obesity was solidified in the mid-2000s as explicitly anti-obesity researchers from the Rudd Center provided a new source of scholarship that met the epistemic standards of high-status STEM fields, i.e., research containing large-scale quantitative samples or randomized control trials. Citing studies from the Rudd Center has become virtually unavoidable in scholarship on weight stigma, leading to the dominance of an attribution-based model of stigma

in which fighting obesity and fighting stigma are not only compatible, but necessarily intertwined projects.

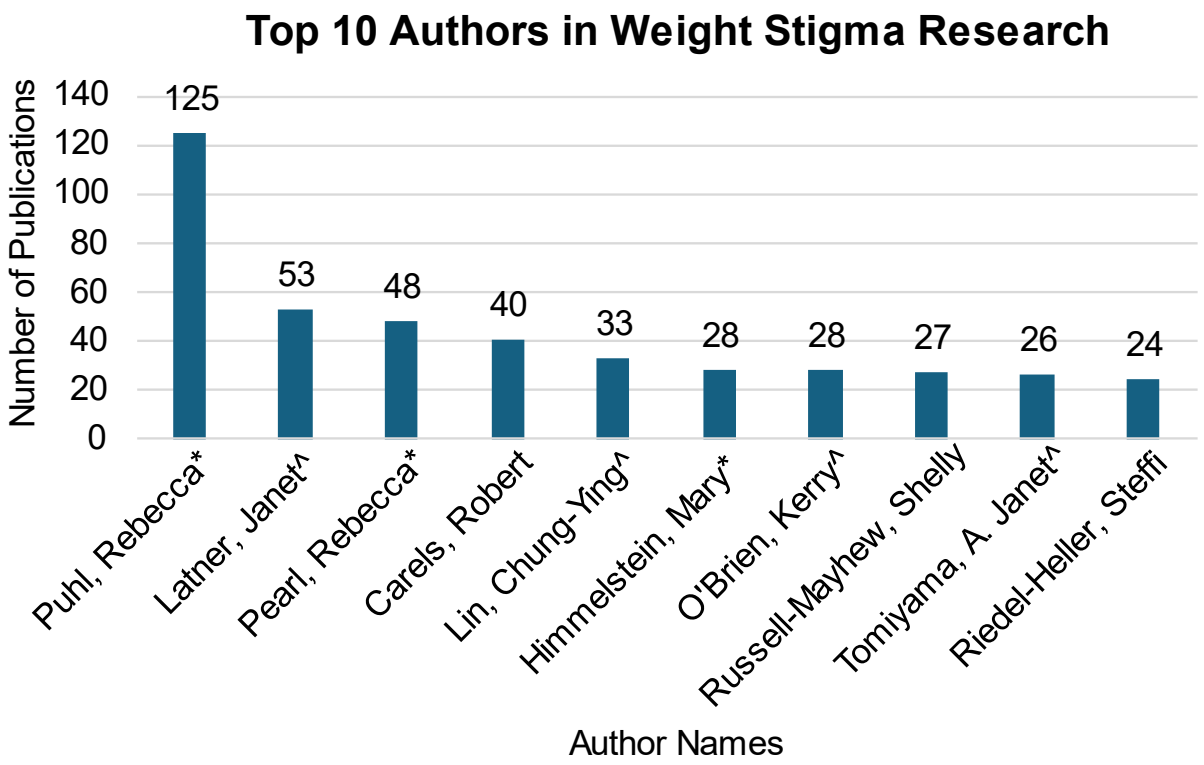

Figure 3: The top 10 most prolific researchers in the field of weight stigma research as of 2024.
* indicates researchers affiliated with the Rudd Center
^ indicates researchers who have co-authored at least one publication with a member of the Rudd Center

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How Weight Stigma Research Enables Obesity Elimination: A Qualitative Analysis

Thus far I have shown that weight stigma research is entangled with the anti-obesity assemblage and has been since its origins. In this section, I use discourse analysis to provide analyze the ways in which weight stigma research enables obesity elimination. I also show how weight stigma research's involvement in the anti-obesity assemblage directs attention away from examining weight stigma in ways that are not predicated on obesity elimination. Specifically, I show that the field's investment in obesity elimination has limited weight stigma research's ability to examine the *social* sources of weight stigma, which has meaningfully constrained efforts to combat them.

Producing Obesity Knowledge in Weight Stigma Research

As I explained above, one way weight stigma research enables obesity elimination is by producing knowledge about obesity. Producing knowledge about obesity primarily enables obesity elimination by honing the means through which obesity elimination is enacted: making obesity elimination more targeted, more efficient, and more effective. Weight stigma research produces knowledge about obesity by focusing on populations seeking or engaging in weight loss as well as through a focus on behaviors associated with weight control, such as eating and

exercise. Specifically, much of this research focuses on how weight stigma acts as a barrier to appropriate anti-obesity interventions and behaviors.

A significant amount of weight stigma research focuses on bariatric surgery patients. I found dozens of articles on this topic even after I excluded research that focused exclusively on the stigma of the surgery itself. Research on these patients often documents how weight stigma prevents them from accessing surgery or interferes with their ability to maintain weight loss post-intervention. Scarano Pereira et al., for instance, begin their abstract for an article on social media representations of bariatric surgery with the sentences: "Bariatric Surgery (BS) represents a viable option for the treatment of obesity and its risks. Nevertheless, it is still being underused by the eligible patient population because of the general lack of information, false beliefs, and the stigmatization of obesity" (2022, p. 158). Other research on bariatric patients studied stigma as a barrier to post-operative exercise (Feig et al., 2022), stigma as a barrier to health providers referring patients to surgery (Holmes et al., 2022), and stigma as a risk factor for weight regain post-operation (Himmelstein et al., 2022).

Similarly, a significant portion of weight stigma research focuses on eating and exercise behaviors among fat people. Research in this vein usually investigates questions about stigma's role in dysregulated eating (restriction and/or bingeing) and "suboptimal" exercise, both of which serve as a proxy for weight loss or body weight. For example, Thedinga et al. (2021) study weight stigma as a driver of "self-exclusion from sport and exercise settings" among fat people. Auster-Gussman et al. (2021) examine "social physique anxiety" as a mediator between "body mass index" and exercise frequency, while Robertson and Vohora (2008) and Chambliss et al. (2004) study bias among exercise professionals and students as potential barriers to fat people's engagement in physical activity. A similar trend is present in studies of eating, such as Palmeira

et al.'s "Exploring the Efficacy of an Acceptance, Mindfulness & Compassionate-Based Group Intervention for Women Struggling with Their Weight (Kg-Free)." They reported the results of a "group intervention (Kg-Free) for women with overweight or obesity based on mindfulness, ACT and compassion approaches [that] aimed to reduce weight self-stigma and unhealthy eating patterns and increase quality-of-life" (2017).

Numerous studies in this vein explicitly condemn weight stigma because of its role in the cycle of weight gain via stress response. In 2014, Tomiyama published the highly cited "Weight stigma is Stressful: A Review of Evidence for the Cyclic Obesity/Weight-Based Stigma Model," which characterizes a "positive feedback loop wherein weight stigma begets weight gain through increased eating and other biobehavioral mechanisms" (2014, p. 8). Since that publication, Tomiyama has authored or coauthored nine additional articles on this topic, including:

- Putting on Weight Stigma: A Randomized Study of the Effects of Wearing a Fat Suit on Eating, Well-Being, and Cortisol (2016)
- How and Why Weight Stigma Drives the Obesity 'Epidemic' and Harms Health (2018)
- Weight Stigma and Health Behaviors: Evidence from the Eating in America Study (2021)

Tomiyama and her colleagues have advocated for weight-neutral healthcare and public health policies based on these studies, but because the goal of their work is to prevent weight gain and obesity, their work enables obesity elimination. Regardless of intention, research focused on the causes of obesity, including weight stigma as a cause of obesity, creates new targets for anti-obesity efforts. Additionally, research on barriers to weight loss, including weight stigma as one such barrier, guides future anti-obesity efforts. Thus, this research is part of the anti-obesity assemblage.

Calling for More Anti-Obesity Efforts Using Attribution Theory

Weight stigma research also enables obesity elimination by explicitly calling for more resources to be directed to anti-obesity efforts. Such statements enable obesity elimination because they directly help to increase the resources that are connected to the anti-obesity assemblage. The most common way that weight stigma researchers call for more anti-obesity resources is by following the logic of attribution theory: if more knowledge about the uncontrollable causes of obesity reduces stigma, then more resources should be put towards obesity education. This idea can be seen in almost every study that measures stigmatizing attitudes and beliefs within a particular population, but is also found more generally throughout weight stigma research (e.g., Allison et al., 1991; R. Darling & Atav, 2019; DeJong, 1980; A. J. Khan et al., 2023; S. S. Khan et al., 2018; Orjuela-Grimm et al., 2021; N. Thompson et al., 2021; TOS Obesity as a Disease Writing Group et al., 2008).

The call to devote more resources to anti-obesity education has continued even in the face of such education failing to reduce stigma. For instance, Harris's 1983 survey of 222 Australian undergraduates revealed that students with more knowledge about obesity did not demonstrate lower prejudice towards fat people. Despite these findings, she wrote in her discussion that education on obesity should continue as an anti-stigma strategy: "It is the author's hope, admittedly only weakly supported by evidence, that information about the complex physiological and psychological determinants and effects of obesity will lead to less negative views of the obese" (1983, p. 281). More recent reviews of weight stigma interventions confirm what Harris found 40 years ago, yet *still continue* to advocate for attribution theory. Alberga et al.'s 2016 review of interventions performed with health professionals found that "manipulating beliefs/attributions about the causes and controllability of obesity is not sufficient to reduce the

implicit attitudes that could be robust and durable among health professionals." Yet in the conclusion of this article, the authors recommend "rais[ing] skills and competencies in health professionals regarding weight, obesity and weight bias" (2016, p. 186). These articles demonstrate that weight stigma researchers not only enable obesity elimination through their calls for more anti-obesity education, but have prioritized this goal despite evidence that it does not mitigate stigma.

The most extreme example of weight stigma researchers explicitly calling for increased resources for anti-obesity efforts is the 2020 "Joint International Consensus Statement for Ending Stigma of Obesity" (Rubino et al., 2020). This statement contained recommendations such as "obesity should be recognized and treated as a chronic disease in healthcare and policy sectors" and "academic institutions, professional bodies, and regulatory agencies must ensure that formal teaching on the causes, mechanisms, and treatments of obesity are incorporated into standard curricula for medical trainees, and other HCPs." The statement was endorsed by 58 additional organizations, 15 scientific journals, 15 academic institutions, and one parliamentary group: an enormous number of people and institutions made a commitment to increasing anti-obesity efforts in the name of addressing weight stigma.

Portraying Fatness as a Threat by Erasing the Social Origins of Weight Stigma

Many articles in my corpus enabled obesity elimination by portraying weight stigma as a consequence of obesity itself. Portraying weight stigma as an effect or consequence of obesity enables obesity elimination by increasing the salience of obesity as a threat – a condition that immiserates those unfortunate enough to afflicted with it. Portraying weight stigma as a consequence of obesity transforms weight stigma into another reason that obesity is a problem to be eliminated and increases the motivation to address *obesity*. Thus, in addition to enabling

obesity elimination, this framing of stigma also directs attention *away from stigma as a problem in its own right* and *erases its origins beyond the fat body itself*.

Many of the articles that portray stigma as a consequence of obesity are written by or for health professionals. They are also often published in medical journals and are more likely to be highly cited as a result. For example, the fifth-most highly cited article in my corpus, Bray's "Medical Consequences of Obesity," presents the relationship between stigma and obesity as follows:

> Obesity is an epidemic disease that threatens to inundate health care resources by increasing the incidence of diabetes, heart disease, hypertension, and cancer. These effects of obesity result from two factors: the increased mass of adipose tissue and the increased secretion of pathogenetic products from enlarged fat cells. This concept of the pathogenesis of obesity as a disease allows an easy division of disadvantages of obesity into those produced by the mass of fat and those produced by the metabolic effects of fat cells. In the former category are *the social disabilities resulting from the stigma associated with obesity*, sleep apnea that results in part from increased parapharyngeal fat deposits, and osteoarthritis resulting from the wear and tear on joints from carrying an increased mass of fat. (2004, p. 2583, emphasis added)

In this quote, the "stigma associated with obesity" is presented as a *disadvantage of obesity itself*, specifically of visible fat mass. Stigma is equated with sleep apnea and osteoarthritis, rendering it a *comorbidity* that belongs to obesity itself rather than a social system that devalues fat people. Similar framings can be seen in the following quotes:

- "The most widespread consequences of childhood obesity are psychosocial" (Dietz, 1998, p. 518).
- "Obesity is regarded as a modern lifestyle problem, causing illness, stigma, discrimination, and psychological problems" (Groven & Heggen, 2018, p. 346)
- "Weight stigma and internalized bias are both drivers and complications of ABCD [adiposity-based chronic disease, a new term for obesity] and can impair quality of life,

predispose to psychological disorders, and compromise the effectiveness of therapeutic interventions" (Nadolsky et al., 2023, p. 417).

In each of these sentiments, obesity is framed as the cause of stigma. The question of *why* fatness is associated with stigma is obscured through the focus on obesity as a problem, leading to justification for addressing obesity rather than investigating stigma.

Conclusion

This chapter has demonstrated the many ways in which weight stigma research is intertwined with the anti-obesity assemblage. Using content analysis as well as historical and thematic investigations, I have provided evidence that the majority of weight stigma research enables obesity elimination in some capacity. As a result, this literature contributes to anti-fatness not only through the anti-obesity assemblage but through treating fat people's oppression as a concern secondary to that of obesity itself. There are very few realms of research (or perhaps only one) in which fat people might reasonably expect their mistreatment to be prioritized over efforts to produce a world without them. Weight stigma research should be one of the only places where obesity elimination efforts are not a priority. My analysis shows that this is not the case. Weight stigma research is overwhelmingly dominated with the same concerns as medical and public health actors: producing a world without fat people.

My analysis of academic articles that make claims about weight stigma in the title or abstract revealed that nearly two-thirds of these articles advance the goal of eliminating obesity. Almost half of this research is published in medical journals, which signals that weight stigma is viewed as relevant because of its relationship to obesity, rather than as a concern in its own right. Research that advances the goal of eliminating obesity is much more highly cited than research

that does not, indicating that anti-obesity messages are more influential and have a wider reach than claims about stigma that do not advocate for obesity elimination.

My examination of the history of this research revealed that support for this goal has been present in weight stigma research since its beginning. Many early articles identified stigma as a barrier to weight loss; roughly half of these articles were published in medical journals and 40% were authored by health professionals. Moreover, the most influential weight stigma research and policy center of the 21st century, the Rudd Center, was founded with the explicit goal of eliminating obesity and has produced hundreds of articles and other media oriented toward this end over the past two decades. The Rudd Center has become an obligatory passage point for weight stigma research and policy, such that even actors who do not support their agenda must rely on their publications for certain prevalence claims.

My thematic analysis of weight stigma research uncovered how the topics and theories that receive the most attention in weight stigma research also advance anti-obesity efforts. Much of this research enables obesity elimination by producing new knowledge about weight stigma as a cause of, and barrier to the elimination of, obesity. Researchers draw on attribution theory to call for additional resources to be devoted to anti-obesity efforts in the form of increased education about the "uncontrollable causes" of the "disease" of obesity, which they claim will reduce stigma. I also found that much of weight stigma research treats weight stigma as a property of obesity, erasing its social origins through discursive presentations of stigma as comorbid with obesity. This presentation intensifies the idea that obesity itself is a threat and directs attention towards fighting obesity rather than inquiry into the sociocultural causes of weight stigma or interventions to reduce stigma itself.

A comprehensive look at the field of weight stigma reveals that it is deeply entangled with the anti-obesity assemblage. This entanglement is longstanding and can be seen in the claims that weight stigma researchers make, where they publish, what topics they prioritize, and what audiences they speak to. Weight stigma research should be the one area of research where the marginalization of fat people takes center stage. Instead, that stage is mostly taken up by efforts to eliminate obesity. The project of making a world with fewer fat people is so important to weight stigma researchers that even studying the marginalization of fat people is often justified by the need to fight obesity, rather than the suffering or harmful effects of that marginalization itself. Even when they talk about the harmful effects of weight stigma, they point to *weight gain* – that is, the *production of more fat people* – as one of the worst outcomes of stigmatization. This is a profoundly stigmatizing message.

Weight stigma research intensifies anti-fatness by enabling obesity elimination instead of contesting, or even thoroughly investigating, the oppression of fat people. The next two chapters demonstrate how this process works in practice and with what consequences. Chapter 3 examines how the theories and priorities of weight stigma research are translated into interventions for health professionals, presenting them with stigmatizing claims and instructions for enacting obesity elimination under the auspices of stigma reduction. There, I highlight the stigmatizing consequences of the entanglement between weight stigma research and the anti-obesity assemblage. Chapter 4 lays out the "regime of signification" formed by many of the ideas discussed in this chapter and highlights the messages communicated when these different assumptions are taken together as a whole. I show how attribution theory has been adopted by pharmaceutical company Novo Nordisk to sell its new weight loss drugs: weight loss

medications are presented as *destigmatizing* because they prove that obesity is a "real" (i.e., uncontrollable) disease.

Chapter 3
Enacting Weight Stigma in Interventions with Health Professionals

Healthcare is a potent site of fat oppression, and health professionals are one of the most common sources of weight stigma in fat people's lives (Puhl et al., 2021). Most fat people will experience weight stigma in a clinical encounter at some point in their lives (Puhl & Brownell, 2006). And as size increases, so does the likelihood that a fat person will be stigmatized when attempting to seek healthcare (Andreyeva et al., 2008). This stigmatization occurs through a number of mechanisms. In a process called diagnostic overshadowing, fat people's primary ailments are often dismissed by health professionals in favor of focusing on their weight; this phenomenon has also been called #diagnosisfat in reference to fat people seeking healthcare for a specific complaint and instead being told that the problem is their weight and that weight loss will fix their problem (Kinzel, 2014; Paine, 2021).[18] Fat people are also denied access to some procedures such as joint replacement and gender affirming surgery on the basis of their size (Brownstone et al., 2021; Chrisler & Barney, 2017). Healthcare spaces often do not contain the appropriate equipment, furniture, or clothing to accommodate fat people (Brown & Ellis-Ordway, 2021; Levan, 2014; Owen, 2012). Moreover, health professionals may engage in explicit, direct ridicule or shaming of patients (Kerbyson & Clark, 2024; Wear et al., 2006).

Given the magnitude of anti-fat harm perpetuated by health professionals, weight stigma researchers have devoted significant attention and resources to reducing stigmatizing attitudes and beliefs against fat people within this population. However, weight stigma interventions with health professionals have been largely ineffective at reducing weight stigma, even per the flawed

[18] This problem is exacerbated in the "weight-first treatment paradigm," which posits that obesity cause of many other ailments and therefore should be treated before attempting to treat other conditions such as hypertension or type 2 diabetes. This approach to treatment has received renewed attention and support since the rise of the GLP-1 agonists (Kyle, 2024).

scales frequently employed by the field (Alberga et al., 2016; Jayawickrama et al., 2024; Moore et al., 2022; Talumaa et al., 2022). From their analysis of the most common form of intervention, educating health professionals on the complex causes of obesity, Talumaa et al. found that "increased general education and a deeper understanding of obesity alone is likely to be insufficient for reducing weight stigma and in contrast, bias may actually increase as a result" (2022, p. 4). Similarly, Alberga et al. assert that "while attributions are important, as is sharing information about the uncontrollability of obesity, these approaches are, in and of themselves, insufficient to change weight bias" (2016, p. 185). Thus, despite a consensus that health professionals are an important group to intervene with, intervention researchers have yet to find a strategy that reliably produces substantial reductions in stigma.

Several weight stigma researchers have speculated that the inefficacy of weight stigma interventions may be connected to broader, societal devaluation of fatness, although most have only gestured at this link rather than making the connection explicitly. Talumaa et al. hypothesize that lack of results from education-based interventions "may be due to the enforcement of and further socialization to weight stigma norms that are commonly expressed in health-related education and working environments" (2022, p. 4). They suggest that interventions must include "discussions of the harm caused by social and cultural norms and messages concerning body weight" in addition to information on obesity causality (2022, p. 4). Alberga et al. likewise speculate that truly reducing weight stigma "requires a change in social norms and the underlying dominant ideologies about weight," although they do not provide additional information on what such norms or ideologies might be (2016, p. 185). Only Schmidt and Brochu provide a more concrete explanation for the limited efficacy of these interventions, asserting, "Many of the interventions framed fatness as problem that is devastating to both fat

people and health care systems…This likely limited the effectiveness of the interventions" (2021, p. 155). However, even this elaboration does not provide a theoretical framework for explaining how portraying fatness as a devastating problem to healthcare systems undermines stigma reduction efforts.

In this chapter, I argue that weight stigma interventions with health professionals do not – and cannot – reduce weight stigma because they are intertwined with the anti-obesity assemblage. Specifically, I perform a praxiographic analysis of multiple weight stigma interventions to explore what participations actually *do, see, and learn* in such interventions. My praxiography reveals two ways that the intertwining of stigma interventions with the anti-obesity assemblage undermines stigma reduction efforts. First, I find that health professionals are exposed to extremely negative messages about fat people in such interventions and that these interventions do not contain any positive or destigmatizing portrayals of fat people. I argue that researchers exercise *afflictive power* in these interventions by portraying fatness as a source of harm and suffering. The exercise of afflictive power devalues fat people and encourages health professionals to see them as miserable, abject patients in need of intervention. Second, I find that most weight stigma interventions are more focused on *training intervention participants to enact obesity elimination* than on reducing stigma. In fact, some interventions treat an increased intention among participants to enact obesity elimination with their patients as evidence of a successful intervention. The focus on obesity elimination in these interventions undermines stigma reduction efforts both through the content presented as well as the deprioritization and/or absence of destigmatizing messages.

This chapter begins with a review of the two Foucauldian conceptions of the power of medicine and public health: disciplinary power and biopower. I argue that there is a gap between

these two concepts; both forms of power rely on the prior devaluation of a way of being. After outlining this gap, I propose a new concept that helps to fill the space between biopower and disciplinary power: *afflictive power*, the capacity to define a way of being as a threat and source of suffering. After reviewing my methodology for the chapter, I show how weight stigma interventions exercise *afflictive power* over their participants, training them to devalue fat people through afflictive associations between fatness and suffering. I also reveal the significant presence of anti-obesity training in weight stigma interventions with health professionals. I end the chapter with the argument that exercising afflictive power is *stigmatizing*, thereby making afflictive education and stigma reduction incompatible. Instead, I show that weight stigma interventions operate as part of the anti-obesity assemblage, increasing health professionals' skills and motivation to enact obesity elimination.

Theoretical Background: Power and the Anti-Obesity Assemblage

As discussed previously, fat studies scholarship on medicine and public health has focused on one of two critiques. On the one hand, fat studies scholars often criticize the extent to which medicine and public health blame individuals for being fat or ultimately put the responsibility on individuals for weight loss. On the other hand, fat studies scholars have frequently investigated the social construction of obesity and the obesity epidemic, generally arguing that the portrayal of fatness as a medical problem is false or biased. Both critiques fail to explain how obesity elimination efforts uphold and intensify anti-fatness *per se* – in these arguments, the war on obesity is stigmatizing because it blames individuals or because it is based on false premises.

These critiques also align with existing Foucauldian concepts of disciplinary power and biopower. Foucault defined disciplinary power as the power to shape individual capacities in

relation to a norm (Foucault, 1995, 2009, p. 58; Lawlor & Nale, 2014, p. 111). Medicine is one of many institutions that exercise disciplinary power. In the context of fatness, doctors exercise disciplinary power when they encourage patients to make lifestyle changes in order to lose weight, or when they remove parts of a patient's digestive system surgically to shape their eating habits. Foucault defined biopower as the power to regulate and manage the biological capacities of a population (to "make live or let die"), typically in order to maximize its productivity (Foucault, 1990, Chapter 5; Stryker, 2014). In the context of fatness, biopower is exercised through population-level interventions usually guided by public health experts, such as public health ad campaigns advocating lifestyle change for weight loss, or a tax on sugary beverages meant to reduce calorie consumption (Wright & Harwood, 2009). These concepts draw attention to the power inherent in efforts to change bodies, both at the individual level and the collective level. They both align with a focus on blame and responsibility, leading scholars to ask questions about topics such as the negative effects of disciplining individuals, or the kinds of population-level solutions that are seen as appropriate. Other scholars contest medical power over fatness by attempting to debunk medical and public health claims.

However, these concepts leave an important gap: why are some ways of being targeted for discipline and management, but not others? It is instructive to dive for a moment into one way that Foucault talks about the devaluation of certain ways of being: through his idiosyncratic conception of "racism." While discussing biopower in *Society Must Be Defended,* Foucault states, "What in fact is racism? It is primarily a way of introducing a break into the domain of life that is under power's control: the break between what must live and what must die" (2003b, p. 254). He continues in this vein, stating that the description of some races as good and others as inferior is "a way of fragmenting the field of the biological that power controls" (2003b, p. 254).

Here, Foucault uses the concept of racism to talk about biopower's reliance on the devaluation of certain groups to operate; some groups must be understood as threats to the population such that their elimination is seen as improving the health and productivity of the population as a whole. Foucault says this dependence of biopower on racism is so fundamental that "the modern State can scarcely function without becoming involved with racism at some point" (2003b, p. 254). That is, according to Foucault, because biopower is crucial to the modern State, and biopower depends on racism in Foucault's formulation, the modern State must be involved with racism.

However, Foucault explicitly contrasts his idiosyncratic use of the term "racism" with other conceptions. This is most clear in his discussion of racism in psychiatry in *Abnormal*. He describes psychiatry's adoption of degeneracy theory in the early 20th century as giving "rise to a racism that was very different in this period from what could be called traditional, historical racism, from 'ethnic racism'" (2003a, p. 316). He characterizes this "neoracism" as "racism against the abnormal," racism against "carriers of a condition, a stigmata, or any defect whatsoever" (2003a, p. 317). He contrasts this "racism against the abnormal" with racism whose function is "the prejudice or defense of one group against another," arguing that the function of this neoracism is the "detection of all those within a group who may be carriers of a danger to it" (2003a, p. 317). Here, Foucault broadens out the concept of "racism" so much that it comes to encompass the devaluation of all ways of being seen as abnormal.

The above passages highlight two key problems with Foucault's portrayal of biopower. First, it portrays biopower as dependent on dividing a population into groups of people that must be eliminated, but (as discussed in Chapter 1) there is an important distinction between efforts to eliminate a group of people and efforts to eliminate a way of being, even if the two can overlap. It is certainly the case that biopower relies on identifying some ways of being as threats to the

population that must be eliminated. The paradigmatic example of biopower is the tracking of infectious disease outbreaks, which always relies on the classification of certain sets of symptoms as particular threats to public health. But a biopolitical project, such as a vaccination program, does not require the destruction of a group of people. Second, both passages above center essentialism, the classification of people into discrete categories whose nature is seen as inherent. Yet biopower does not only operate on ways of being understood as essential; biopower targets threats to a population regardless of their cause.

The above textual exegesis highlights a key gap in Foucault's theoretical framework: the processes that produce the devaluation of certain ways of being. Disciplinary power always relies on some pre-existing norm, some framework for evaluating which ways of being are harmful and in need of discipline. Similarly, the exercise of biopower always depends on some framework for evaluating which ways of being are harmful threats to the productivity of a given population. Foucault deployed an idiosyncratic conception of racism to talk about the underpinnings of biopower, but as other scholars built on his short discussions of biopower and biopolitics, this theoretical lacuna has persisted through the lingering focus of Foucault's original analysis. Some theorists, such as Thomas Lemke (2011), have broadened out the concepts of biopower and biopolitics and lumped the evaluation of ways of being as threats under this broader umbrella. And, of course, numerous scholars have explored how existing hierarchies of valuation around race, class, gender, and other salient social markers shape which ways of being are seen as threats to be targeted by disciplinary power and biopower (McWhorter, 2009; Stoler, 1995).

However, there is a form of power that medicine and public health wield that is worth distinguishing analytically from both disciplinary power and biopower, even though it is intertwined with them. After all, if modifying an individual's behavior or managing a population

are important exercises of power worthy of investigation, we must also investigate the power to define which ways of being count as threats in need of discipline and/or management to begin with. Furthermore, without attending to the ways that medical and public health experts define certain ways of being as threats, we risk assuming that such discourses simply legitimize and reproduce existing hierarchies of valuation. In so doing, we obscure the ability of discourses of health and medicine to intensify, transform, or change these hierarchies of valuation through claims about harm, suffering, and threat.

Hence, I propose a third type of power that is intertwined with disciplinary power and biopower but must be distinguished from them, which I term *afflictive power*. Afflictive power is the capacity to define a way of being as a source of harm or suffering – a threat to afflicted individuals, the people around them, or society. The phrase "way of being" refers to an ongoing characteristic, pattern of behavior, or bodily state. Thus, anything from a habitual practice to a visual feature to a genetic variation could be the focus of afflictive power. The exercise of afflictive power turns ways of being into problems by defining them as incompatible with continued life, a good life, the flourishing of others, or the health of a population. In the typical case, afflictive power portrays a way of being as causing an *affliction*, a particular form of suffering, harm, or threat. This portrayal can be internalized by the audience as an *afflictive association*: an affective and cognitive link between an affliction and a way of being. That is, the most successful exercise of afflictive power creates or intensifies an association between a way of being, beliefs about its harmful consequences, and negative emotions (such as disgust or concern). Importantly, the targets of afflictive power are not simply the afflicted themselves, i.e., those who embody a given way of being. The target of afflictive power is anyone who is made an audience to its exercise (a news consumer, a doctor watching a presentation, a person reading

a pregnancy guide). Afflictive power is reproductive, in the sense that those upon whom it acts most successfully gain the capacity to exercise afflictive power in kind.

One key difference between afflictive power and its companion concepts, biopower and disciplinary power, is its fundamentally rhetorical nature. By rhetoric here, I mean something similar to Bitzer, who defined rhetoric as a "mode of altering reality, not by the direct application of energy to objects, but by the creation of discourse which changes reality through the mediation of thought and action" (1968, p. 4). Afflictive power at its root involves meaning, an association between two things that is reproduced through its exercise. It is more discursive and representational than both biopower and disciplinary power, because it operates most frequently through claims, depictions, and portrayals. Importantly, afflictive power does not train or instruct individuals to carry out specific behaviors. There are many different kinds of actions that a person might take based on their internalization of an afflictive association. Rather, because of its basis in sentiment, the repeated exercise of afflictive power can yield a surplus of affect (Ahmed, 2004) attached to afflicted ways of being and the people who are seen to embody those ways of being. As Ahmed emphasizes, "affect does not reside in an object or sign, but is an affect of the circulation between objects and signs" (2004, p. 120). The exercise of afflictive power can generate and circulate negative affect that is associated with – or "stuck to" – particular ways of being.

Like disciplinary power and biopower, asserting that a claim exercises afflictive power does not imply that claim is false. Although afflictive power is at its most effective when it is seen as accurate and authoritative, identifying a statement as exercising afflictive power should be understood as a claim about its effects, and not its perceived or actual truth value. A useful contrast is with the term "stereotyping," which, like afflictive power, involves associating a way

of being with negative qualities. Yet explicit stereotyping is often seen as irrational, biased, and ignorant, while afflictive power often speaks with a voice of expert authority, even when exercised by lay people.

Eliminationist assemblages, including the anti-obesity assemblage, exercise disciplinary power, biopower, and afflictive power. The specific mechanisms of the anti-obesity assemblage align with different forms of power. For example, enacting obesity elimination typically involves the exercise of disciplinary power, while enabling obesity elimination through the transformation of fatness into obesity is a biopolitical project. The concept of afflictive power draws attention to the form of power involved with one of the mechanisms of the anti-obesity assemblage identified in Chapter 1: turning obesity into an eliminable threat. Thus, analyzing the exercise of afflictive power within weight stigma research allows us to investigate how turning obesity into an eliminable threat upholds anti-fatness even in the context of interventions meant to reduce stigma. Nonetheless, within the anti-obesity assemblage, these three forms of power are imbricated and often depend on each other.

Methods

Praxiography

Praxiography is the study of practices and how they enact particular realities. This method was developed by philosopher Annemarie Mol in *The Body Multiple* (2002). Despite her training, Mol was not interested in epistemological questions about disease, such as what is a "real" disease or how to best engage with individual experiences of illness. Instead, she was interested in how disease is brought into being – the practices that make it visible, touchable, and intervenable, its ontological existence and status. She describes the practices that make disease real and present as "enactments" of disease (2002, p. 33). Her praxiography follows doctors,

histology technicians, medical staff, and other actors through the various practices they undertake to diagnose, visualize, or otherwise assess atherosclerosis. She traces *how* a given configuration of people, ideas, and objects (for example, a laboratory technician, a tissue sample, a slide, and a microscope) enable the production of evidence for the presence of atherosclerosis. In so doing, Mol argues that the disease does not exist "out there" regardless of human observation, but that it is *done* (or brought into being) in different settings by different actors. Praxiography is an inquiry into the practices of reality as we make it.

Praxiography provides a way to study a given thought collective (Fleck, 2012), such as a group of experts, without relying on their conventions and paradigms. For Mol, it provided a way to study the disease of atherosclerosis without limiting the scope of her inquiry to either the medical concerns of the health professionals and technicians or the "social" dimensions of the disease (e.g., how patients experience disease). For my purposes, it provides a way to query and evaluate weight stigma interventions without being limited to the questions typically asked by weight stigma researchers, including the question of whether such interventions "work." Instead, by following the practices of those who perform the interventions, I can recreate how they *enact* weight stigma. This enables me to analyze what kinds of experiences these researchers are creating for the health professionals who participate in their interventions, rather than limiting me to the data they provide as their results. Moreover, though I am not limited to analyzing their results, I can connect their reported results to their interventions practices as a way to demonstrate how their investment in obesity elimination leads to particular anti-obesity intentions among their participants. In other words, by studying the practices of weight stigma intervention researchers, I can examine how such interventions operate as part of the anti-obesity assemblage.

To perform my praxiographic analysis, I used the materials and methods sections of each intervention to reconstitute its enactment to the best of my ability. Although this is not the same as witnessing each intervention in person, Mol suggests that this approach is a valuable way to perform praxiography: the materials and methods sections of articles "specify as much as possible about the practices of investigation," and, in so doing, "instantiate the recognition that the practices forcing an object to speak are crucial to what may be said about it (2002, p. 158; see also Mak, 2006). For the purposes of my analysis, attending to the reported materials and methods of these interventions provides a way to see what weight stigma researchers prioritize in their interventions as well as what kinds of information they collect from their participants. More pragmatically, praxiography also enabled me to analyze research practices across dozens of interventions rather than limiting me to studying only the ones I could attend in person.

Textual Analysis

To gain insight into the consequences of these interventions – how they influence the ways intervention participants think and feel towards fat people after the interventions – I turned to the quantitative and qualitative data provided as results in these studies. The quantitative results from these interventions often depend on measures of stigma or bias that can be subversively read as measures of an afflictive orientation. For example, several studies utilize the Nurses' Attitudes Toward Obesity and Obese Patients Scale (NATOOPS) (Hunter et al., 2018; Swift et al., 2013). This scale measures how much nurses agree with statements like "Obese adult patients are depressed" and "Obese adult patients are the subjects of ridicule" (L. Watson et al., 2008). An afflictive analysis of health professionals' endorsements of these items can provide insight into their beliefs about fat people as fundamentally wretched and in need of intervention – increasing agreement with these statements indicate an increase in afflictive orientation

towards fat people. Qualitative results, although they are highly mediated, can also provide insight into how participating in a weight stigma intervention impacted the intervention participants. For example, many interventions explicitly asked about participants' anti-obesity intentions post-intervention. Analyzing the results of such inquiries can illuminate the degree to which health professionals took up an anti-obesity orientation after participating in the intervention.

Inclusion and Exclusion Criteria

The material for this analysis is the global body of academic literature published in English prior to April 2023 involving weight stigma interventions performed with health professionals. My corpus of texts includes articles, dissertations, and theses in which the authors describe engaging in an intervention with the explicit purpose of changing or reducing biased, stigmatizing, prejudiced, or discriminatory attitudes, beliefs, or practices of health professionals towards overweight, obese, and/or fat people. Studies that did not report on an intentional intervention to reduce stigma, such as those that measured stigma before and after general medical/health education or between medical/health institutions, were excluded. In the interest of capturing the relationship between these interventions and the anti-obesity assemblage, one intervention published in 1992 was excluded for significantly pre-dating the rise of the war on obesity.

Previous systematic reviews have focused exclusively on peer reviewed studies, thus excluding dissertations and theses. I have elected to include non-peer reviewed texts because I am not concerned with the accuracy, efficacy, or replicability of these interventions as rated by current measures of stigma, bias, or empathy. Rather, I am interested in what messages and experiences health professionals are being exposed to in the name of stigma reduction. Health

professionals or pre-professionals pursuing advanced degrees often have much easier access to other health professionals who can participate in their interventions, so including theses and dissertations by extension includes data about a much larger number of intervention participants.

I have chosen a broad definition of health professionals inspired by Nikolas Rose's (2007) work on "somatic experts." As ideas of illness, health, and wellness have expanded well beyond the clinic through the rise of biomedicalization, so too has the range of professionals who regulate and intervene on these matters, including "obesity." In recognition of this, my definition of health professional extends beyond medicine and doctors to any person who is either practicing within a health profession (medicine, nursing, nutrition, exercise, therapy, etc.) or in explicit training to practice within a defined medical or health profession (e.g., dietetics students training to become dieticians). Undergraduates are excluded unless they are able to become practitioners with a bachelor's degree (e.g., kinesiology or exercise science degree to become a personal trainer). This expansive definition reflects the wide range of actors concerned or involved with obesity elimination efforts – essentially, any professional with the power to engage in explicit obesity elimination practices with fat patients or clients.

The final inclusion criterion for this corpus is the presence of some kind of methodological information or material that provides insight into what participants experienced during the intervention. This material may be included as a supplement or linked in the article, thesis, or dissertation and may include things like a video that was played as part of the intervention or the PowerPoint slides shown to participants (Table 4, Appendix C). For interventions involving fat suits, a description of the activities participants engaged in is sufficient for inclusion. For some interventions, I also draw on other information available online about the research, such as lectures, conference presentations, interviews, and news media

(**Error! Reference source not found.**, Appendix C). For one recent publication (Gajewski, 2023), I initiated a personal communication with the author to gain access to more details about the intervention.

Literature Search/Extraction

The search for these texts began in April 2022 and continued until April 2023. I began with two existing reviews of weight stigma interventions with health professionals to gain a sense of what search terms would be relevant (Alberga et al., 2016; M. Lee et al., 2014). I found relevant texts using Google Scholar, Web of Science, and the Proquest Dissertations and Theses database, searching combinations of terms such as obesity stigma, weight stigma, weight bias, empathy, reduction, intervention, health professionals, healthcare providers, doctors, nurses, medical students, nutritionists, and dietitians. I also searched for terminology related to fat suit interventions, including bariatric empathy suit, bariatric weighted suit, and obesity simulation suit. I also set Google alerts for many of these terms, which led to the discovery of several interventions until April 2023. The citations of each intervention were also explored to find additional relevant texts. Finally, I also Googled the name of every author whose work was included in the corpus plus relevant terms such as obesity stigma to find additional materials (e.g., conference presentations and interviews). In general, my search strategy emphasized comprehensiveness over systematicity – rather than use a single coherent search strategy as a systematic review or meta-analysis would utilize, I employed many different search strategies to gather sources that would not ordinarily be included in scholarship concerned with replicability or rigor of research.

Final Corpus

The final corpus for this analysis can be found in Table 3 (Appendix B) Appendix B: Corpus of Weight Stigma Interventions (Chapter 3)which contains information about all of the publications documenting interventions, and Table 4 (Appendix C) which lists all of the supplementary material used in my analysis. My final corpus includes 41 weight stigma interventions, as well as the myriad videos, scripts, PowerPoint presentations, news articles, academic articles, online modules, and clinical practice guidelines used in these interventions.

Enacting Affliction in Weight Stigma Interventions

The following vignette is a reconstruction of what a student nurse might have experienced participating in Hunter et al.'s (2018) intervention, in which participants were asked to wear a fat suit (which they call a "bariatric empathy suit") and perform several highly visible activities. To recreate the practices of the intervention, I drew on the materials and methods provided in the article, the manual for the bariatric empathy suit (benmor medical, 2019), and a blog post and YouTube video uploaded by the study's authors (Attenborough, 2014). To provide a more immersive sense of what it might have been like to be a participant in this intervention, I also used critical fabulation (Hartman, 2008) to imagine the participant's thoughts and possible dialogue with the researchers. Double quotation marks indicate a verbatim quote from a participant, while single quotation marks indicate imagined thoughts or speech. Italics indicate imagined participant thoughts.

It's spring 2014 and you're in the second year of your nursing degree program at City University London. An email pops up in your inbox from one of the professors you met last year: do you want to participate in an experimental program meant to increase your empathy? Yes,

absolutely! You fill out the forms – kind of strange, they ask about surgery, recent pregnancy, disabilities, you check no, no, and no, and wait to hear back. A few days later, you hear back – you're in! Come to the clinical practice building this Wednesday and next for a simulation exercise. Wear comfortable clothes and sneakers.

The first Wednesday, you arrive at the building and find out your friend Kim was also selected. Two of your professors, Janet and Karen, give you both the rundown of what's going to happen. Some of your other classmates will be doing the same thing later this month, but since you two seem very excited, can they film you for an educational video? You consent. This week will be Kim's turn, they explain. She'll be wearing an "Old Age Simulation Suit." You watch them strap her in, bracing her knees, ankles, elbows, wrists, and chest and covering her eyes with large goggles. They grab the camera and give you instructions – you help Kim to her feet and watch her navigate the room with a cane. Over the next half hour, you watch her try to make herself a cup of tea, then Janet and Karen ask you to interview Kim about what her experience was like. You're moved as she describes, still wearing the suit, her newfound insight into what it's like to be elderly.

The next Wednesday, you both arrive again. It's your turn, only you're not wearing the suit Kim wore. You're wearing a "bariatric empathy suit," meant to simulate extreme obesity. You feel a little panicked but take some deep breaths as you step into the trousers and hook their suspenders over your shoulders (Figure 4). Your feet are totally covered so Karen bends down and cuffs the trousers at the bottom, revealing your socks. You hold your arms out as Janet shimmies a jacket with stuffed sleeves onto each arm, then stand still as both Janet and Karen lift the torso of the suit and place it on your shoulders, tying the front and back parts together at your waist. Immediately, you feel suffocated. This suit is heavy and all your limbs are immobilized.

‘Now we have to put on the clothes,’ Janet says. *Clothes? How?!* You can barely breathe, let alone move! They enlist Kim to help you balance as Karen assists you in lifting one leg at a time and Janet pulls some stretchy black pants over your padded lower half. The shirt is a little easier, although pulling the sleeves over your pillowy arms takes a few minutes. You’re exhausted by the time they’re finished getting you into the suit, but Janet takes out the camera. Time to “begin” the simulation.

Figure 4: Visual instructions for how to put on the bariatric empathy suit from the Benmor Medical Bari-suit® User Manual (2019).

The suit is stiflingly hot. You find yourself craning your neck at strange angles to try to get a little breeze under the chest piece, but you find no relief. Sweat begins to trickle down your spine.

Kim leads you over to a chair and you wedge yourself into it. Karen brings over your sneakers and places them on the ground in front of you, just out of reach. You bend, fruitlessly pressing yourself forward as the cushion of the suit barely compresses. You snag one shoe with a finger, twisting to bring it closer to your foot. You slide it on, but you can’t bend your leg enough to get it close enough to tie (Figure 5). The suit legs keep slipping down over your feet.

After what feels like an eternity of struggle, you sit up, red faced and defeated. Kim asks if you want help with the laces and you nod.

Figure 5: A woman wearing the bariatric empathy suit from Hunter et al.'s intervention struggles to put on her shoes (1:41-2:30).

Next, Janet instructs you to hoist yourself out of the chair. You do so, then shuffle through the room and out into the hallway, praying that it stays empty. Karen guides you to the bathroom. You and Kim enter, with Janet and the camera following behind. You look at the door to the toilet stall. Can you even fit inside? You turn sideways and step in, holding onto the walls of the stall for support. "I'm a bit worried…it's going to be difficult for me in here by myself but I want to close the door" you say. You try to sit but it's difficult to sense where the toilet is below you, and you remark as such. Once seated, you begin contorting your upper body to try to tell where you have landed on the toilet. "Are you seated properly?" Kim asks. "I can't even tell," you respond.

"Would you be able to wipe yourself? Or would you need help?"

"Umm…"

You lean forward and attempt to reach behind you, feeling only the back pads of the suit.

"I think I would need some help…and I can't see how you would be able to come in here with me."

You sit, flustered and humiliated, imagining how hard it would be to have a body this big (Figure 6).

Figure 6: A woman wearing the bariatric empathy suit from Hunter et al.'s intervention struggles to maneuver within a toilet stall (2:38-3:24).

You're sweating everywhere now, your hair starting to stick to your neck. You want to be done but Janet tells you there's more. She films you as you shuffle out of the bathroom and to the staircase, heaving your lumbering legs up each step, huffing and puffing, clinging to the cool metal railing to stop yourself from tripping (Figure 7). You take frequent breaks to fan your face, feeling the extra 15 kilograms (33 pounds) of the suit resisting every movement. Your heart pounds. You don't know how much longer you can take it.

Figure 7: A woman wearing the bariatric empathy suit from Hunter et al.'s intervention struggles to walk up the stairs (3:30-4:00).

For the final exercise, Janet instructs you to lay flat on your back on the floor. The suit pushes on your sternum and blocks your ability to see below your chest. You try to sit up and fail miserably.

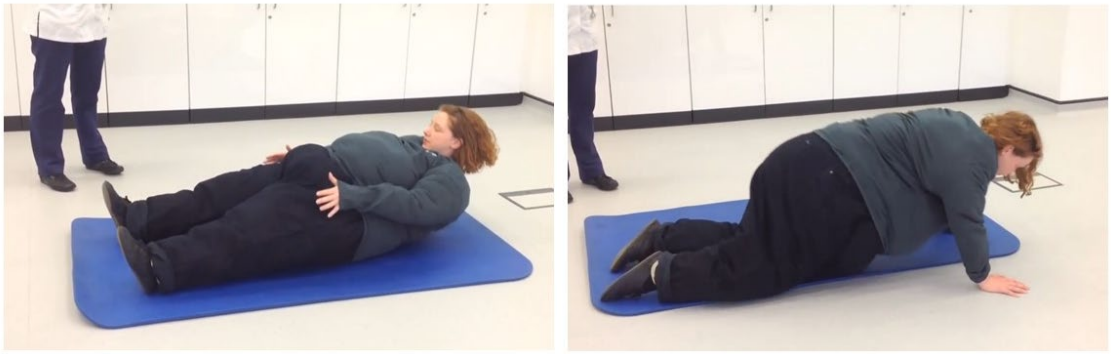

Figure 8: A woman wearing the bariatric empathy suit from Hunter et al.'s intervention struggles to get up from the ground (4:25-5:00).

Okay, new strategy. Gotta get this over with. With a heave, you roll over, first to your side and then to your stomach, where you manage, by some miracle, to get into a crawling position (Figure 8). The floor is cool on your hand. Okay, another heave and you're mostly onto your knees, but you can't stand. Everything is off balance; the weight of the suit is dragging you backwards. Kim drags over a chair as you wipe the sweat from your eyes (Figure 9).

Figure 9: A woman wearing the bariatric empathy suit from Hunter et al.'s intervention wipes the sweat out of her eyes (5:31).

You crawl forward and lean heavily on the chair, begging your muscles for one final push to get yourself up. You turn and collapse into the chair, exhausted. Janet films as Kim pulls up another chair and asks you about your experience. You worry about how sweaty you must look.

"How long have I been in it?"

Kim checks her watch.

"About half an hour."

"Half an hour? I'm sweating, I feel uncomfortable…I'm self-conscious as well. It's quite an experience."

You look over to Kim but her eyes are fixated on your foam gut. After a beat, she forces her eyes back to your face. You speak for a while longer, breathing heavily, feeling even your usual hand gestures limited by the foam around your arms. You struggle to find the words to describe your discomfort and articulate the humiliation you're sure people this size feel. You understand now why they don't want to leave their houses. They don't fit. They need an aide everywhere they go. It's so much work, physically, emotionally, and logistically. You can't wait to take the suit off and feel the smallness of your own body. Thank god you're not trapped this way forever.

This vignette describes one of several weight stigma interventions in which researchers exercised afflictive power by enacting affliction. Afflictive power is the capacity to define a way of being as a source of harm and suffering. Weight stigma researchers exercise afflictive power when they portray being fat as incompatible with a good life and a good world. However, Hunter et al.'s intervention, as well as the other weight stigma interventions in my corpus that relied on the use of fat suits (Hales et al., 2018; Hunter et al., 2018; Ladwig, 2023; Luig et al., 2020; Renold et al., 2023), do more than provide afflictive portrayals: they *enact* affliction through the practice of "simulating" the suffering of fat people for their participants. Enacting affliction in these interventions can be broken down into three component parts: the fat suit, which is meant to stand in for the experience of fat people; the intervention protocol, which ensures participants experience discomfort; and the felt experience of the participants, wherein they internalized the link between the fat suit as a stand-in for all fat people and their discomfort to develop a sense of fat people as afflicted.

Enacting affliction in fat suit-based weight stigma interventions depends on researchers and participants taking for granted that fat suits accurately represent the experience of being fat. These suits are generally made of some combination of fabric, foam, and weighted material, and they are designed to encase the wearer's body in these materials to some extent. As such, suits add both size and weight (typically 10-20 pounds) to the wearer's body (see Table 5, Appendix D for details). Each article contains some version of the sentiment that the suits "simulate obesity" and/or spur "empathy" for obese patients by providing the wearer insight into how fat people experience the world. Indeed, this idea is part of the justification for the existence of the suits themselves. For example, the brochure for the "XXL-Rehab Bariatric Suit," used by Luig et al.

in their intervention, asserts: “When you put on the suit, you obtain a wide view of the mobility patterns, the restricted movement of the body and other issues related to a bariatric user that you never thought of before!” (2019). In this quote, the ability of this suit to accurately simulate what it is like to be fat (to be a “bariatric user”) is its primary selling point.

The idea that such suits simulate being fat is, however, a fantasy. The suits are not a simulation of fatness as much as they are a *simulacrum* of it. In Baudrillard’s formulation, a simulacrum is a sign that “bears no relation to any reality whatever” (1994, p. 6) A simulacrum is a copy without an original, signifying despite the absence of a referent, or, in hyperreality, to conceal the absence of a referent. Fat suits operate as simulacra because there is no original referent for them to signify: no fat body actually operates as if it is a thin(ner) body that has been instantaneously covered in weighted foam. Foam is insensate and external to the boundary of the body; fat flesh is an enervated organ in physiological exchange with the rest of the body. The thin wearer has physical capacities developed over time that are interrupted by foam. In contrast, fat people *also* have physical capacities that have developed over time, such as stronger muscles to better lift heavier limbs (Garcia-Vicencio et al., 2016; Tomlinson et al., 2016), denser bones to support higher weight (A. L. Evans et al., 2015; Turcotte et al., 2021), and a tacit ability to sense the boundaries of their bodies. These capacities are shaped, rather than interrupted by, embodied fatness. Said more simply, a fat person’s exertion would also change if they were put into a 20 pound fat suit; the exertion created by instantly carrying extra weight is not a property of fatness but a property of the exercise itself. Despite this falsehood – and despite scholarship that has contested the use of fat suits in weight stigma research (Fox et al., 2023; Meadows et al., 2017) – health professionals are encouraged to understand their experiences wearing fat suits as *more real* or *truer to life* than knowledge they could glean any other way. In so doing, the simulacrum

becomes truth in its own right. The participants accept that their experience in a fat suit is the truth of what it is like to be fat.

The intervention protocols – what participants are asked to do while wearing the fat suit – are a second key part of enacting affliction. Although any task wearing such a suit would likely be strenuous and difficult due to the instantaneously added weight and encumbrance, intervention researchers can intensify the degree to which participants feel afflicted by selecting tasks that are especially difficult or humiliating. For example, as discussed in the vignette, Hunter et al. had their participants simulate wiping themselves in a too-small bathroom stall, a task guaranteed to fail as participants had no sensation at the edges of the suit nor time to learn how to stretch and twist in a way that would help them access the space between their legs. Across interventions, participants were asked to do everyday tasks that would ordinarily be easy for them to complete, such as getting out of bed, tying their shoes, taking public transportation, eating, and walking. Choosing tasks that are ordinarily mindless ensured that participants would feel maximal disruption from wearing the suits. Additionally, researchers can also intensify the degree to which participants feel afflicted by manipulating how *visible* participants are while wearing the suit. The protocols used by Hales et al. and Renold et al., for instance, had participants spend time in public so that they could experience the feeling of being stared at (Thomson, 2017). Indeed, it is likely that people encountering a participant wearing a fat suit would stare at them, given the suits' artificial shapes, awkward proportions, and disconnection from the head and neck of the wearer (see Figure 10).

Figure 10: Two people wearing the fat suit from Hales et al. These photos show how conspicuous the fat suit is. Photos sourced from the presentation "Simulating Size Study Findings" (Hales & Gray, 2017).

Fat suit interventions help participants create an afflictive association between fatness and a lack of basic physical capacities. The creation and sedimentation of this association can be seen in statements from participants after these interventions. Most participants commented on how difficult it was for them to do the activities in the suits:

> And I was just, 'Oh God, this is exhausting!' Just getting a book out of my bag! (Participant 1, Hales et al., 2018)

> Going through the different activities made me extremely breathless and insecure at every point of the way where I was unable to see my own feet and not knowing where I am stepping. I was extremely scared to even step into the bathtub! (R52, Luig et al., 2020)

> To do my shoelaces, it was hard for me to just bend forward. I couldn't move properly to even see my feet. (Participant 1, Hunter et al., 2018)

> It felt like a workout to me just doing activities of daily living in the twenty minutes I was wearing the empathy suit, which only weighed 10 lbs. (R36, Luig et al., 2020)

In these quotes, participants express surprise and frustration at how difficult wearing the suits made daily tasks, providing the foundation for the association between being fat and struggling

to do basic life activities. The next step in generating an afflictive association – extrapolating from their experiences to generate beliefs about all fat people – is also visible in participant responses. This extrapolation is often executed using the conditional verb "would," which indicates that a participant is imagining the experiences of someone else:

> My legs were rubbing together, I've never had that before. Everything would take much longer and I think more energy as well. (Participant 1, Hunter et al., 2018)

> After this experience, it is much easier to sympathize with the reluctance to exercise. When every little movement is difficult, painful and requires a significant effort, why would anyone be motivated to do any additional physical activity? (R35, Luig et al., 2020)

> I see bigger people sitting on those seats (outside shops)... Now I realize they just have to sit there. Otherwise they can't even go in the shops... Everything is just a big effort... I can see how you would just need to sit down in between little tasks here and there. (Participant 5, Hales et al., 2018)

In these quotes, it is clear that participants believe that the difficulty they experienced performing activities while wearing the suits reflects what it is like to be fat: if they *were* fat, they *would* struggle. In these quotes, the afflictive association is sedimented. Participants leave the weight stigma intervention with an embodied belief in fat people's physical incapacity.

These interventions also encourage participants to create an afflictive association between fatness and suffering. Many participants recounted feeling excluded, surveilled, or stigmatized by others while wearing the suit, expressing a form of social suffering:

> You sort of felt very observed by people who were staff members in the hospital. Some patients or visitors were quite conspicuous in their observation as well, but not as much. There were a couple staff members who I really felt were observing me… *[sic]* it did feel like I was being judged a couple of times. (Participant 7, Hales et al., 2018)

> What I did notice was walking along the corridors in the hospital, hospital staff don't look at you. Well they don't look at your eyes. They don't make eye contact. As they go past, they drop their eyes and look across at your body... And not a single person smiled at me. (Participant 3, Hales et al., 2018)

> I was surprised by how self-conscious I actually started to feel while wearing the empathy suit (even just for a few minutes). I have always been a small person and I almost felt a sense of embarrassment while wearing the suit. (R4, Luig et al., 2020)

In these quotes, participants imagine themselves as stigmatized subjects while wearing the fat suits. In addition to identifying interpersonal sources of stigma and suffering, they also commented on their own negative judgments of themselves in the suits, further implying that fat people suffer from self-marginalization:

> I could hardly recognize myself. I admit I am ashamed that I felt disgusted at how I looked (R31, Luig et al., 2020)

> I think the more difficult thing for me to think about was looking in the mirror with the suit on. I felt pretty awful and would hate if I ever ended up with a weight like that. (R15, Luig et al., 2020)

These reflections indicate that participants were forming a link between being fat and self-imposed suffering. In addition to social suffering, participants also reported physical suffering, with one participant stating that they were "very exhausted and hot. And uncomfortable…I just feel hot and bothered" (Participant 2, Hales et al., 2018) and another saying the suit felt "heavy and restrictive and claustrophobic" (Participant 2, Hunter et al., 2018). In sum, participants experienced myriad forms of physical, mental, and social suffering during their time wearing fat suits.

As with their experiences of physical limitation, weight stigma intervention participants used their experiences of suffering to imagine that fat people must also live lives defined by abject misery, thus solidifying the afflictive link between fatness and suffering. Participants again used the conditional "would" to discuss how they would behave based on their experiences in the fat suit:

> I wouldn't go out. I'd probably do online shopping. I'd do my supermarket shopping online too. Yep, it's not fun being out and about…*[sic]* Quite isolating I

> think. Really lonely. Miserable actually. I could be quite easily depressed in this suit if I had to wear it for ages. Awful... I feel really isolated in this suit. Nobody wants to be near you. (Participant 1, Hales et al., 2018)
>
> If I was in my home, I probably wouldn't want to leave it. (Participant 3, Hunter et al., 2018)
>
> If I was overweight, I'd probably use humour a lot, but that would be so emotionally draining I'd probably hesitate going out. (Participant 7, Hunter et al., 2018)

In these responses, participants imagine the lives of fat people to be inevitably miserable, depressing, and isolated based on the afflictive experience they had in the intervention. This afflictive imaginary of fat life has a social component – they imagine the rejection fat people must face from others – but through the intervention, they ultimately understand this affliction as inherent to being fat. In other words, these responses indicate that participants solidified an afflictive association between fatness and suffering through their experiences in these interventions. By instructing them to don a fat suit and carry out the intervention protocol, the researchers exercised afflictive power on the participants, training them to link being fat with various afflictions in a deeply embodied way.

The authors of these interventions frame the development of afflictive associations as positive and evidence of reduced stigma. Hales et al. state, "The findings from this study are positive and suggest simulation suits have the potential to reduce weight stigma among health professionals toward patients" (2018, p. 23). Luig et al. conclude that interventions like theirs can "help to foster critical consciousness" and "'rehumanize' relationships and improve patient care" (2020, p. 8). Among these interventions, Hunter et al. make the most explicit claims about increased afflictive associations as a positive outcome. These authors used the Nurses' Attitudes Toward Obesity and Obese Patients Scale (NATOOPS) to measure stigma. This scale includes numerous items that, in essence, measure afflictive associations, e.g., "Obese adults experience

unresolved anger" and "Fatigue is a problem for obese adults" (L. Watson et al., 2008). On this scale, a higher score indicates a more negative attitude, so increased agreement with these statements is evidence of *increased stigma*. However, Hunter et al. misinterpreted the scale and portrayed increased scores as evidence of a successful stigma intervention: "In our study, students were more likely to state that obese patients would experience ridicule, low self-esteem, fatigue and depression following the simulation activity" (2018, p. 230). They refer to this strengthened afflictive association as an "improvement in attitudes" and later restate that "this study suggests that following a structured simulated educational experience student nurses' attitudes were more positive towards obese patients" (2018, p. 230). When I drew the journal editor's attention to Hunter et al.'s mistaken interpretation of the scale, the article was retracted (Hunter et al., 2023). However, this retraction has not prevented other researchers from using the intervention as a model (Can Gür & Yılmaz, 2024) or including it in reviews about effective strategies for reducing weight stigma in healthcare (Moore et al., 2022; Talumaa et al., 2022).

The case of Hunter et al., detailed in the vignette above and eventually retracted, exemplifies an assumption underlying most weight stigma interventions with health professionals: the assumption that strengthening their associations between fatness and suffering is reducing stigma against fat people. Hunter et al. designed a study that would make participants suffer and interpret that suffering as an essential aspect of living while fat, and as their results indicate, their design was successful in that end. They then interpreted their data showing strengthened afflictive associations as a reduction in negative attitudes. In other words, although they made an error when interpreting their quantitative data, the error Hunter et al. made follows a logic widely held among these researchers: convincing health professionals that fat people live miserable lives defined by physical, mental, and social suffering, increases empathy, and reduces

weight stigma. In the next section, I show that this logic operates even outside the context of fat suit interventions, in studies that use representations of fat people to reduce stigma rather than enacting affliction with participants. Across these interventions, weight stigma researchers present almost exclusively negative, afflictive portrayals of fat people in their attempts to educate health professionals about weight stigma.

Representing Affliction

Across the variety of weight stigma interventions, fat suit interventions exercise afflictive power most intensely. However, other kinds of interventions also exercise afflictive power in different ways. While fat suit interventions create afflictive associations by having participants don a simulacrum of fatness and suffer through an intervention protocol, most other interventions exercise afflictive power by presenting participants with representations of fatness as a source of suffering or threat. In other words, most weight stigma interventions *represent* affliction rather than enacting it. This section reviews the materials presented to participants across numerous interventions, highlighting the various afflictive messages that participants receive during these interventions

Some weight stigma interventions used performances or dramatic readings that exercised afflictive power through the depiction of fat characters narrating their own lives as suffused with suffering. Participants in Price et al. (2017) and Finbow's (2019) interventions watched the play *Balancing the Scales*, which depicts a clinical encounter between a self-hating fat woman and her resentful primary care doctor. The play was written by Price et al. based on an earlier interview study with patients, doctors, and policy makers documenting barriers to obesity treatment in Canada (archresearchgroup, 2013a, 2013b; Kirk et al., 2014). The play primarily consists of each actor monologuing to the audience while interacting with each other only

briefly. The fat woman's monologues represent her life as deeply afflicted, defined by suffering, bitterness, and an inability to flourish without weight loss. Without prompting, she rejects the idea that she could try to live without losing weight:

> People say, "Can't you just accept that this is who you are and deal with it?" Well, would you say that to a burn victim? Because that is not how they're supposed to look. Something happened to change the course of their life. I want to experience what it's like to be the woman inside for once, even if it's just for a little while. It's an empty life when you hate yourself. (2013b, 7:14-7:51)

In this quote, the totality of the woman's life is suffering. Because she is fat, her life is "empty." She frames fatness as a deviation that changed the course of her "real" life, the life that exists for the thin woman "inside" her that she longs to be. Here, the study authors create an afflictive association between fatness and suffering for intervention participants watching the play by presenting a fat character describing her life in extremely negative, evocative terms. She compares being fat to being a burn victim, when burning is widely recognized as one of the most painful and damaging kinds of trauma the human body can sustain. In addition, this character dismisses acceptance of her weight as an impossible task: the only way her life can be livable is through losing weight.

In a similar study by Matharu et al. (2014), participants read the play *The Most Massive Woman Wins* aloud as part of their intervention. In this play, each character shares multiple stories of woe, self-hatred, and weight-based discrimination as the rationale for seeking out liposuction. Additionally, one character self-immolates during the play, monologuing about lighting herself on a fire as a way out of her lifetime of suffering due to her fat body:

> So I needed a final solution. Get rid of all the flesh at once…my body---I wanted to light it on fire. Hear the fat sizzle into smoke. With all the fat gone I could dance---more that that, I could run and jump and fly maybe even, just me and my bones running naked through the meadows feeling the breeze. (George, 1997, p. 291)

This quote also creates a deeply afflictive association for the participants who read and hear it. For this character, being fat is so miserable that she needed to end her life to escape it. Moreover, she frames dancing, running, jumping, and feeling the breeze as activities that are only possible once she is no longer fat, thus associating fatness not only with a lack of basic physical capacities, but also with a lack of freedom, agency, and joy. Thus, in this study titled "Reducing obesity prejudice in medical education," intervention participants are left with the afflictive message that burning alive is a preferable alternative to a continued fat existence.

Other weight stigma interventions exercised afflictive power through representations of actual fat people discussing their own lives. For example, two interventions (Fitterman-Harris & Vander Wal, 2021; Williams, 2022) screened a video, "Stigma: The Human Cost of Obesity," from the documentary series *The Weight of the Nation*. This video features talking head-style interviews with approximately 20 fat people of multiple races and genders, all of whom recite stories about how terrible their lives are because they are fat. Within the first minute of the video, viewers hear and see clips of multiple fat people spliced together:

> Person 1: I don't want to be fat for the rest of my life. I've got diabetes.
>
> Person 2: Sleep apnea.
>
> Person 1: High blood pressure.
>
> Person 3: I get dizzy when I get up.
>
> Person 4: Everything's hurting now (0:42-0:45).

These quotes (which, again, are meant to *reduce stigma*) create a very simple afflictive association for the intervention participants. Fat people uttering the names of various medical conditions and symptoms associates those conditions with fatness in the most basic sense: fatness is pathological and being fat means suffering. However, even the more stigma-focused

parts of this video do not provide a reprieve from afflictive associations. Rather than drawing attention to the *injustice* of stigma, these moments simply present stigma as *another affliction caused by being fat*. One person recounts discrimination from strangers: "People that I don't even know have walked up to me and taken items out of my shopping cart when I'm at the store" (2:05-2:13). Another describes romantic rejection: "He just told me 'you're just too fat and I can't be seen with you because how am I gonna talk to my family and home and bring you around?'" (12:39-12:55). Juxtaposed with other afflictive claims, these tales of woe reinforce, rather than undermine, the association between fatness and suffering. In the film's 20-minute run time, only a few seconds are devoted to positive sentiment when Rudd Center researcher Kelly Brownell says of fat people: "They're every bit as talented, they're every bit as sincere, they're every bit as loving, they have all the qualities that you have. They just have more weight" (3:42-3:50). This message is then contradicted by the remaining 19 minutes and 40 seconds of the film, which contains exclusively negative messages about how hard and miserable the lives of "obese" people are.

Some interventions contained more subtle afflictive messages. One piece of media that contained many of these messages is a video titled "Weight Bias in Health Care," produced by the Rudd Center in 2009 and used in 13 different interventions (Burke, 2018; Flinchum, 2020; Ghartey, 2019; Isom, 2020; Marcum, 2009; Nestorowicz & Saks, 2021; T. L. Oliver et al., 2020, 2022; C. J. O'Reilly, 2018; Poustchi et al., 2013; Quirk, 2017; Swift et al., 2013; Tanner, 2017). Midway through the video, the narrator (plus size supermodel Emme) states:

> Most of you know that obesity has doubled in the past twenty years in both children and adults, and frighteningly, it's tripled in teens. One in five children is overweight and overweight children tend to become overweight adults…Whether or not you want to deal with this, the obesity epidemic is increasingly going to impact your practice." (2009, 4:35 - 4:54)

In this quote, an increase in obesity is portrayed as "frightening" and obesity itself is portrayed as an epidemic. Even though the nature of harm and suffering produced by obesity is not discussed as explicitly as it is in most of the examples provided above, this language still implies that obesity is a concerning threat that needs to be addressed. Thus, the video reinforces an afflictive association between fatness and threat in a more generalized, unspecified way. This film also depicts a fat woman enduring a deeply stigmatizing doctor's appointment: she is weighed in the hallway rather than a private room, given a gown that is too small to cover her body, treated as a burden by the nurse who must find a large blood pressure cuff to treat her, and overhears an insult from a child in the waiting room with her and gossip from the office's staff and nurse. Like the segment from *Weight of the Nation*, this depiction, juxtaposed with generalized afflictive claims about obesity, makes misery seem like part of being fat, even when the source of that misery is other people. While the film is meant to highlight discriminatory practices, it does so without providing a clear explanation of the system of oppression driving their behavior. Without this anchor, viewers merely watch a fat woman experience embarrassment, discomfort, and humiliation from her poor treatment.

While the first half of the "Weight Bias in Healthcare" video depicts a fat woman suffering through interpersonal and structural stigma, the second half is meant to depict a non-stigmatizing encounter where the health professional treats the fat woman correctly. However, this corrected interaction takes the form of an *encouraging and supportive conversation about weight loss* between the woman and her doctor. Rather than depicting a respectful and accommodating conversation about the patient's healthcare needs, this video shows an enactment of obesity elimination as the non-stigmatizing way to treat a fat patient. It is this anti-obesity focus of the weight stigma interventions that I turn to now.

Training Health Professionals to Enact Obesity Elimination

Nearly all of the weight stigma interventions in my review contained anti-obesity messages, and many provided specific instructions for participants on how to improve their weight loss counseling practices. Anti-obesity research has shown that health professionals are reluctant to weight loss counsel, i.e., direct patients to lose weight and/or provide guidance on weight loss (Dewhurst et al., 2017; Sonntag et al., 2012). Dewhurst et al. (2017) report that physicians decline to weight loss counsel because it rarely leads to substantial patient weight loss and because they feel uncomfortable navigating weight-related conversations for fear of "shaming" a patient. As a medical student from Essel et al.'s intervention phrased it, "I just hope I can learn a way to explain how this affects their health and motivate them to be healthy without offending anyone and making their lives more difficult" (2022, p. 9). In this context, many weight stigma interventions, like the "Weight Bias in Healthcare" video, involve providing health professionals with instructions on how to weight loss counsel without "shaming" their patients. Some interventions measure comfort and confidence in weight loss counseling as a way to demonstrate intervention efficacy.

Thus, most weight stigma interventions with health professionals are part of the anti-obesity assemblage. Anti-obesity weight stigma interventions *enable* obesity elimination by training health professionals to *enact* obesity elimination with their patients. These interventions grow the anti-obesity assemblage by bringing additional actors into the assemblage and by encouraging those actors to be more invested in obesity elimination under the guise of anti-stigma efforts.

Numerous interventions showed or demonstrated weight loss counseling practices for participants. In the "Weight Bias in Healthcare" video, the narrator states: "Patients are three

times more likely to address diet and lifestyle changes if their doctor constructively and sensitively called their weight to their attention" (14:08-14:18). After this statement, the patient and the doctor have the following corrected, "non-stigmatizing" encounter:

> Doctor: Well, Mrs. Cole, all your vitals look great, it sounds like you're doing great. Would you mind if we talked about your weight?
>
> Patient: Sure. I know I could eat better, get more exercise.
>
> Doctor: I'm glad to hear you're thinking about ways to improve your health but it's important to remember that body weight is only partly determined by diet and exercise. Still, we can all stand to make lifestyle improvements. Let's talk about what you're doing now and how effective that is. (14:22-14:45)

By showing this encounter as an exemplar of how clinicians should be speaking to their fat patients, this video trains its viewers to engage in weight loss counseling rather than highlighting the importance of addressing a patient's presenting complaints. Moreover, it tells participants that this course of action is non-stigmatizing and perhaps even part of fighting weight stigma.

Similarly, Farooqi (2022), Gajewski (2023), and Moto et al. (2020) all present or assign participants materials that provide explicit instructions on weight loss counseling as part of their interventions. Moto et al.'s materials, for instance, include a guide for how health professionals can use Motivational Interviewing to "enhance self-efficacy and personal control for behavior change" in their patients. To spur weight loss without stigmatizing patients, the guide encourages health professionals to make statements such as, "I believe that your extra weight is putting you at risk for heart disease. Making some lifestyle changes could help you lose weight, and improve your health substantially" (The Rudd Center for Food Policy and Obesity, 2017). In these interventions, "reducing weight stigma" amounts to training health professionals to be nicer to their patients as they engage in obesity elimination.

Several interventions included not only instructions on weight loss counseling, but opportunities for participants to practice it in a simulation activity with a standardized patient (SP).[19] In such a simulation, participants practice telling a patient to lose weight and offering weight loss strategies with a professional actor trained to perform the part of a patient. Notably, most standardized patients are not fat, so several interventions had SPs wear a fat suit as part of the encounter (Gajewski, 2023; Herrmann-Werner et al., 2019). Participants in Luig et al.'s intervention received training on how to counsel a patient using the "5As of Obesity Management™" (Ask, Assess, Advise, Agree, Assist), which is an "evidence-based framework to guide practitioners' obesity counseling" (2020, p. 2). After this training (and after wearing a fat suit for 15 minutes), participants practiced the "5As" by counseling a standardized patient about weight loss. The resident then discussed their counseling performance with the standardized patient, their peers, and their preceptor, hammering home the association between weight loss counseling and good clinical conduct with fat patients. The 127 first-year medical students in Kushner et al.'s intervention also practiced their weight loss counseling skills with standardized patients. In eight-minute encounters, students were "instructed to discuss the SPs' perception of their weight, take a weight history and probe for how their weight has affected them socially and physically" (2014, p. 3). Standardized patients acted out six scenarios in which they had varying levels of knowledge about, and resistance to, weight loss. Rotating through these SPs gave Kushner's et al.'s participants the chance to develop strategies for counseling patients with varying views about obesity and weight loss.

[19] "To train medical professionals in proper care, the standardized patient program uses actors to simulate illness and disability. Once given an assignment, the "patients" are interviewed and examined by medical trainees seeking to be nurses or physicians, who try to diagnose the performers. The entire process is monitored, and the trainees are evaluated on their methods, the accuracy of their diagnoses, and the compassion that they demonstrate during their interactions with the standardized patients (SPs)" (Mulvin, 2021, p. 145)

Several weight stigma interventions in my corpus occurred *as part of* broader anti-obesity courses or seminars. Table 6 contains additional details on several of these interventions, including Luig et al. (2020) and Renold et al. (2023)'s fat suit interventions as well as Isom's (2020) use of the "Weight Bias in Healthcare" video during lunch on "Obesity Day" for a group of dietetics interns. Across these studies, weight stigma represented a small percentage of the overall time participants spent learning about obesity elimination: 15 minutes of a two-day workshop (Luig et al.), part of two lectures and 30 minutes outside of class during a two-month course (Renold et al.), and one hour out of a full day seminar (Isom). This time allocation indicates that reducing weight stigma is treated as a potentially useful, low priority part of training effective anti-obesity health professionals. Even the title of Luig et al.'s article, "Improving obesity management training in family medicine: multi-methods evaluation of the 5AsT-MD pilot course," indicates this view. The logic implied by including weight stigma education in anti-obesity courses is that reducing health professionals' weight stigma *will make them better at eliminating obesity*.

In a handful of interventions, participants actually engaged directly in obesity elimination as part of their intervention experience. Two interventions involved exposing participants to a live bariatric surgery. As noted in Table 6 (Appendix E) third- and fourth-year medical students in Renold et al.'s "Obesity and Related Diseases" course/intervention remotely viewed a bariatric surgery in real time with the narration of the operating surgeon. This surgical viewing provides intervention participants with detailed knowledge of an obesity elimination practice, encouraging them to refer their future obese patients to bariatric surgery. The medical students in Roberts et al.'s year-long direct contact intervention got an even stronger dose of this training. These students were each paired with a bariatric surgery patient for months prior to surgery and

attended all the pre-operation appointments. After that time together, each student scrubbed into the surgery of the patient they were paired with, helping with "camera positioning, Foley catheter placement, and superficial skin closures" as well as "suture removal and lap band fills" post-surgery (2011, p. 177). As such, these students enacted obesity elimination as part of their weight stigma intervention.

Evidence of Obesity Elimination Training Efficacy

Since obesity elimination is not recognized as a source of weight stigma – and is often seen as a *positive outcome* of weight stigma interventions – many interventions measured changes in participants' comfort and confidence in performing weight loss counseling pre- and post-intervention. Kushner et al. operationalized "Confidence in Clinical Interaction with Obese Patients" by asking participants how much they agreed with the statements "I feel comfortable talking to people about their weight," "I know what meaningful questions to ask to take a body weight history," and "I know what meaningful questions to ask to help obese people manage their weight." Shortly after the intervention and at follow up one year later, over 85% of students showed more confidence in clinical interaction with obese patients, and this change was statistically significant (2014, p. 5). Luig et al. reported a similar result using a custom measurement scale: after their intervention, participants reported feeling more confident "advising patients on available treatment options for obesity" and "referring patients with obesity to the appropriate healthcare provider for care," among other items (2020, p. 5). The 24 first-year medical students in Nestorowicz and Saks' medical humanities-inspired intervention increased their agreement with the statement, "I feel comfortable counseling overweight or obese patients about their weight," and the authors present this increase as a positive finding (2021, p. 1120).

Discussion

In this chapter, I put forth a new concept to capture the harmful effects of weight stigma interventions with health professionals. Afflictive power is the capacity to define a way of being as a source of harm and suffering. Through my analysis of this research, I show that weight stigma interventions with health professionals exercise afflictive power in two ways: by enacting affliction and by representing affliction. When researchers enact affliction with health professionals by putting them in fat suits, health professionals experience discomfort, physical incapacity, and physical and social suffering, which they associate with fatness. They then, with support from the intervention researchers, extrapolate these negative experiences outwards to imagine all fat people as afflicted. When researchers exercise afflictive power by exposing health professionals to afflictive representations of fat people, health professionals create associations between fatness and a lack of physical capacity, freedom, agency, and joy. Moreover, when suffering from weight stigma is presented alongside representations of fat people suffering from their pathological bodies, stigma can become *another affliction caused by being fat*. When afflictive representations of fat people suffering from weight stigma are presented without explaining anti-fatness as a system of oppression, intervention participants receive the message that fat people suffer from physical *and social* anguish that can only be cured by *changing their bodies*. In addition to the exercise of afflictive power, I also show that weight stigma interventions often train health professionals to fight obesity and provide them tools to do so. I find that health professionals often receive instructions on how to weight loss counsel their fat patients without "shaming" them. Health professionals may also simulate weight loss counseling with standardized patients or engage directly in obesity elimination through participating in bariatric surgeries.

Thus, this chapter demonstrates that weight stigma interventions with health professionals are intensely intertwined with the anti-obesity assemblage. The exercise of afflictive power in these interventions *enables* obesity elimination by helping to transform obesity into an eliminable threat and increasing the urgency of acting on it. Afflictive representations of fat people heighten health professionals' felt sense that fat people are suffering and need medical intervention for their own good. Weight stigma, presented as an affliction caused by being fat, becomes part of the rationale for anti-obesity interventions. Weight stigma interventions also enable obesity elimination by training health professionals how to enact obesity elimination more kindly and efficiently. Numerous interventions explicitly aimed to increase health professionals' comfort with and confidence in weight loss counseling their patients. Several interventions also included health professionals directly enacting obesity elimination through weight loss counseling or helping to perform weight loss surgery. Put plainly, most weight stigma interventions with health professionals can be understood as anti-obesity training more than anything else. The time health professionals spend in these interventions enrolls them as agents of the anti-obesity assemblage. Moreover, in the interventions, they are encouraged to see obesity elimination as a more urgent and dire project that they can support and carry out. And, alarmingly, given that such education and affective interpellation occurs during what is supposed to be a session about stigma, health professionals may receive the tacit message that engaging in anti-obesity efforts is part of addressing weight stigma.

The anti-fat effects of weight stigma interventions demonstrate how advancing the goal of eliminating obesity prevents researchers from actually fighting weight stigma. My findings indicate that these goals are mutually exclusive for two reasons. First, fighting obesity prevents

intervention researchers from fighting stigma because fighting obesity necessarily entails depicting fatness negatively. The simplest way to stigmatize a way of being is by associating it with negative qualities. Enacting and representing affliction in weight stigma interventions thus stigmatizes fat people in this basic way: it associates fatness with physical incapacity, misery, lack of agency, and joylessness. Associating fatness with these negative qualities is *stigmatizing*, not destigmatizing. But in order for researchers to teach health professionals that obesity is a problem in need of intervention, they must associate fatness with harmful outcomes.

Moreover, enacting affliction in weight stigma interventions with health professionals does not just *associate* fatness with suffering, it makes fatness *the source of* that suffering. When researchers do not make clear that *anti-fatness* – a system of oppression – produces fat people's suffering, that suffering appears as if it caused by fatness. In other words, exercising afflictive power actually sediments a *causal link* between fatness and suffering – including social suffering from weight stigma itself. In so doing, this sedimentation erases the possibility of *addressing stigma alone,* since it posits that fat people experience stigma *as a result of being fat*, rather than because of a system of oppression. Thus, the exercise of afflictive power in weight stigma interventions interferes with fighting stigma by making stigma seem like something that cannot be addressed without fighting obesity, which, as I have just outlined, is itself stigmatizing.

Second, fighting obesity prevents fighting stigma by simply deprioritizing destigmatization as a goal. Weight stigma interventions are often short, lasting an hour or two. Devoting even some of this time to talking about how to fight obesity means that less of this limited time is dedicated to combatting the devaluation of fat people. Destigmatizing a way of being necessarily involves associating it with positive qualities, not negative ones. However, weight stigma interventions do not and cannot contain even *neutral*, much less positive,

depictions of fat people because such depictions would impart the message that fat people are fine and can be left alone to live their lives. Trying to fight obesity and stigma simultaneously virtually ensures that health professionals will never be exposed to positive messages about fat people as part of weight stigma interventions, as the absence of positive depictions in my corpus makes clear. Even vaguely supportive messages such as Brownell's "they're every bit as talented" line from *Weight of the Nation* inspire *pity*, not genuinely positive sentiment, especially when such messages are juxtaposed with afflictive claims. Fighting obesity leads not only to negative messages about fat people, but an absence of positive messages as well.

Trying to fight obesity and weight stigma simultaneously leads not only to an absence of positive representations, but to an absence of any political mobilization. None of the interventions in my corpus discussed the underlying causes of anti-fatness. None of them discussed social or political solutions to weight stigma. In fact, most of the examples of stigma depicted were interpersonal. At best, health professionals received the message that many people are mean to fat people and that they should not openly mock a patient. Most likely they learned that their job is to be kinder when they engage in obesity elimination with their fat patients. And at worst, they learned that fighting obesity *is fighting weight stigma*, a point I will explore further in the next chapter. They did not learn that fat people are oppressed by efforts to eliminate obesity. They did not learn that their standards of practice likely harm fat people (Bombak et al., 2022; Brownstone et al., 2021; O'Hara & Taylor, 2018; D. Watson et al., 2021). They generally learn about anti-fatness only to the extent that it assists with the goal of obesity elimination.

In the introduction to this chapter, I argued that even fat positive critiques of weight stigma interventions could not explain why framing fatness as a medical problem interfered with stigma reduction efforts. The concept of afflictive power provides a new theoretical framework

for explaining how elimination efforts are stigmatizing. In contrast to previous Foucauldian explanations of power that center on the stigma of failing to discipline oneself appropriately (e.g., through weight loss) and support the state's biopolitical aims, afflictive power draws attention to the stigmatizing effects of associating a way of being with negative qualities. Afflictive messages are not dependent on the presence of any particular disciplinary mechanism or biopolitical logic. Rather, they work in concert with such phenomena. As such, afflictive power helps to explain why portraying obesity as a dangerous disease and fat people as (a source of) suffering hinders efforts to reduce weight stigma, regardless of who is considered responsible for fatness or what, specifically, should be done about it. Eliminationist assemblages, including the anti-obesity assemblage, are stigmatizing because working to eliminate a way of being involves portraying it negatively and encouraging actors to invest in elimination efforts by internalizing and reproducing those negative messages. Research that is part of an eliminationist assemblage can never destigmatize the way of being targeted for elimination.

In this chapter, I have discussed afflictive power as it is exercised by weight stigma researchers over health professionals. However, medical and public health actors are often those exercising afflictive power. By virtue of their missions – healing the sick, containing disease, "improving" populations, etc. – medicine and public health must draw lines between desirable and undesirable states, behaviors, and ways of being. This project necessarily involves making afflictive claims. In fact, health professionals as a group are likely exposed to more afflictive claims than those in other occupations because health education involves learning about the near-infinite ways humans can be afflicted. Similarly, patients are subject to the exercise of afflictive power by their providers when they learn about the harms of various illnesses and diagnoses. However, medicine and public health are not the only institutions that make or circulate afflictive

claims, nor does one have to be a professional in such fields to exercise afflictive power. For instance, news media is a frequent source of afflictive claims, and journalists exercise afflictive power over their audiences (see Briggs & Hallin, 2016 for more on the relationship between medicine and media in health news). Fat studies scholars have also documented how fat people are subject to the exercise of afflictive power online through the practice of "concern trolling," wherein a "troll" (or cyberbully) harasses a fat person through bad faith exhortations about caring for their "health" (Payne et al., 2024).

The range of contexts outside of medicine and public health where the concept of afflictive power may be analytically useful is yet to be determined. Charting the precise terrain of such inquiries is beyond the scope of this chapter and this dissertation. However, given that afflictive power refers to a phenomenon that some scholars (e.g., Lemke, 2011) have treated as part of biopolitics, it is likely that afflictive power is relevant to other sites of biopolitics.

Conclusion

The goal of this dissertation is to illuminate how fighting obesity (obesity elimination efforts) structures anti-fatness. My first chapter provided a conceptual model for this phenomenon, the anti-obesity assemblage. My second chapter showed how weight stigma research is intertwined with the anti-obesity assemblage; I demonstrated not only the anti-obesity focus of the bulk of this research but also how the goal of obesity elimination has led to research that focuses on specific parts of stigma over others. The present chapter also demonstrated how weight stigma intervention research participates in the anti-obesity assemblage. During weight stigma interventions, health professionals are explicitly taught how to engage in "kinder" obesity elimination and are provided with afflictive narratives about fat people's miserable lives to heighten the urgency of such elimination efforts. From these findings, I argued that the capacity

of weight stigma researchers to meaningfully fight stigma is constrained by being part of the anti-obesity assemblage. Obesity elimination efforts are stigmatizing, so prioritizing obesity elimination in anti-stigma efforts not only undermines those efforts but may actually *increase* stigma rather than decreasing it.

The question that remains after these inquiries is: how do weight stigma researchers and advocates reconcile these two contradictory projects? What rhetorical or discursive techniques do they employ to portray fighting obesity and fighting stigma as compatible goals? This chapter has hinted at one way this contradiction is elided: the interventions that increased health professionals' comfort and confidence with weight loss counseling often framed these results as positive, indicating that researchers may see an increased investment in obesity elimination as evidence of reduced stigma. The next chapter takes up these questions. Through an analysis of media supported by pharmaceutical company Novo Nordisk, I analyze an intensification of this intervention logic and show how weight stigma advocates are portraying fighting obesity and fighting weight stigma as synonymous projects.

Chapter 4
Selling Stigma to Sell the Cure:
Novo Nordisk's Weight Stigma Media Network

At the beginning of this dissertation, I introduced the concept of the anti-obesity assemblage: a material-discursive structure constituted by all the people, things, and ideas that enable and enact obesity elimination. In Chapter 1, I argued that the anti-obesity assemblage structures fat oppression. As such, I hypothesized that participating in, or expanding, the anti-obesity assemblage was incompatible with reducing weight stigma (defined as the sociocultural devaluation of fatness and, by extension, fat people). In Chapters 2 and 3, I demonstrated how weight stigma research is entangled with the anti-obesity assemblage: almost two-thirds of weight stigma research enables obesity elimination, and many weight stigma interventions focus on training health professionals how to enact obesity elimination. I also showed that this entanglement with the anti-obesity assemblage restricts weight stigma research's ability to meaningfully address stigma. Weight stigma research focuses disproportionately on topics and populations that aid in obesity elimination over exploring the sociocultural roots of stigma. Weight stigma interventions, in their effort to convince health professionals that obesity is an urgent medical problem, portray fat people as deeply afflicted.

As previously mentioned, fat positive scholars have struggled to make sense of the entanglement between weight stigma advocacy and anti-obesity efforts. The findings I outlined above are evidence of how deeply incompatible the projects of fighting obesity and fighting weight stigma are. Given this blatant incompatibility, it is understandable that fat studies scholars have struggled to make sense of how weight stigma researchers and advocates could undertake these two projects without recognizing their conflicting aims. For example, Gingras and Stranz (2023) accuse *Obesity Canada* advocates of engaging in "magical thinking" when they assert

that it is possible to fight obesity and weight stigma at the same time, rather than attempting to make sense of the underlying logic of those advocates' views. Similarly, in Calogero et al.'s critique of weight stigma research, they describe this contradiction as "difficult to understand" (2016, p. 14). Now that I have provided evidence of the stigmatizing effects of participating in the anti-obesity assemblage, I am left with a similar question: how do weight stigma researchers and advocates portray fighting obesity and fighting stigma as compatible goals? How do they reconcile the anti-fat consequences of their actions with their ostensible goal of reducing stigma?

In recent years, pharmaceutical company Novo Nordisk has been using its resources to bring weight stigma into the spotlight. As of 2024, this pharmaceutical giant is Europe's most valuable company, with a market value in excess of $555 billion (Nelson, 2023; Nelson & Fuente, 2024). This value has derived primarily from the company's two GLP-1 agonist semaglutide drugs: Ozempic, a lower dose diabetes treatment, and Wegovy, a higher dose that is one of the only drugs in the US that has been FDA-approved specifically to treat obesity (US Food and Drug Administration, 2021).[20] As part of their effort to sell these drugs, Novo Nordisk has spent millions building a network of agents who produce content about obesity, weight stigma, and weight loss treatments. In contrast to previous models of pharmaceutical advertising that focus on direct-to-consumer marketing (i.e., print and television ads), Novo Nordisk has adopted a fundamentally neoliberal, flexible, and networked approach to raising awareness about obesity and its new treatments (Bombak, 2023; Willis & Delbaere, 2022). Despite pausing all advertising for Wegovy in 2023, when demand for the drug well-outstripped supply, Novo Nordisk has funded numerous unbranded advertising campaigns, faux-grassroots patient advocacy organizations, celebrities, social media influencers, and celebrity-influencer-doctors to

[20] Although these two drugs are distinct and target different conditions, in popular discourse, "Ozempic" has come to refer to Ozempic, Wegovy, and all the other GLP-1 agonist drugs.

speak and generate cultural products about obesity and weight stigma. In other words, Novo Nordisk has injected a huge amount of capital into the anti-obesity assemblage through concern for both obesity and weight stigma, yielding countless new elements, actors, and linkages within the assemblage.

Novo Nordisk's weight-stigma related media does not disguise the company's capitalist goal to sell as much product as possible for profit. Indeed, such obfuscation would be impossible given the current popularity of the company and its drugs; a Wegovy commercial was the third most viewed television ad in the US during June 2024 (Gil, 2024). As such, analyzing this media provides an opportunity to bracket the critique that capital always pursues its own ends and instead look at processes of meaning-making and its consequences within this network. By bracketing the critique of capitalist corruption, I do not mean to imply that Novo Nordisk is refraining from downplaying side effects, skirting regulation, and engaging in other unethical practices that pharmaceutical companies do to maximize profits (Brody & Light, 2011). Rather, attending to that dimension of this network is a separate endeavor from looking at how fighting weight stigma is portrayed as compatible with fighting obesity. Critiques of corruption are fundamentally oriented towards showing how the pharmaceutical industry undermines *health* and overburdens the healthcare system with unnecessary costs (Dumit, 2012). I am interested in how the pharmaceutical industry is undermining fat liberation and upholding fat oppression.

Additionally, Novo Nordisk's weight-stigma related media does not disguise its anti-obesity orientation. As such, these media – and the actors who produce them – provide a valuable opportunity for analyzing how weight stigma researchers and advocates portray fighting obesity and fighting stigma as compatible projects. Given its explicit anti-obesity orientation, this media allows a glimpse into the anti-obesity assemblage itself. Specifically, studying Novo

Nordisk's media and its network reveals the impact of the anti-obesity assemblage on weight stigma advocacy.

In this chapter, I show how Novo Nordisk's media network intertwines weight stigma advocacy within the anti-obesity assemblage by producing a novel *regime of signification*. Within this regime of signification, the goal of addressing weight stigma is subsumed to the goal of obesity elimination; fighting obesity is cast as the *solution* to weight stigma. Novo Nordisk's media network makes these goals compatible by narrowing the concept of weight stigma, reducing it to a matter of blame, shame, and the belief that weight is individually controllable. In so doing, this regime of signification is temporarily stabilized by producing a break between the devaluation of fat people as a problem and the devaluation of fatness as a problem. Anti-obesity efforts become defined as the solution to the devaluation of fat people, even as they maintain the devaluation of fatness.

This chapter begins with an exploration of how Deleuze and Guattari conceptualize regimes of signs within assemblages and what kinds of analytic techniques align with this conceptualization. Next, I apply assemblage theory to trace the network Novo Nordisk has helped to assemble by acting as a *persona*, an "imminent agent" that "arrange[s]" the elements of the anti-obesity assemblage (Nail, 2017, p. 27). After making visible the actors, institutions, and organizations that comprise this section of the anti-obesity assemblage, I turn my attention to the regime of signification that has emerged through their participation in the AOA. Analyzing audiovisual media from these agents reveals that the concept of weight stigma itself, the sources and harms of stigma, the proposed solutions to stigma, the disease of obesity, and the fat body itself have all been resignified to better support obesity elimination. The chapter ends with a

discussion of the implications of this case for the theory of eliminationist assemblages and for fat studies scholarship.

Methodology: Analyzing a Regime of Signification

This chapter analyzes how the anti-obesity assemblage is transforming weight stigma advocacy through resources provided by pharmaceutical company Novo Nordisk. Specifically, I am examining a transformation in *meaning*, or what Deleuze and Guattari call the "assemblage of enunciation." In *A Thousand Plateaus*, Deleuze and Guattari outline the two axes of every assemblage: the horizontal axis, which consists of two segments (a machinic assemblage and an assemblage of enunciation), and the vertical axis (its territoriality and lines of deterritorialization) (1987, p. 88). I take up the vertical axis of the anti-obesity assemblage – its lines of deterritorialization, the processes of change within an assemblage – in the Conclusion of this dissertation. This chapter focuses instead on the horizontal axis, the machinic assemblage and the assemblage of enunciation, with a specific focus on the latter.

Within each assemblage of enunciation is what Deleuze and Guattari call a "regime of signs," a "machine of expression whose variables determine the usage of language elements" (1987, p. 90). A regime of signs is not reducible to the idea of language or ideology, but rather draws attention to the ways in which signs "express organizations of power" (1987, p. 68). Although Deleuze and Guattari use the term "sign" in a way that appears to reference traditional semiotics, they trouble the proposed arbitrary relationship between signifier and signified first put forth by Levi-Strauss and later taken up by Foucault to emphasize the power of discourse. Instead, drawing on Peirce and Hjelmslev's multi-partite models of the sign, they put forth the terms "forms of expression," which they use as another term for a regime of signs, and "forms of content." A "form of expression" is "a set of statements arising in the social field considered as a

stratum" while a form of content is "a complex state of things as a formation of power" (1987, p. 66). Each of these forms is "highly relative, always in a state of reciprocal presupposition" (1987, p. 66). Thus, determining the relationships between them – how they are "formalized" from their "state of unstable equilibrium" – requires not only an investigation of the forms themselves but also the "whole organization articulating formations of power and regimes of signs," the assemblage through and within which they enunciate and are enunciated (1987, p. 67). The form of content and form of expression are each material-discursive and each immanently determined by one another within an assemblage. My analysis investigates how weight stigma media sponsored by Novo Nordisk *temporarily formalizes* the forms of content and expression within the anti-obesity assemblage.

Assemblage Construction

Since I was trying to trace the numerous connections engendered in the anti-obesity assemblage by the influx of capital and actors from Novo Nordisk, I engaged in unconventional methods while collecting the material for this analysis. During the early stages of this dissertation project near the beginning of 2022, I began routinely searching recent uses of the phrases "weight stigma" and "weight bias" as well as the hashtags #weightstigma and #weightbias on Twitter (now renamed "X") to see who was using these phrases and for what purpose (Airoldi, 2018). I was especially interested in users who combined these phrases and hashtags with content that I evaluated as enabling obesity elimination. This included tweets that discussed weight stigma as a barrier to weight loss counseling in clinical care, framed weight stigma as a source of obesity, and that advocated for education on obesity as a disease to reduce weight stigma. It also included tweets by prominent anti-obesity figures, such as those involved in national anti-obesity public health efforts. From these searches, I began to develop a sense for

the social network of anti-obesity weight stigma advocates, the organizations they worked for, and the causes they were championing. I also began to see the common signifying frames they employed to reconcile fighting weight stigma and fighting obesity.

Simultaneously, I maintained my presence within online fat activist spaces and networks (Payne et al., 2024). Activists in these networks began to amplify anti-fat media about weight stigma by criticizing it. Between January 2022 and September 2023, I collected all the media I came across that was explicitly sponsored by Novo Nordisk or involved one of the actors I had identified as holding a prominent place within the anti-obesity weight stigma social media network funded by Novo Nordisk. I also used journalistic coverage of weight stigma and Novo Nordisk to help me find additional sponsored media. Finally, I found some media through pharmaceutical marketing coverage (Fierce Pharma, Endpoints News, and Medical Marketing and Media) of Novo Nordisk's weight stigma-themed marketing campaign *It's Bigger Than Me*. In spite of these efforts, however, I do not claim to have performed a systematic search for media directly and indirectly funded by Novo Nordisk, as such a search is not possible. Moreover, this media represents a snapshot of one period of time within the ever-changing anti-obesity assemblage. As Deleuze and Guattari encourage, I could only account for the signs that were temporarily formalized during the period of my analysis and through my examination.

Inclusion and Exclusion Criteria

In order to trace how Novo Nordisk's presence as a persona in the anti-obesity assemblage was leading to a resignification of weight stigma, I traced the linkages Novo Nordisk generated through their funding. I focused on weight stigma advocacy because this advocacy is public-facing and meant to reach a broad audience, thus expanding the regime of signification to consumers, prescribers, and policy-makers, among others. From this focus, I examined media

that was created directly by Novo Nordisk, explicitly sponsored by Novo Nordisk, or created by organizations that have explicitly received funding from Novo Nordisk, such as the Obesity Action Coalition. I selected media that mentioned weight stigma or weight bias as well as media that addressed the mistreatment of fat people and responses to it more generally, such as anything about body positivity, discrimination, or empathy. Additionally, I elected to primarily focus on audiovisual media, rather than written media or social media posts, because media in this genre is often intended to circulate through online spaces and social media networks to distribute the more official narrative of the content creator (Newport, 2022).

Although I identified as many linkages as possible, I could not account for all the places this media circulated. Additionally, I excluded journalistic coverage of weight stigma, despite the explosion in writing on this theme, as there is no way to determine how much this coverage was spurred by an explicit link to Novo Nordisk. I also excluded academic research, as the resignification of meaning within research occurs via different mechanisms than those in advocacy, but I did include media that covered such publications for a broader audience.

Novo Nordisk's Media Network

By tracing the linkages produced by Novo Nordisk's role as a persona in the anti-obesity assemblage, I identified a network of media and actors linked through the resignification of weight stigma within the AOA. Novo Nordisk's weight stigma-related media network consists of three of their own websites with corresponding initiatives and educational materials, seven major organizations that have received funding from Novo Nordisk to produce weight stigma-themed content, and numerous thought leaders who have disclosed funding from Novo Nordisk. These thought leaders are mostly health professionals, although increasingly Novo Nordisk is targeting fat or body positive activists to platform their messaging. However, I only identified one such

activist who has begun to produce independent content about weight stigma with Novo Nordisk sponsorship; to date, most activists have either appeared in Novo Nordisk sponsored videos or reposted Novo Nordisk content to their social media, so I did not classify such activists as thought leaders at this time. An abbreviated list of this network can be found below in Table 2 and a complete list can be found in Table 7, Table 8, and Table 9 (Appendix F).

From this network, I identified approximately 55 pieces of media relating to weight stigma or efforts to improve fat people's sociocultural standing. A list of my complete corpus can be found in Table 10 (Appendix G). Media from this network spanned myriad genres and included actors speaking from many different subject positions, including medical expert, celebrity advocate, patient/disease advocate, social media influencer, and activist.

Table 2: Actors in Novo Nordisk's Weight Stigma Media Network

Novo Nordisk-Owned Websites	
It's Bigger Than Me	Website and campaign designed to spread the message that obesity is a chronic and misunderstood health condition with struggles and impacts that go beyond weight.
Truth About Weight	Patient facing website with information about obesity treatment.
Rethink Obesity	Provider facing website with information about obesity treatment. "Addressing weight bias" page listed under diagnosing obesity.
Novo Nordisk-Sponsored Organizations	
Obesity Action Coalition	National nonprofit organization; core focuses are to raise awareness and improve access to the prevention and treatment of obesity, provide science-based education on obesity and its treatments, and fight to eliminate weight bias and discrimination
The Creative Coalition	A nonprofit advocacy group consisting of writers, actors, producers, directors, agents, designers and lawyers from the entertainment world

Table 2: Actors in Novo Nordisk's Weight Stigma Media Network

Novo Nordisk-Sponsored Organizations	
AMC/ Sundance TV/9.14 Pictures/ Wavemaker Global – Thick Skin Docuseries	Thick Skin follows the lives of four women in Philadelphia as they pursue professional success, face challenging relationships with their parents and search for love.
STOP Obesity Alliance	The Strategies to Overcome and Prevent STOP Obesity Alliance is made up of a diverse group of business, consumer, government, advocacy, and health organizations dedicated to reversing the obesity epidemic in the United States
Media Empathy Foundation	501c3 nonprofit organization; mission is to reduce health stigma by promoting empathy, compassion and inclusivity in all forms of media.
Vox Creative	A creative collective within Vox Media that connects brands and audiences through the things that really matter to them. They leverage the technology, insights, measurement tools and influence of our editorial networks to connect brands to a community that's 125MM strong.
The DEI Shift Podcast	Podcast series on diversity, equity, and inclusion (D.E.I.) in medicine that sparks discussion and provides practice-changing data and stories for a physician, student, allied health professional, and health care leader audience
Mediflix	"Edutainment" video streaming platform intended to help patients, families, and caregivers.
Novo Nordisk-Sponsored Thought Leaders	
Anna O'Brien	Fat/Body Positive Social Media Influencer
Fatima Cody Stanford	Obesity Medicine Specialist
Robert Kushner	Obesity Medicine Specialist
Karl Nadolsky	Obesity Medicine Specialist
Rebecca Puhl	Rudd Center weight stigma researcher
Scott Kahan	Obesity Medicine Specialist

Results: Novo Nordisk's Regime of Signification

Because I am analyzing a regime of signification within an assemblage, there is no designated "beginning" from which I should start unspooling this network of meanings for a reader. All of these meanings are connected and interdependent both discursively and materially. In this section, I have elected to begin from what might seem like the "end result" of a discourse: how obesity elimination is portrayed as the solution to weight stigma within this regime. Yet by starting from this signification within the assemblage, I can trace the network of meanings that enable it. This analysis reveals that weight stigma media within the anti-obesity assemblage is almost entirely about obesity and obesity elimination. It also shows how this regime depends on excluding the devaluation of fatness from conceptions of weight stigma.

Resignifying Solutions to Weight Stigma

In Novo Nordisk's regime of signification, expanding anti-obesity efforts and educating people about obesity become the solution to weight stigma. While this claim may sound hyperbolic, numerous actors straightforwardly make this argument in response to questions about how to combat stigma. For instance, in an *Endocrine Today* video tellingly titled "Stigma Hampers Care for People with Excess Weight and Diabetes" (2022), columnist Susan Weiner asks obesity medicine specialist Fatima Cody Stanford: "[W]hat can the diabetes care and education specialists do to reduce that [weight] stigma, … to change policy? What can we actually do that's actionable?" After comparing what she perceives as the undertreatment of obesity compared to diabetes, Stanford says: "From a policy perspective, there is one bill that we have been introducing, in both the House and Senate since 2013. And it's called TROA or the Treat and Reduce Obesity Act." TROA would expand Medicare coverage for anti-obesity treatments, such as intensive behavioral therapy, weight loss surgery, and weight loss

medications, with the hopes that private insurers will also follow suit (*Treat and Reduce Obesity Act - Obesity Action Coalition*, n.d.). By asserting that health professionals can reduce weight stigma by supporting the passage of TROA, Stanford portrays expanding access to anti-obesity treatment as the best anti-stigma strategy. This strategy elides the possibility of non-discrimination ordinances or other kinds of structural changes to affect stigma. The proper target for stigma reduction is portrayed not as stigma, but rather the stigmatized trait: obesity itself.

Two videos produced by the Obesity Action Coalition present a similar message: educating people about obesity is cast as the solution to weight stigma. In one, the OAC interviews Queen Latifah, the original spokesperson for Novo Nordisk's anti-obesity/anti-stigma campaign *It's Bigger Than Me* (IBTM). When OAC President Joe Nadglowski asks Queen Latifah what the IBTM movement is about, she responds: "[T]he movement is basically about educating people about obesity and the stigma attached to it, the shame that can be attached to it, and dispelling all of that in a creative way" (2021b). Thus, according to Novo Nordisk, obesity education will dispel stigma. A Novo Nordisk representative, Yvonne Bryant, states this explicitly in a separate interview with the OAC as part of their "Stop Weight Bias" campaign. After OAC Vice President of Marketing James Zervios states that the OAC appreciates how Novo Nordisk is working to publicly "debunk" the narrative that obesity is a matter of personal responsibility, Bryant responds:

> [W]e try to educate on the many factors [that cause obesity], so that people can understand why they're seeing or thinking what they think, and why it's not actually true. We have to give that knowledge, we have to share that information, for people to learn and to grow and begin to think differently. (2021a)

Like the previous quote, this statement frames public obesity education as the solution to weight stigma. Novo Nordisk does not advocate for portraying fat people positively or for policies that

could reduce weight stigma at the societal level. Instead, the proper target for stigma reduction is not stigma itself, but the lack of obesity knowledge.

Resignifying Causes of Weight Stigma

In line with the solutions offered for weight stigma within this regime of signification, a lack of knowledge about obesity is frequently portrayed as a key cause of weight stigma. This is most clear in discussions of weight stigma in healthcare. For instance, the Vox Creative video "How Weight Stigma in the Doctor's Office Harms Patients" opens by declaring:

> In 2021, a survey found that 43% of Americans felt stigmatized when they went to the doctor. Why? Their weight. Despite the fact that the American Medical Association, Centers for Disease Control, and the World Health Organization recognized obesity as a chronic disease, most healthcare providers don't receive training in how to treat patients with obesity. (2022)

Shortly after this opening, the video repeats this point using evidence from a review of medical school curricula, which found that medical schools "dedicate an average of only 10 hours to obesity education" (2022). During an OAC presentation on weight bias for Obesity Care Week 2022, researcher Rebecca Puhl makes a nearly identical point:

> It's important to acknowledge that medical training on topics of obesity and nutrition are often inadequate and issues of weight bias are rarely if ever being included in medical school curriculum. So that can also contribute to one of the reasons why healthcare is a setting where weight bias is present. (2022)

These examples both assert that weight stigma in healthcare is caused by a lack of sufficient training in obesity. The problem of stigma is reduced to a problem of insufficient knowledge about obesity itself. However, as I demonstrated in the last chapter, afflictive claims about obesity as a health problem are *stigmatizing*. Given the stigmatizing consequences of afflictive claims, a more appropriate anti-stigma strategy would be drawing attention to *medicine as a source of weight stigma.*

Other Novo Nordisk-funded actors have claimed that the public's lack of knowledge about obesity is the source of weight stigma. These claims also often lean on some undefined idea of "society" or "culture" as the barrier to this knowledge. In a podcast episode titled "How to Challenge Obesity Bias and Stigma in Healthcare," obesity doctor Robert Kushner asks OAC President Joe Nadglowski: "What contributes to weight bias in our society?" Nadglowski responds that we live in a "weight-obsessed culture," explaining, "A lot of that [bias] has to do with this lack of education around what actually controls your body size or what controls the disease of obesity" (2023). Obesity medicine specialist Deborah Horn makes a nearly identical statement in the *IBTM* video "Feeling Like a Failure: The Journey of Living with Obesity." Following celebrity host Yvette Nicole Brown's incredulous statement that: "there is no other disease I can think of where people just expect you to fix it yourself, just like bootstrap your way out of being 400 pounds." Horn says: "Until we can change how our culture and our society views obesity, we're going to continue to struggle to give people the real help they desperately need and deserve" (2023c). In both of these quotes, a key source of our "weight-obsessed culture" is society's lack of understanding of the nature of obesity. In this framing, obesity education becomes a necessary solution to weight stigma; medical knowledge *about obesity* is cast as a technical fix for irrational societal prejudice.

Resignifying Fatness

In Novo Nordisk's regime of signification, fatness is reduced solely to the "complex disease" of obesity. For instance, in the *IBTM* video quoted above, Deborah Horn shares that she tells her patients:

> Listen, it can still be hard to remember and accept that obesity is a disease, even when you know it's true, because we've been replaying an inaccurate talk track for so long. Obesity is not a moral failing. It's not a lack of responsibility or motivation or dedication or willpower. It's a complex, multisystem, biologically

> driven disease. There are genetic, emotional, and environmental factors that contribute to obesity. (2023c)

Here, we see a dichotomy drawn between the conception of fatness as the complex disease of obesity, and the conception of fatness as a moral failing due to a lack of responsibility or willpower. The word "complex" refers to the many different factors that are portrayed as contributing to obesity. Though Horn portrays fatness as having many causes, none of them are a lack of moral fortitude or motivation to change. As this quote indicates, this regime of signification depends on the "fact" that the state of being fat *is* the "complex disease of obesity." Thinking of fatness as *anything other than* the complex disease of obesity is framed as the source of weight stigma. Accordingly, spreading the message that obesity is a complex disease, including discussing its many causes, is portrayed as the way to reduce stigma. The idea "Obesity is a complex disease" is the knowledge about obesity that the public is portrayed as lacking. Given the interdependence of these signs, fatness can have no other meaning within the regime. This excludes the possibility of revaluing fatness as a way to reduce stigma.

This equation of obesity knowledge and stigma reduction is made stark in a Public Service Announcement (PSA) produced as part of the Creative Coalition's project "Destigmatizing Obesity Through the Arts." "If You Told Me..." is a celebrity-packed, 60 second video with the message that "we" treat people with obesity in ways that we would never treat people living with a "real" disease, such as epilepsy, because we hold the stigmatizing belief that obesity is not a real disease (2021). Based on this premise, the celebrities in the PSA work to "destigmatize obesity" by using their social capital to convince the audience that obesity *is* a real, dangerous disease:

> Steven Weber: Obesity is a medical condition
>
> BokHee An: A disease

S. Epatha Merkerson: Obesity is treatable

Boris Kodjoe: It's treatable

Then, after another comparison to other illnesses that "you would get help for," they continue:

Nicholas Gonzalez: You can get help for obesity

Boris Kodjoe: Because obesity is a disease

All: We're all in this together

At the end of the video, the screen displays the afflictive claim that "Obesity is linked to 60+ other health conditions including severe illness from COVID-19." This PSA highlights the centrality of the conception of obesity as a disease to this regime of signification. "Obesity is a disease" becomes a mantra that the actors repeat as part of this resignification. In this PSA, defining obesity as a disease means that it is treatable, that it is not a matter of personal discipline, and that it is dangerous. These messages are only intelligible as *destigmatizing claims* in the context of this regime of signification, where educating people about obesity is cast as the solution to weight stigma.

Just as calling obesity a disease becomes defined as destigmatizing within this regime of signification, using the phrase "person with obesity" to refer to a fat person becomes cast as destigmatizing. Obesity physician Fatima Cody Stanford makes this point in an episode of "The DEI Shift" podcast titled "Defining Obesity, Challenging Weight Bias," which appeared as part of the podcast's "Obesity Management Mini-Series" (sponsored by the American College of Physicians with a grant from Novo Nordisk). After the podcast host asks Dr. Stanford where she sees weight bias in her advocacy work with health professionals, Stanford responds:

> I really want to start first with looking at just the language we use when we're talking about patients that have this disease of obesity…Instead of calling a patient "obese," I want you, as you're listening to this, to just delete the word

> "obese" from your vocabulary. "Obese" is a label and "obesity" is a disease. (Walimbe & Parker, 2021)

In this response, Stanford indicates that one of the most harmful things a health professional could do is use the wrong language to refer to their patients. Stanford draws a distinction between the disease of obesity and the "label" of obese, implying that obesity is not a label, but simply an objective category, something a person might "have." In this vein, the phrase "person with obesity," referred to as "person first language," is continuously contrasted with the stigmatizing alternative of "obese person" or simply "the obese." In the above quote, the medical connotations and origin of the term "obese" are erased, allowing Stanford to effectively distinguish between the bad, pejorative, "non-medical" conception of fat people and the (seemingly almost identical) good, destigmatizing, medical conception of fat people. Within this regime, obesity is a disease, and referring to obesity as a disease is destigmatizing, and therefore referring to fat people using the term obesity must also destigmatizing. The possibility of referring to fat people in other ways is thereby rendered stigmatizing.

Resignifying Weight Stigma

In this regime of signification, the concept of weight stigma is almost always reduced to shame, blame, and the belief that weight is individually controllable. Patty Nece, former chairperson of the OAC, titled her profile on the Stop Weight Bias website "No one should ever be shamed or blamed for their body or their weight." In it, she outlines her perspective on how misperceptions about obesity controllability drive weight stigma:

> For my entire life, I've been a target of ridicule simply because of my weight. People rarely take time to look beyond my weight to see, well, me…And whose fault was that? Well, mine, of course, because I was unable to control my weight. I deserved to be considered "less than" slimmer folks. At least that's what people told me; medical professionals, school personnel, advertisements, entertainment, every type of media in the world, and even family members. And I believed them.

> Weight bias taught me that I should be ashamed of my weight…and myself. (2021a)

Here, Nece talks about her own experience of ridicule and prejudice. She describes being seen as "less than" others due to being fat. Yet she emphasizes that the foundation of the discrimination and prejudice she has faced is *not* her social devaluation, but instead, the belief that she could and should control her weight. From her perspective, people blamed her for her fatness *because* they believed she could control her weight, and therefore saw mistreating her as what she "deserved." Within this nexus of meanings, weight stigma becomes defined primarily as the circuit between the behaviors of shaming and blaming, the affective responses of shame and blame, and the cognitive belief that weight is individually controllable. As such, the societal devaluation of fatness as a way of being itself effectively drops out of weight stigma. In this conception, negative societal associations with fat are, at most, an *effect* of the link between shame, blame, and controllability beliefs. What truly matters is not stigmatizing behaviors themselves, but the beliefs *behind* those behaviors.

Nece's narrative highlights how the entire regime of signification I have been tracing here depends on resignifying weight stigma as a matter of shame, blame, and controllability. After several more paragraphs describing how terrible her life has been, Nece's narrative culminates in her finding salvation through "the right medical professionals who helped me learn about managing weight" (2021a). She describes the lessons she learned from these medical professionals, including "learning more about how our bodies regulate weight and fight against weight-loss." She also discusses "working to reduce weight bias" she had internalized, by learning the correct answer to the question, "Was I really a failure just because I had not yet successfully managed my weight? Of course not." These passages reveal why defining weight stigma through shame/blame/controllability is so crucial: this resignification narrows the

problem of weight stigma such that obesity treatment and education become legible solutions. As described in the narrative quoted above, Nece is able to shed her internalized shame and blame, and even become an advocate against weight bias, *because* she is taught by medical professionals that weight is not controllable. If the heart of weight stigma is portrayed as the belief that weight is controllable, then medical knowledge, especially knowledge about obesity as a "complex disease" that is not controllable by individuals, becomes the antidote to weight stigma. The claims that weight stigma is caused by a lack of education about obesity and that weight stigma will be solved through obesity education and expanding access to obesity treatment are made sensible by excluding the devaluation of fat people from the definition of weight stigma and reducing stigma to a matter of blame, shame, and controllability beliefs.

The semiotic dominance of this conception of weight stigma is visible even when weight stigma is defined in other terms. As part of The Media Empathy Foundation's campaign to raise awareness of weight stigma in the media, Rebecca Puhl gave a 10-minute presentation about weight stigma and its harms. She began the presentation with a definition of weight stigma that appeared to account for the devaluation of fatness but quickly pivoted back to blame/shame/controllability:

> Let me first begin by defining weight stigma, which broadly refers to societal devaluation of people because of their higher weight or larger body size. And at the foundation of weight stigma are strongly ingrained stereotypes that people who have a higher weight or larger body are lazy, lacking in willpower and discipline, unmotivated to improve their health, sloppy, unsuccessful, and personally to blame for their weight. (2022)

Here, despite starting with a definition that includes stereotyping and the societal devaluation of fat people (but not fatness itself), Puhl still ultimately attributes weight stigma to some source *behind* these actions. The content of the stereotypes that she describes depends on blame/shame/controllability as the real "foundation of weight stigma." When she focuses on

stereotypes of fat people as "lazy," "lacking in willpower and discipline," "unmotivated to improve their health," and "personally to blame for their weight," we see the same dodge away from devaluation as in Nece's narrative. Puhl's definition of weight stigma excludes the devaluation of fatness itself, and through her focus on these stereotypes, she portrays the belief that weight is controllable as weight stigma's "foundation."

Conceptualizing weight stigma as blame and shame also allows actors within this regime to portray resistance to medically-guided weight loss as itself stigmatizing. For instance, in a video from the *It's Bigger Than Me* campaign titled, "My Body Isn't My Identity," Novo Nordisk celebrity spokesperson Yvette Nicole Brown asserts that there has been a "pendulum swing" in recent years, "where you can now get shamed for gaining weight as well as for wanting to lose weight." Fat social media influencer Katie Sturino reemphasizes this idea later in the video:

> Sturino: I've heard some people say that they sometimes feel betrayed when they see their heroes losing weight. But with that said, I believe this feeling of betrayal leans a little into reverse body shaming territory and it's actually quite harmful.
>
> Brown: Yeah, because this reaction can really discourage someone from doing something that could be beneficial to their health. I mean, if losing weight can help them improve their health, why would you shame them for that? (2023a)

In this dialogue, an unidentified group of people hypothetically expressing negative feelings about prominent individuals losing weight is described as harmful, irrational "reverse body shaming." The rhetoric is enabled by the narrowing of stigma into shame within this regime of signification. By detaching the devaluation of fatness from the problem of stigma, the concept of shame elides structural anti-fatness and allows the Novo Nordisk media network to flatten the power imbalance involved in decisions to lose weight.

Ultimately, the focus on shame within this regime of signification individualizes the issue of weight loss, taking it out of the context of the anti-obesity assemblage. This is made clear in another video from the same series titled "Defending Your Right to Lose Weight." In this video, Dr. Tiffany Lowe-Clayton equates a hypothetical resistance to weight loss with weight stigma: "Doctors have so many more tools at their disposal now, so we should never let anybody rob us of the benefits of that life by stigmatizing our desire to lose weight when necessary to improve our health" (2023b). Reducing stigma to shame in this regime of signification allows Lowe-Clayton to portray "stigmatizing a desire to lose weight" as part and parcel of fat people's mass stigmatization because the potential for someone to disapprove of weight loss could make a "person with obesity" feel bad, just like other stigmatizing encounters that inspire shame. The idea that individuals may feel shame due to someone questioning any part of individual anti-obesity efforts precludes any kind of structural fat positive critique. Fat activist resistance to weight loss is portrayed as harmful, unjust, and irrational.

Within this regime of signification, one of the most important consequences of weight stigma is depicted as its negative effects on anti-obesity efforts. This message appears numerous times throughout the Novo Nordisk media. For example, in a video put out by the OAC as part of the Stop Weight Bias campaign, OAC member Nikki bluntly laments:

> [T]he problem with weight bias is that it's not doing anything to improve the obesity epidemic. It's not motivating people to lose weight; it's not putting people in a position where they have any help to meaningfully change. (2021b)

Similarly, introducing a video put out by the STOP Obesity Alliance, "A Day in the Life of a Patient with Obesity," Bill Dietz says, "[W]eight stigma in healthcare settings is of a particular concern, because it can be a significant barrier to [obesity] care for patients with obesity" (2017).

Fatima Cody Stanford also lays this relationship out most explicitly after being asked "What is the relationship between weight stigma and an individual's body weight?":

> [W]e see a direct correlation with those that have a higher body weight experiencing more weight stigma and bias. This is really problematic because you can imagine that many of those individuals are those that need care. And if they feel particularly stigma within the healthcare setting, which is often what they're experiencing, they're going to be less likely to seek care, they're going to avoid us as health care providers, physicians, etc. And by the time we often end up in care for their obesity and obesity related diseases, it's so far along and advanced that we really have a really uphill battle. (2022)

In these videos, the "problem" with weight stigma is reduced to its impact on efforts to fight obesity. Specifically, delaying anti-obesity treatment is portrayed as the most important effect of weight stigma – this is what is "really problematic" and "of particular concern." Within this regime of signification, weight stigma is portrayed as important because it dissuades people from seeking out medical interventions for obesity. As I discussed in Chapter 2, this idea is also prevalent within weight stigma research, but here we see how this idea aligns with all the other components of this regime of signification.

Weight stigma is sometimes portrayed as a treatable complication of obesity within this regime of signification. In fact, one actor in this regime makes this claim explicitly. In a video interview titled "Address Weight Bias as a Complication of Obesity," Dr. Karl Nadolsky states:

> Patient internalized weight bias is not only a complication of obesity… but it's also a contributor, a driver, an exacerbating factor of that… [W]e really need to focus on the patient's internalized weight bias. When they take that bias and stigma and they devalue themselves, that's a complication of weight. (2023)

Through the concept of "internalized weight bias" Nadolsky portrays weight stigma as a complication of obesity. He asserts that a person with obesity who "devalue[s] themselves" is experiencing a medical complication of their disease. This has two important implications. First, the term complication defines weight stigma as a *negative effect of obesity itself*. Internalized

weight stigma is cast not as an effect of societal stigma but instead as an effect of *obesity* that manifests within the context of societal stigma. I initially discussed the portrayal of weight stigma as a harmful effect of obesity in Chapter 2, and then in Chapter 3 I developed the term afflictive power to analyze such portrayals in weight stigma interventions. Here, we see how the concept of "internalized weight bias" individualizes and decontextualizes anti-fatness in order to recenter obesity as the key problem. Through an afflictive claim about fat people suffering from weight stigma *as a result of their obesity*, Nadolsky makes stigma a problem associated with obesity rather than society.

The second important implication of framing weight stigma as a complication of obesity is that *obesity treatment can be portrayed as a solution to weight stigma*. Nadolsky compares weight stigma to other complications of obesity, stating, "We know that interventions to help with 'weight loss' actually improve those [complications]." Though he asserts that "we don't know" if weight loss reduces internalized weight bias "yet," he suggests that "we think that could be [true]" (2023). Thus, within this regime of signification, defining weight stigma as a complication of obesity is another way that obesity treatment becomes cast as the solution to the societal prejudice and discrimination that fat people face.

Weight stigma can even become a justification for more intensive and risky obesity treatment. In the video quoted above, Nadolsky was being interviewed about the idea of weight stigma as a complication of obesity because he was the chair of a committee of the American Association of Clinical Endocrinology (AACE) that developed a new classification of obesity severity based on this idea (2023). This classification focuses on the presence of complications to determine the severity, or "stage," of obesity.[21] The presence of one or more "mild to moderate"

[21] The AACE is working to rename obesity to "Adiposity-Based Chronic Disease" or ABCD. However, they still use the term obesity as well.

complications of obesity justify categorizing a patient with "Stage 2" disease, while the presence of at least one "severe" complication warrants categorizing a patient with "Stage 3" disease. Yet because weight stigma is considered a complication of obesity in this classification, even if there are *no other complications*, a patient with "internalized weight bias and stigmatization" that has "adverse effects on quality of life" or "could potentially impair the… treatment plan" *would still be classified as Stage 2*. Similarly, even if there are no other complications, a patient with internalized weight bias that has "pronounced adverse effects on quality of life or may render weight-loss treatment plans ineffective or harmful" would be classified as having Stage 3 disease (2023, p. 422). Here, we see the formalization of the conception of weight stigma as a complication of obesity: a patient who experiences negative consequences due to anti-fatness is classified as having a more severe pathology than another patient who is the same weight. More severe stages justify more intensive and risky obesity treatments; for example, in the older classification that formed the foundation for this one, bariatric surgery was recommended for the equivalent of Stage 3, but not Stage 1 or 2 (Garvey et al., 2016). Ultimately, the example of the AACE guidelines highlights how, within this regime of signification, prejudice and discrimination against fat people can be transmuted into a basis for more aggressive obesity treatment.

My analysis here does not diverge significantly from how the actors within this regime of signification portray the relationship between anti-obesity efforts and weight stigma. Consider the following diagram, which was featured in the keynote lecture at the 2024 International Weight Bias Summit, "Ending Weight Stigma: Priorities for Action."[22] In this diagram, weight

[22] This summit was sponsored in part by the World Obesity Federation, the European Association on the Study of Obesity, Obesity Canada, and the Obesity Society, all of which have received significant funding from Novo Nordisk.

stigma as a problem in healthcare is fully enmeshed within the anti-obesity assemblage. Bias is framed as believing that weight is individually controllable. Stigma is defined as not referring a person for anti-obesity treatment. Discrimination is defined as healthcare systems not treating obesity as a chronic disease or covering anti-obesity treatments. The outcomes of weight bias are a lack of clinician obesity education and corresponding lack of obesity treatment, patients believing that obesity is their fault and not seeking obesity treatment, and an increase in obesity severity itself.

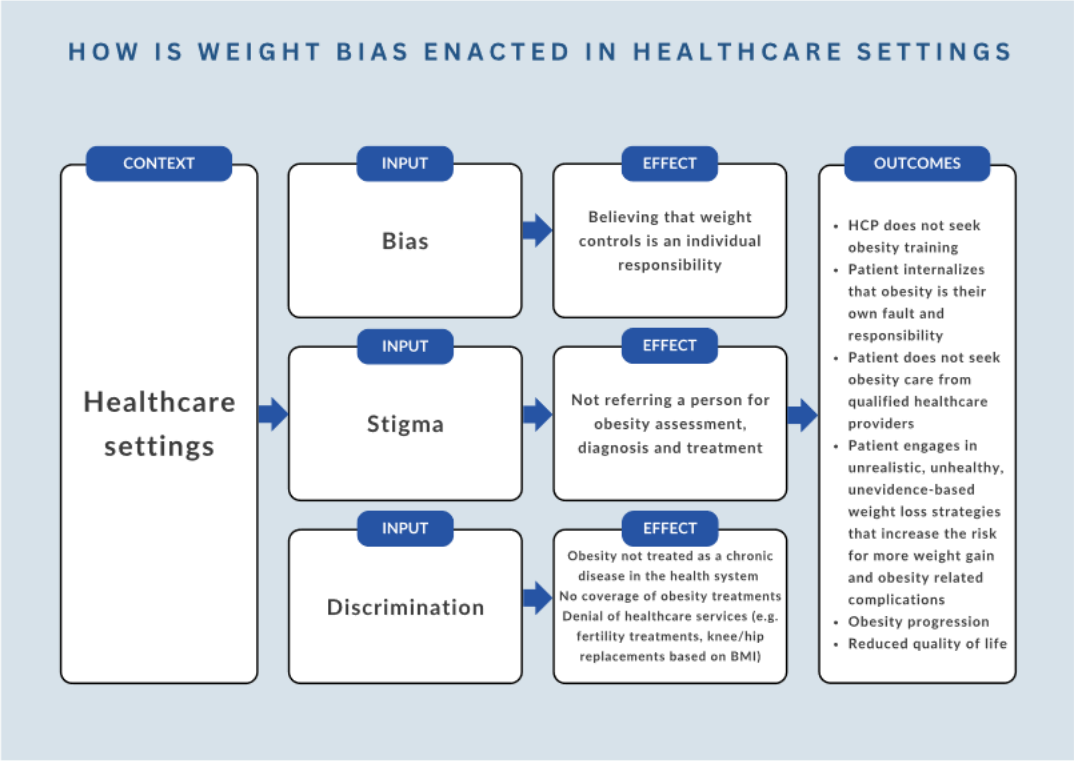

Figure 11: How weight bias in enacted in healthcare figure from the presentation "Weight Stigma Interventions: Where to go from here?" (Salas, 2024).

As this figure summarizes, in this regime of signification, fighting obesity is a crucial, inextricable part of fighting weight stigma, and vice versa. They are both targets of the anti-obesity assemblage.

The Machinic Assemblage

This chapter has largely focused on the assemblage of enunciation within the horizontal axis of the anti-obesity assemblage. However, Deleuze and Guattari assert that this axis also contains a machinic assemblage or "form of content," defined as the "complex state of things as a formation of power" that complements the "set of statements arising in the social field" (the form of expression) (1987, p. 66). The form of content and form of expression "constantly intertwine, embed themselves in one another" (1987, p. 68). As such, it is important to note at least some of the components of the machinic assemblage that are relevant for making sense of this regime of signification. Said differently, this regime of signification is enunciated within particular contexts and practices arranged through the anti-obesity assemblage, and attending to the machinic assemblage can shed light on those contexts and practices.

One significant component of the machinic assemblage is GLP-1 agonist drugs themselves – their existence, their manufacture, their prescription, and their effects in bodies. These pharmaceuticals are notable because, as actants within "obese bodies," they transform obesity and thereby also act on and within weight stigma as construed within this regime of signification. In most people, these molecules spur weight loss. On average, they produce greater weight loss than any other existing medication and significantly greater weight loss than that produced on average by changes in lifestyle, diet, and exercise (Kolata, 2022). Because the anti-obesity assemblage has classified a large portion of the US population as obese, the potential reach of these drugs is enormous; already they are acting within hundreds of thousands of bodies. Moreover, because the US has very few regulations controlling the price of prescription drugs, the potential profit for Novo Nordisk based on its patents for Ozempic and Wegovy is astronomically large: the flow of capital through the anti-obesity assemblage outstrips the GDP

of many small countries (Nelson, 2023). GLP-1s and massive amounts of capital are both "intertwined" with this regime of signification, just as the regime is embedded within them.

Novo Nordisk seeks to maximize the number of prescriptions for Ozempic, Wegovy, and other similar drugs that are filled. As part of this effort, Novo Nordisk's marketing and lobbying efforts have been working to overcome anything limiting the number of prescriptions filled for these drugs in the US. Their efforts reveal another part of the machinic assemblage: the wide array of actants involved in getting GLP-1s into bodies. To receive Wegovy, potential patients must interact with a medical professional. To address this, Novo Nordisk's media network portrays obesity as treatable and encourages fat people to return to medical professionals even if they have had negative experiences in the past. For Wegovy to enter a patient's body, a medical professional must prescribe the drug. To address this, Novo Nordisk's media network portrays doing *anything besides* medication-facilitated anti-obesity care for fat patients as stigmatizing and counterproductive. They also highlight the importance of increasing education on obesity in medical training. For many patients to afford Wegovy, insurers must cover the costs of the drug, which is quite expensive. To address this, Novo Nordisk's media network encourages viewers to support federal legislation that would expand coverage for obesity treatment (TROA) and portrays resistance to this legislation as anti-fat bigotry. Once in possession of Wegovy, a patient must inject themselves with it. To pre-empt any hesitation a patient might feel over the drugs not being "body-positive," Novo Nordisk has provided affirmation from prominent fat influencers and scripts that lambast such hesitation as itself a sign of stigma. This network extends far beyond what I have discussed here, but each part is intertwined with the regime of signification I have outlined.

Discussion

This chapter has demonstrated the production of a new regime of signification within the anti-obesity assemblage thanks to an influx of resources and capital from pharmaceutical company Novo Nordisk. While many of the messages in this regime are not new, the regime has helped to homogenize and focus the orientation of weight stigma advocacy towards the singular goal of obesity elimination. In this discussion, I unpack how the Novo Nordisk media network has achieved the complete absorption of weight stigma into the anti-obesity assemblage, and I identify the anti-fat consequences of this enclosure. I also outline the implications of this absorption for the theory of eliminationist assemblages as well as the field of fat studies.

This regime of signification subsumes the problem of weight stigma under the goal of eliminating obesity; the stigma against fat people is defined as a problem that can be reduced through weight loss ("obesity treatment"). Most of the individual pieces of media produced by Novo Nordisk's network do not explicitly make this claim. Nevertheless, taken together, this regime of signification communicates – through what it says as well as what it does not say – that weight loss is the solution to weight stigma. In this media ostensibly meant to tackle the problem of weight stigma, the nature of obesity, its causes, and its treatability are discussed in great detail. Being fat is portrayed as a treatable disease. Expanding access to obesity treatment is portrayed as a solution to weight stigma. Internalized weight bias is portrayed as a complication of obesity. Educating doctors and the public about the disease of obesity is portrayed as the best route to fighting societal stigma. In contrast, other social or political solutions to weight stigma are almost never discussed in Novo Nordisk's media network. Any social or political solutions that are offered are oriented toward obesity elimination. Patient advocates are frequently given the opportunity to speak about how miserable it is to be blamed

and shamed for the "disease of obesity," but activism is generally not portrayed as a route toward improving the valuation of fat people. Though fighting weight stigma is portrayed as aligned with anti-obesity efforts in many ways within this regime of signification, the overarching message expressed by these links is that fighting obesity will address weight stigma.

On its face, there is a contradiction inherent in the idea that fighting obesity will solve weight stigma: portraying fatness as a treatable disease necessarily involves asserting that it is bad to be fat, which is stigmatizing. But within this regime of signification, this apparent contradiction is smoothed over by a disjuncture that casts the devaluation of fatness itself as a separate issue from the devaluation of fat people. This disjuncture is made possible by framing weight stigma as a problem of blame, shame, and beliefs about weight as controllable. That is, weight stigma is portrayed as manifesting whenever an individual judges a fat person negatively based on the belief that fat people can lose weight but simply fail to do so. In this definition, weight stigma is the devaluation of fat people based not on the devaluation of fatness but on blaming fat people for failing to modify their devalued way of being. Hence, defining weight stigma as blame and shame allows the devaluation of fatness as a way of being to be cast as legitimate and justified, while maintaining that the devaluation of fat people is unjust and irrational. In this way, the blame/shame/controllability conception of weight stigma creates a disjuncture that obscures the contradictions between fighting obesity and fighting weight stigma.

However, within this regime of signification, the blame/shame/controllability conception of weight stigma brings its own contradiction: believing that weight is controllable is portrayed as stigmatizing, but fighting obesity is portrayed as destigmatizing. This contradiction is downplayed through another disjuncture: weight loss *without* medical supervision is portrayed as fundamentally distinct from weight loss *with* medical supervision. In particular, the belief that fat

people can lose weight without medical treatment (i.e., through diet and exercise) is cast as blaming fat people for being fat and therefore stigmatizing, while the belief that fat people can lose weight with medical treatment is cast as recognizing that obesity is a complex disease and therefore *destigmatizing*. Though Novo Nordisk's media network often avoids mentioning specific drugs (likely because doing would trigger FDA requirements regarding side effect warnings), this media frequently references the presence of unspecified "new treatments" that fat people should "talk to your doctor" about. In this way, GLP-1 agonist drugs as a material component of this assemblage are also central to stabilizing this regime of signification and covering over its contradictions. The notable weight loss efficacy of these drugs, at least in the short term, enables Novo Nordisk's media network to draw this dichotomy between non-medical and medical weight loss, even as the specific drugs are left unstated. Thus, the GLP-1 agonists also temporarily stabilize the blame/shame/controllability conception of weight stigma.

This regime of signification can be critiqued on epistemic grounds, because it depends on numerous inaccurate assumptions, and on normative grounds, because it is morally repugnant. Epistemically, portraying a way of being as undesirable but biologically determined does not reduce stigma. The idea that shifting causal explanations for a way of being will reduce stigma was discussed in Chapter 2 under the name "attribution theory." However, attribution theory has not fared well in more recent stigma research (Angermeyer et al., 2011; Kvaale, Gottdiener, et al., 2013; Kvaale, Haslam, et al., 2013; Payton & Thoits, 2011; Read et al., 2006; Schomerus et al., 2012). In addition, as I showed in Chapter 3, trying to fight obesity necessarily involves devaluing it. This devaluation persists regardless of whether weight is considered individually controllable. Within Novo Nordisk's media, there are no messages that challenge the devaluation of fatness, only messages about the dangers of obesity and the urgency of treatment. Positive

messages about fatness and fat people are almost nonexistent. As in weight stigma interventions, media from this network focused almost exclusively on the health risks and suffering attached to fatness, including numerous first-person testimonials about how being fat precludes a person from living a good life. These messages increase stigma rather than decrease it.

Moreover, the idea that medical knowledge will solve cultural stigma elides the possibility that the "cultural stigma" against fatness *comes directly from medical knowledge*. Actors within this regime of signification frame beliefs about weight as controllable as irrational, biased, and *fundamentally social* beliefs in need of correction from objective medical knowledge. Yet beliefs about weight as controllable come directly from medicine and public health. The *primary message* of the war on obesity was that individuals needed to modify their behaviors to avoid weight gain and spur weight loss (Boero, 2012; Herndon, 2014; J. E. Oliver, 2006). This message is still frequently trumpeted by prominent public health agencies and in medical education (Gomez, 2024). As such, even in this limited conception of weight stigma, *medicine is still the source of stigma.* While these actors attempt to draw sharp boundaries between "objective medical knowledge" and "biased social knowledge," medicine and society are in constant, reciprocal exchange. In addition, historical accounts of the devaluation of fatness *also* implicate medicine as an integral source of this devaluation, even as health professionals presented themselves as objective, enlightened, and unbiased compared to laypeople (Farrell, 2011; Rasmussen, 2019b; Strings, 2019). The idea that "true medical knowledge" will fix stigma *this time* is an absurd fantasy. Medicine treats diseases. Part of the disease treatment process is making afflictive claims. At best, those afflictive claims are worth the devaluation they cause because of the treatments they enable. At worst, those claims are oppressive. At no point can afflictive claims destigmatize. Medicine can only ever increase stigma.

Even if portraying fatness as a disease and reducing blame *could* reduce stigma against fat people slightly, the idea that fat oppression can be solved with weight loss should be understood as abhorrent. Oppression is a social injustice. Claiming to address stigma by reducing the number of individuals with a devalued characteristic does not actually address the stigma and oppression that those people face; it intensifies it. It does not reduce the devaluation of that stigmatized characteristic, but instead makes that devaluation seem more legitimate. In this sense, the people who believe that fat people should be shamed and the people who believe that fat people should be treated medically are all in *agreement* that the world would be better off without fat people. Working to eliminate a stigmatized way of being so that people can escape oppression should be understood as a *completion* of the oppression, a totalizing continuation of the project of oppression. Even if some people experience health benefits or improvements to their quality of life as a result of obesity treatment, such treatment cannot possibly address the oppression they face. Fat oppression cannot be solved by achieving the goals of fat oppressors.

In this vein, my investigation of Novo Nordisk's media network contributes to the understanding of eliminationist assemblages and how they work more generally. Eliminationist assemblages can expand by defining more problems (such as stigma) as solvable through enabling and enacting the elimination of a way of being. When eliminationist assemblages position other problems as solvable through elimination, there are two primary effects worthy of note. First, the devaluation of the way of being targeted for elimination is reinforced, and the assemblage of enunciation narrows how other problems are defined to make them compatible with the goal of elimination. Second, resources are directed toward enabling and enacting the elimination of that way of being, and not toward addressing other problems. For example, in the context of weight stigma research and advocacy, the anti-obesity assemblage calls for more

resources to be funneled to obesity treatment and education, rather than directing resources toward activist organizations attempting to combat stigma and oppression through social and political change. Thus, when eliminationist assemblages become intertwined with other goals, those other goals are funneled into the project of elimination.

Notably, the framings and messages communicated by Novo Nordisk's media network are not fundamentally distinct from those found in weight stigma research in Chapters 2 and 3. Even though Novo Nordisk is a corporation, and the Rudd Center is a nonprofit research organization, the messages produced by the most financially motivated actors within the anti-obesity assemblage are similar to those produced decades ago by actors funded by universities and private philanthropy. The massive injection of pharmaceutical capital into the anti-obesity assemblage does not seem to have radically altered the messages produced about weight stigma, when compared with the sample of scientific articles analyzed in Chapter 2. At most, the influx of capital has simply elaborated and intensified existing links between weight stigma advocates and the anti-obesity assemblage. Though I did not perform a quantitative analysis of Novo Nordisk's media network, the percentage of media intertwined with the anti-obesity assemblage would likely be much higher than the two-thirds figure I found when studying weight stigma research. In other words, it seems likely that the injection of pharmaceutical capital has only further homogenized weight stigma discourse around obesity elimination, crowding out any other approach to weight stigma.

This analysis also shows that the focus on contesting blame and controllability within fat studies scholarship does not challenge the anti-obesity assemblage. Even claims that seem critical of anti-fatness, such as the oft-repeated rallying cry "diets don't work," have been co-opted by Novo Nordisk's media network as justification for the expansion of anti-obesity

education and treatment. Twenty years ago, LeBesco criticized fat activism for pursuing a "will to innocence" and predicating the injustice of their abuse on the idea that they could not lose weight (2004). However, while LeBesco correctly identified that this was not an effective political strategy, she could not have imagined just how thoroughly it would fail. The focus on debunking claims about weight and weight loss within fat activism and scholarship has failed to stop the expansion of the anti-obesity assemblage because it decenters fat oppression and centers questions of medical expertise. The regime of signification I traced here can be understood as the product of the anti-obesity assemblage co-opting all fat positive rhetoric that contests medicine on its own terms and repurposing it for anti-obesity ends (see also Eyal, 2013). In the Conclusion to this dissertation, I provide an alternative agenda for fat positive research.

Conclusion

In this chapter, I have shown that weight stigma advocates make fighting obesity and fighting stigma compatible goals by defining weight stigma in a narrow way that makes obesity education and treatment seem like a plausible solution. I found that portraying weight stigma as a matter of blame, shame, and controllability creates a disjuncture between the devaluation of fatness and the devaluation of fat people. When stigma is reduced to blame and the belief that weight is individually controllable, it becomes possible for weight stigma advocates to portray obesity education as a plausible strategy for reducing stigma. Yet entangling the anti-obesity assemblage with weight stigma advocacy prevents actual anti-stigma efforts by upholding the devaluation of fatness and directing attention and resources toward obesity elimination rather than social and political activism meant to fight fat oppression. Within Novo Nordisk's media network, the possibility of meaningful fat activism becomes unthinkable; instead, weight loss is cast as the only imaginable solution to the prejudice and discrimination that fat people face.

In the previous three chapters, I have primarily focused on how the anti-obesity assemblage has shaped weight stigma research and advocacy. In the Conclusion, I turn to focus on what weight stigma research and advocacy is doing for the anti-obesity assemblage.

Conclusion:
A New Face of the War on Obesity

This dissertation has investigated three main questions. First, how is weight stigma research and advocacy intertwined with the anti-obesity assemblage? Second, how is weight stigma research and advocacy's capacity to meaningfully fight stigma constrained by being part of the anti-obesity assemblage? Finally, how do weight stigma researchers and advocates portray fighting obesity and fighting stigma as compatible goals? Over the course of my dissertation, I have found that the answers to these three questions are deeply interconnected. The primary ways that weight stigma research and advocacy are intertwined with the anti-obesity assemblage are the *same* aspects that limit its capacity to fight stigma. This entanglement is also directly related to the way that weight stigma researchers and advocates portray the goals of fighting obesity and fighting stigma as compatible. The answers to my three research questions manifest in the two overarching themes of this dissertation: devaluation and resource allocation.

Weight stigma research and advocacy is intertwined with the anti-obesity assemblage through its commitment to the devaluation of fatness. As discussed in Chapters 2 and 4, weight stigma research and advocacy portray fatness as an eliminable threat, an "undesirable and dangerous condition," in the words of the founders of the Rudd Center. In Chapter 3, I detailed one mechanism by which the devaluation of fatness limits the capacity of weight stigma research to fight stigma: afflictive power. Through the concept of afflictive power (the power to define a way of being as a source of harm or suffering), I showed how associating fatness with harmful effects stigmatizes fat people by portraying their lives as miserable and wretched. I also found a glaring absence of positive representations of fat people within weight stigma research and advocacy. In other words, I have shown that defining fatness as an "undesirable and dangerous condition" inevitably involves portraying fat people negatively. Yet, as I explained in Chapter 4,

weight stigma research and advocacy obfuscate this by relying on a narrow conceptualization of weight stigma as a matter of blame, shame, and beliefs about fatness as controllable. That is, by reducing stigma to blame against fat people for possessing this devalued characteristic, weight stigma research and advocacy bracket the devaluation of fatness, casting that devaluation as completely unrelated to the devaluation of fat people. Thus, weight stigma researchers and advocates fail to reduce anti-fatness because they uphold the devaluation of fatness while claiming to combat the devaluation of fat people.

Weight stigma research and advocacy also allocate attention and resources toward the anti-obesity assemblage. I have enumerated many examples of this phenomenon throughout this dissertation. Weight stigma researchers frequently prioritize investigating the causes of obesity and the barriers to obesity elimination. Weight stigma research and advocacy often involves educating audiences about the causes of obesity, and weight stigma interventions with health professionals frequently involve training in obesity treatment. Researchers and advocates call for more resources to be directed toward educating health professionals and the public about obesity. Weight stigma advocates also portray directing resources toward expanding access to obesity treatment as itself fighting stigma. Prioritizing anti-obesity efforts constrains the capacity of weight stigma research and advocacy to address anti-fatness in three ways. First, obesity elimination and weight stigma reduction are distinct goals; every sentence in a weight stigma article about obesity is one less sentence about weight stigma, and every minute of a weight stigma intervention dedicated to obesity training is one less minute for addressing weight stigma. Second, by continuously prioritizing obesity elimination, weight stigma research and advocacy erase the possibility of addressing anti-fatness through social and political change via activism meant to improve the valuation of fatness and fat people. Third, insofar as the anti-obesity

assemblage structures anti-fatness through other mechanisms hypothesized in Chapter 1, allocating more resources to it strengthens anti-fatness. Ultimately, weight stigma researchers and advocates make fighting obesity and weight stigma compatible by portraying obesity education and treatment as the solution to weight stigma. In this way, weight stigma becomes yet another way to expand the anti-obesity assemblage.

In this Conclusion, I discuss how the anti-obesity assemblage is using the topic of weight stigma to adapt and absorb its existing critiques, as well as what kinds of new critiques and activism could dismantle the anti-obesity assemblage. In Deleuzian terminology, I discuss the territoriality of the anti-obesity assemblage and its lines of flight. In the rest of my dissertation, I have investigated how the anti-obesity assemblage shapes weight stigma research and advocacy. Here, I pivot to ask: what utility does the issue of weight stigma have for the anti-obesity assemblage? What does "weight stigma" do for the war on obesity? I argue that weight stigma research and advocacy is part of a "new face" for the war on obesity, one that is more empathetic, reflexive, and scientific. I conclude by discussing the implications for fat positive research and activism. I call for fat positive scholars and fat activists to dismantle the anti-obesity assemblage.

Weight Stigma as a Site of Deterritorialization

In this section, I argue that weight stigma research and advocacy provide a way to view the vertical axis (Deleuze & Guattari, 1987, p. 88) of the anti-obesity assemblage – its lines of *deterritorialization*, which can be understood as the processes of change within an assemblage. Deleuze and Guattari identify four different kinds of deterritorialization that always coexist within an assemblage, relative negative, relative positive, absolute negative, and absolute positive (1987, pp. 508–510). My analysis of weight stigma research and advocacy suggests that

these efforts are working to modify and reproduce the anti-obesity assemblage in ways that grow its power, which fits the definition of *relative negative deterritorialization*. Relative negative deterritorialization is the "process by which pre-established assemblages adapt and respond to changes in their relations by incorporating those changes" (Nail, 2017, p. 34). Weight stigma research and advocacy serve two main purposes for updating and reproducing the anti-obesity assemblage. First, they work to obstruct attempts to spur divestment from the AOA – what Deleuze and Guattari call "lines of flight" out of the assemblage – put forward by actors critical of anti-obesity efforts. Second, they serve as a way to address the current failure of the anti-obesity assemblage to actually reduce the number of fat people in the world. In this capacity, weight stigma research and advocacy are enabling the anti-obesity assemblage to reterritorialize in a more medical form, disavowing its previous reliance on individual behavioral change and moving towards pharmaceutical and surgical interventions as the "non-stigmatizing" solutions to obesity. The incorporation of weight stigma research and advocacy is part of the development of a "new face" for the war on obesity.

To understand what weight stigma research and advocacy are doing for the anti-obesity assemblage, it is helpful to compare the current form of the anti-obesity assemblage to how it has looked at previous times.[23] At the end of the 20th century, the AOA was smaller, sustained by a few dedicated actors whose explicit goal was to persuade the world that obesity should be considered a crisis (Brown, 2016; J. E. Oliver, 2006). Between 2000 and 2005, the AOA expanded rapidly as the US declared a "war" on obesity (Biltekoff, 2007; Boero, 2007). As several scholars have noted, US mass media helped to rapidly transform obesity into a public health crisis during this time through an exponential increase in news coverage of the "obesity

[23] This is not meant as a genealogical investigation, but rather a comparison of snapshots at different times. It is not a causal claim or origin story for the AOA.

epidemic" (Gard & Wright, 2005; J. E. Oliver, 2006). In addition to news media, the AOA expanded through the efforts of "obesity epidemic entrepreneurs" who helped to stoke a "moral panic" over obesity (Campos, 2004; LeBesco, 2004; Monaghan et al., 2010, 2019; Murray, 2008b; Saguy, 2013). Boero describes how the American Obesity Association and the North American Association for the Study of Obesity lobbied the US Department of Health and Human Services to include obesity as a leading health indicator in their *Healthy People 2010* report, raising it to the top of the list of US public health priorities in 2000 (2012, Chapter 1). Post-2005, obesity became a taken-for-granted problem and target for interventions of all kinds. In 2010, then-President Barack Obama and First Lady Michelle Obama established a Task Force on Childhood Obesity and the *Let's Move!* campaign to advance the goal of "solving the problem of childhood obesity within a generation" (Jette et al., 2016). Obesity became a problem for individuals to tackle within their own bodies and families, but it also became something that needed to be fought in schools, by community and religious organizations, by the corporations responsible for the US food supply, and by regional zoning boards with the power to dictate land allocation. The profits of the weight loss industries have grown by tens of billions of dollars annually; this market is currently valued at $90 billion annually (LaRosa, 2024). Since 2000, concern for "obesity" has become part of the everyday life of many, if not most, people in the US. As I described in Chapter 1, most people in the US live with/in the anti-obesity assemblage, whether they want to or not. It has transformed the landscape of American life.

Despite the enormous growth of the anti-obesity assemblage over the past several decades, however, the number of fat people in the world has not substantially decreased (Koliaki et al., 2023). Even according to prominent anti-obesity actors, the "war on obesity" has not been won. In fact, by most metrics, it has failed (Bombak, 2014; Seraphin, 2023). In the words of Bill

Dietz, one of the first people to call obesity an epidemic, "We haven't reversed the epidemic" (Wilson & Roberts, 2012). Several weight stigma researchers have framed the "war on obesity" as itself obesogenic, further adding to this sense of failure. For example, Tomiyama et al. assert that "many common anti-obesity efforts are unintentionally complicit in contributing to weight stigma," which they argue causes weight gain (2018, p. 3). Likewise, Salas asserts, "The public health war on obesity has had little impact on obesity prevalence and has resulted in unintended consequences," such as weight gain, "excessive weight preoccupation among the population,…and obesity surgery complications" (2015, p. e79). Moreover, medical education and practice research has lamented the reluctance of health professionals to engage in weight loss counseling with fat patients, noting that some of this reluctance is due to a sense of futility over the failure of such counseling to produce lasting weight loss (Block et al., 2003; M. Smith et al., 2023; Vinson, 2016).

As the anti-obesity assemblage has grown over the past 25 years, it has also faced resistance on a number of different grounds, many of which serve as the foundation for my scholarship. As I have discussed, many researchers, clinicians, and activists have worked to expose the high failure rate of weight loss dieting and have used this information to push back against public health weight loss guidance (Campos, 2004; Gaesser, 2002; Gard & Wright, 2005; Rothblum & Solovay, 2009; Sobal & Maurer, 1995, 1999).[24] Others have tracked the harms brought about by weight loss interventions such as weight loss pharmaceuticals, supplements, and surgeries (Boero, 2009a; Herndon, 2014; Mundy, 2010). In the field of critical weight

[24] This critique does, arguably, predate the anti-obesity assemblage. In the Fat Liberation Manifesto, the Fat Underground wrote: "WE demand that they [the reducing industries] take responsibility for their false claims, acknowledge that their products are harmful to the public health, and publish long-term studies proving any statistical efficacy of their products. We make this demand knowing that over 99% of all weight loss programs, when evaluated over a five-year period, fail utterly, and also knowing the extreme proven harmfulness of frequent large changes in weight" (Freespirit & Aldebaran, 1979).

studies, many researchers have deconstructed epidemiological claims about the harmful health effects of higher weight, especially an infamous 2004 claim that obesity causes 400,000 excess deaths per year in the US (Flegal, 2021; Gard et al., 2021; Guthman, 2013; Harrison, 2021; Saguy, 2013; Saguy & Almeling, 2008). Some critiques have also focused on the history of the BMI as a statistical tool. Critics argue that the BMI was never meant to serve as an indicator of individual health, and that it was developed on a small population of white men, making it an even less accurate measure for people who are not white or men (Strings, 2019, 2023). As previously mentioned, anti-obesity efforts have also been criticized for the ways that they depend on and exacerbate other forms of oppression such as racism, sexism, and classism. Over the past decades, several overlapping social movements, including fat activism, body positivity, and Health at Every Size® have successfully raised awareness of the detrimental effects of "diet culture" and "fat shaming."

Based on my research, I suggest that weight stigma research and advocacy operate as a site where the anti-obesity assemblage adapts to both its failure to reduce obesity and the backlash it has received. As an assemblage, the AOA is constantly changing, losing and gaining elements and linkages. When this process of change maintains and reproduces the AOA, this can be considered relative negative deterritorialization. Since relative negative deterritorialization is not fundamentally meant to reduce the size or power of the AOA (because it is *re*productive), it is often accompanied by "compensatory reterritorialization," a process that constrains the changes to an assemblage to *adaptation* rather than dissolution or transformation (Deleuze & Guattari, 1987, p. 508). Nail explains the process of relative negative deterritorialization (and compensatory reterritorialization) using the example of the relationships between social movements and state governments:

> For example, popular social movements against the policies of governments can often be satisfied through the adaptation of state politics: legal reform, increased political representation, and party support. These processes allow the pre-established state assemblage to remain in place precisely through adaptation to popular demands… Popular movements against war, poverty, the exclusion of minorities, and so on are "lines of flight" or expressions of political realities different from the established ones. Relative negative deterritorialization aims to obstruct these lines of flight by offering them an increased incorporation of their desires into the state assemblage. In doing so, these desires become normalized as part of the state itself. (2017, pp. 34–35)

To extend this example to the anti-obesity assemblage, the critiques of anti-obesity efforts from critical weight studies, fat studies/activism, and the body positivity movement are analogous to social movements against a state assemblage – they produce the "lines of flight" out of the assemblage. The role of weight stigma research and advocacy, then, is to reconfigure the AOA in a way that incorporates the desires of these actors into the assemblage, parallel to the legal reforms that placate social movements. Weight stigma research and advocacy are themselves the relative negative deterritorialization of the anti-obesity assemblage. They change the AOA to maintain and reproduce it. They obstruct the attempts to undermine or delegitimize the anti-obesity assemblage. My research suggests that one prominent way this obstruction occurs is via an intensification of the medicalization of fatness. The more fatness is brought into the realm of a "real" medical problem, the harder it is to find lines of flight out of the AOA.

Actors within the anti-obesity assemblage are mobilizing weight stigma to address critiques of anti-obesity efforts and intensify the medicalization of fatness. One way they do this is by mobilizing weight stigma to change how "obesity" is defined. For instance, in June 2023, the American Medical Association voted to adopt a new policy that decentered the use of the BMI in clinical encounters. This policy pointed to the "historical harm" of the BMI and the "use of BMI for racist exclusion" as reasons for this change, which appeared to many as a victory in the fight against the AOA (Berg, 2023). However, this policy did not call for ending the medical

classification of fat bodies as pathological. Instead it expressed support for additional research into measuring adiposity, ultimately calling for more resources to be directed toward the AOA. Several other medical organizations have used stigma as a justification for classifying obesity as a disease. The Obesity Society's (2008) white paper on this topic argued that classifying obesity as a disease would reduce stigma against fat people and increase support for anti-obesity treatment. Similarly, the World Obesity Federation listed stigma as one of many "pathologic changes associated with obesity," arguing that these changes – *including stigmatization* – necessitate treating obesity as a "chronic, relapsing, progressive disease process" (Bray et al., 2017). In sum, stigma becomes a reason to intensify the classification of fatness as pathological, which also has the effect of curtailing criticisms about the ambiguity of classifying fatness with the BMI and about the complicated relationship between higher weight and poorer health.

Anti-obesity actors are also mobilizing weight stigma to intensify the medicalization of weight loss interventions and address critiques of the harms these interventions have caused. These efforts draw on the false binary established by weight stigma research and advocacy between the "stigmatizing" position of expecting individuals to lose weight via diet and exercise and the "destigmatizing" position of treating obesity like a disease that needs medical intervention. For example, a 2022 article authored by numerous obesity researchers, some with substantial ties to the weight loss industry, instructed healthcare providers on how to treat obesity while "actively addressing weight stigma and eating disorder risk" (Cardel et al., 2022). The authors constructed a boundary between "harmful, self-directed dieting" oriented towards achieving an "appearance ideal" and "supervised evidence-based obesity treatment" with the goal of "improving health." Using this division, they argued that clinicians have an ethical obligation to reduce weight stigma by providing "evidence-based obesity treatment" to "patients

for whom it is medically indicated" rather than urging them to undertake an unsustainable fad diet (2022, p. 1093). In doing so, this article both calls for an expansion of the AOA and addresses critiques about the patriarchal/capitalist pursuit of thinness and the harms of fad dieting. WW International (WeightWatchers) has also employed weight stigma to address criticism and intensify medicalization. In 2023, the company pivoted after acquiring a telehealth company to provide weight loss drug prescriptions to its members. In a highly publicized CNN interview, the WW CEO announced that "we got it wrong" by insisting that members could lose weight with lifestyle change alone, asserting that:

> These medications have shown, and science has evolved to say, that living with obesity is a chronic condition. It's important, no matter what it means for our business, to just be clear about that. It's not willpower alone…And what we are now saying is we know better and it's on us to do better so that we can help people feel positive and destigmatize this conversation around obesity. (Saha, 2023)

Here, stigma is again being used to obstruct attempts to undermine the anti-obesity assemblage and reterritorialize the terrain created by such critiques with more intensive anti-obesity interventions.

These examples of the de- and reterritorialization of the anti-obesity assemblage reveal what I have termed a "new face of the war on obesity." A concerted group of actors is working to reconstitute anti-obesity efforts as empathetic, socially aware, reflexive, and scientific. They contrast their new approach with the old anti-obesity approach, which they portray as regressive, punitive, stigmatizing, and ineffective due to its focus on lifestyle change. Weight stigma researchers and advocates feature prominently among these actors, and their projects are helping the anti-obesity assemblage persist and adapt to the changes of the first few decades of the 21st century. The discourses these groups produce are being increasingly enrolled to neutralize criticisms that would otherwise help to undermine the AOA. Caring about weight stigma has

become a way for anti-obesity actors to shed the bad reputations they developed through the early years of the war on obesity and account for the ongoing failures of anti-obesity efforts. Weight stigma research and advocacy helps the anti-obesity assemblage reinvent itself in a way that simultaneously addresses existing critiques while increasing their legitimacy (see Whooley, 2019). Said differently, weight stigma discourses transform the existing critiques into instructions for the AOA to adapt, expand, and become seen as more legitimate – enabling the war on obesity to be recast as a fight for social justice.

Updating Fat Liberation for the 21st Century: Identifying New Lines of Flight

Fat studies and fat activist critiques of anti-obesity efforts have provided a roadmap for the AOA to grow. We now need new approaches, ones that do not depend on anti-obesity efforts being false or ineffective. The only way to resist the anti-obesity assemblage is to recognize how it works and set our sights on dismantling it.

Deleuze and Guattari call this process of dismantling *absolute positive deterritorialization* (APD). Absolute positive deterritorialization is, in essence, the opposite of relative negative deterritorialization – instead of destabilizing the assemblage in a way that the elements released by destabilization can be reabsorbed, this process of change destabilizes the assemblage and uses the parts shaken loose by this effort to form a *new* assemblage, connected to other elements that have also escaped capture. As Nail describes it:

> The goal of this type of change is to "prefigure" a new world; that is, to create a new world in the shell of the old…. Absolute positive deterritorialization is thus the kind of change that is capable of creating and sustaining a revolutionary movement. It is constructive insofar as it builds an alternative, irreducible to the preconstructed or pre-established assemblages of the past. (2017, p. 36)

The beauty of APD is that it begins from the assemblage itself. In other words, the anti-obesity assemblage is not some hidden horror lurking in the shadows. It is right in front of us. It is

mundane and blatant. My scholarship is not conspiratorial: anti-obesity actors are explicit about what they are doing and what they are trying to achieve. Thus, to engage in APD involves three steps. First, we must recognize anti-obesity efforts and the structure they form as the anti-obesity assemblage. Second, we must make visible how the anti-obesity assemblage structures fat oppression, connecting anti-obesity efforts to their specific, harmful consequences for fat people. Third, we must work, wherever and whenever possible, to dismantle the anti-obesity assemblage. APD involves unlinking the material-discursive elements of anti-obesity efforts in all their myriad contexts and being explicit about why we are doing so.

A world where the anti-obesity assemblage has been greatly reduced is possible. In this world, we would no longer see headlines about fatness as pathological or epidemic. Epidemiology would no longer quantify and classify people on the basis of weight; doctors would no longer encourage patients to lose weight. There would be little to no research into the causes or consequences of variable body size. Fatphobic jokes and jabs would lose the medical authority that currently lends them so much credence. Changing body size would be, as much as possible, a neutral event. WeightWatchers would go out of business. Social media influencers and celebrities would no longer use their physiques to sell thinness-oriented supplements or cosmetic procedures. Fat people would no longer be told to stop glorifying obesity.

One of the first steps towards dismantling the anti-obesity assemblage is undermining the idea that increasing the medicalization of fatness, i.e., making "obesity" a "real disease," is destigmatizing. This idea is a complete misrecognition of reality. Yet right now, more people and organizations are attempting to "destigmatize obesity" by entrenching the very ideas and practices that impede fat liberation. As I have explored, there are many reasons why increasing medicalization is appealing to myriad interest groups, but fundamentally, one reason this idea is

palatable is because there is no counter-discourse about fat people as valuable members of society. When valuing fatness has been rendered so unthinkable, reducing blame and condemnation appears like the best possible outcome. We must reject this limited thinking. Fat people deserve more than to be treated as a misfortune that the world must hold its nose and tolerate.

In that vein, another step towards dismantling the anti-obesity assemblage is more research into the assemblage itself and its effects. Descriptive research about the AOA will help make it visible to those who are not yet aware of its existence; critical intersectional research can demonstrate the ways in which the anti-obesity assemblage interacts with and upholds other structural forms of oppression. We also need research that provides evidence of the ways that anti-obesity efforts harm fat people, especially research that accounts for the specific and intensified harms faced by those who are targeted by multiple forms of oppression. Currently, the weight stigma literature does not measure how much individuals understand about the relationship between anti-obesity efforts and the stigmatization of fat people. With colleagues, I have begun to develop a new self-report measure, the Knowledge and Beliefs about Weight Stigma (KABAWS) Scale, to address this gap. Along with measuring knowledge and beliefs about weight stigma, researchers can also test what kinds of messages about weight stigma are most effective in persuading the public, professionals, and organizations to divest from anti-obesity efforts. For example, it will be useful to know what kinds of messages are likely to persuade doctors to stop counseling their patients on weight loss and remove weight loss counseling from medical education curricula.

Once the efforts to dismantle the anti-obesity assemblage have begun, it will be important to collect evidence that shows the positive effects of decreasing anti-obesity efforts for fat people

and US society broadly. While such research is likely to start at the individual level, over time, it could expand to measure population level attitudes and quality of life. Many fat studies scholars have noted that thin people are also impacted by anti-fatness, as the threat of weight gain and subsequent mistreatment serves as motivation for them to discipline themselves (see Strings, 2019). Based on this premise, dismantling the anti-obesity assemblage should have positive effects for people of all sizes. Researchers could measure decreased fear of fatness among all populations. Research on decreased fear of fatness in children would be an excellent indicator of the positive effects of dismantling the AOA, since existing research indicates that children internalize negative messages about fatness from very young ages.

While the anti-obesity assemblage is comprised of anything that helps to enable or enact the elimination of obesity, fat studies scholarship has focused heavily on the ways that obesity elimination is enacted and with what consequences. With the concept of the AOA, we can now also challenge the ways that obesity elimination is enabled. Enabling obesity elimination takes place largely through discourse and knowledge production. For instance, discourses about fat people as sick and burdensome are frequently invoked as justification for obesity elimination. Another goal of fat positive research should be to intervene in these discourses and begin to raise awareness about weight stigma as a mediating factor between higher body weight and poorer health outcomes. Said more simply, part of dismantling the AOA involves asserting that it is *stigma*, rather than fatness, that makes fat people sick. Fat liberation researchers Monica Kriete and Marquisele Mercedes have provided a useful model of how these claims could work through their concept of the "Stigma-Harm Justification Cycle" (2023). This model shows that although stigma drives poor health and poor healthcare for fat people, when fat people are sick and/or die prematurely, this morbidity and mortality is used as evidence of the pathology of *fatness* instead

of stigma. This enables an increase in stigmatizing claims about fat people as pathological. Concepts such as the Stigma-Harm Justification Cycle can help raise awareness not only of the detrimental effects of weight stigma, but also how these detrimental effects serve to enable obesity elimination. Sociologists and public health scholars who study the social determinants of health should shift their focus from the social determinants of obesity to weight stigma as a social determinant of disproportionate illness and death among fat people. Research on this topic would provide useful evidence for the case to dismantle the AOA.

The task of fat activists and activism-oriented fat studies scholarship is to work towards a world in which it is widely recognized that trying to eliminate obesity is stigmatizing. Working towards this goal will involve intentionally changing how we talk about and critique anti-fatness. Fat activism will need to decrease its reliance on critical weight science and claims about the "truth" of fatness. Fat activists should no longer entertain debates about whether being fat is a "choice," as such debates a) make anti-fatness unjust only if fatness is not volitional, b) keep the focus on what causes fatness, which implies that fatness is a problem, and c) distract from the more important topic of anti-fatness. Similarly, discussions about the BMI need to shift from debating its accuracy and history to pinpointing its prominent role in the anti-obesity assemblage and thus in the harms that fat people face. Armed with the concept of the AOA, fat activists can begin proactively critiquing the entirety of the structure of fat oppression, rather than reactively criticizing it piece by piece depending on what injustices are salient in the public consciousness (Mercedes, 2024).

Fat activism has struggled to articulate the structures that harm fat people, which has weakened the movement. Without a clear and common enemy, it is difficult to unite a marginalized group, and many fat people do not see themselves as facing marginalization beyond

their own failure to achieve thinness. Recognizing the anti-obesity assemblage as a primary structure of fat oppression can help fat activists reconstruct a social movement with a clear, coherent political strategy. This movement will no longer depend on fat people being blameless, but center on the harms fat people have faced from the war on obesity. For instance, fat activists could, like gay liberation activists in the 1970s, make claims about medicalization as a prominent source of weight stigma and begin pressuring medical professional organizations to demedicalize fatness. In 1971, gay liberation activists stormed a prestigious event at the annual convention of the American Psychiatric Association, where activist Frank Kameny told the audience of psychiatrists: "Psychiatry has waged a relentless war of extermination against us. You may take this as a declaration of war against you" (Bayer, 1987, p. 105). Fat activists have the ironic advantage of facing an *explicit* "war on obesity." Although there is no longer one conference to target for disruption, fat activists *can* treat the war on obesity as a condemnable elimination effort, just as gay liberation activists treated psychiatry's homophobia.

More simply, even *reducing* anti-obesity efforts could dramatically improve fat people's lives. Fat activists could pressure institutions and organizations to simply stop using the term "obesity" or asserting that there is an "obesity epidemic." Even if a few news organizations or academic publishers stopped printing stories or scholarship about "obesity," anti-fatness would decrease. Most importantly, fat activists need to make resoundingly clear at every opportunity that they are oppressed by efforts to produce a world without fat people and that there is no way to reduce fat oppression while expanding anti-obesity efforts.

With obesity elimination efforts identified as an oppressive force, working to revalue fat life becomes more urgent and meaningful. The body positivity and Health at Every Size® movements have faced pushback for asserting that fat people should love themselves and that fat

people are healthy. Some have criticized these messages for excluding fat people who do not love themselves and are sick or disabled (Gibson, 2022; Schott et al., 2023; Stadnyk, 2024). Understanding fat oppression through the anti-obesity assemblage provides a way to correct for the limitations of these messages; for instance, it is unlikely that any fat person can be truly "healthy" within a system that targets them for elimination. At the same time, the concepts of the AOA and afflictive power highlight the importance of positive representations of fat people. While we do not need to assert that fat people are healthy, it is still important to assert that fat people *can* flourish and that fat lives *are* livable. We should assert that fat people can love themselves and deserve *the right to feel positively about their bodies*, even as we recognize that these possibilities have been systematically diminished. Fat activism should work to actively counter the wide-ranging effects of obesity elimination efforts by revaluing fat life in all its diversity.

How Will Fat Liberation Survive in the Era of Ozempic?

Since the FDA approved Wegovy in 2021,[25] nearly every major US news publication has published some article about how the new class of GLP-1 weight loss drugs is undermining fat activism. In a podcast for *The Atlantic*, Hanna Rosin asks "Could Ozempic Derail the Body-Positivity Movement?" (Rosin, 2023). An *NPR* Weekend Edition interview ran with the title "Is the Resurgence of Weight Loss Drugs a Blow to the Body Positivity Movement?" (Rascoe & Al-Shalchi, 2023). An article in the *Wall Street Journal* inquired: "Will Ozempic Change 'Body Positivity' for Good?" (S. A. O'Brien, 2023). A headline in *Time Magazine* disposed with even the pretense of a question, asserting: "Ozempic Exposed the Cracks in the Body Positivity Movement" (Mhloyi, 2023).

[25] Wegovy was the first drug to receive FDA approval specifically for weight loss since 2014 (2021). Eli Lilly's GLP-1 agonist, ZepBound, has since also received approval.

Although body positivity and fat activism/fat studies are somewhat distinct, these headlines expose a legitimate vulnerability in the ongoing efforts to revalue fat people: the lack of a structural conception of anti-fatness. Lacking a structural conception has resulted in two profound weaknesses in the fat activist movement and in fat studies scholarship. First, as I have discussed extensively throughout this dissertation, fat activism and fat studies display a near-total reliance on the idea that obesity science is false/biased and has been debunked. Part of this debunking has included the idea that "diets don't work," i.e., that intentional weight loss is not sustainable for the vast majority of people. Ozempic and other GLP-1 agonists are threatening this truism because they do produce weight loss that, at least at this time, appears to be substantial and lasting for at least some percentage of the people who take them. As such, this class of drugs, as the headlines above indicate, reveal why debunking "bad science" cannot serve as the foundation for an activist movement. The right of fat people to live without oppression cannot be forever contingent on the inefficacy of weight loss drugs.

The second weakness that these headlines call attention to is the disproportionate focus on individual behavior in fat activism and fat studies scholarship. Without a structural understanding of how medicine produces anti-fatness (beyond the flaws of the BMI), many scholars have inappropriately focused on the question of whether individuals engaging in intentional weight loss is fatphobic (Cahill, 2010; K. Gupta, 2019; Heyes, 2006; LeBesco, 2014; Meleo-Erwin, 2011). In the introduction to the most recent special issue of the *Fat Studies Journal* on "Fat Social Justice Now," editor-in-chief Carla Pfeffer writes:

> I find myself wondering whether fat-and-size acceptance and health at every size (HAES®) approaches are the most effective – or even necessary – pathways toward fat social justice… does working toward fat social justice *require* personal acceptance of one's own fatness or size? (2024, pp. 113–114)

That Pfeffer would consider "personal acceptance" relevant at all to achieving "fat social justice" reveals the absence of a structural politic within fat studies. This is not sustainable. A field dedicated to arguing that fat people deserve to live without oppression cannot make this argument based only on studying, interrogating, or defending the lives and choices of fat people.

The fight for fat liberation, even in the era of Ozempic, must begin with a recognition that the existence of the anti-obesity assemblage structurally constrains fat people's life opportunities and ability to flourish. The rhizomatic network generated by anti-obesity efforts has shaped nearly every realm of US life, from eating and dating to schooling, entertainment, and healthcare. Such a network – dedicated to producing a world without obesity, and, by extension, without fat people – is incompatible with fat liberation, with access to a self-determined life. The goal of fat liberation, then, must be to increase fat people's freedom by dismantling the anti-obesity assemblage. Such an endeavor does not depend on obesity science being false. Whether a fat person accepts their size or pursues weight loss is irrelevant. What deserves our attention is, instead, bringing about a world in which dignity, access, and agency are not dependent on attempting thinness. If fat studies and fat activism take up this mission, based on a structural understanding of anti-fatness and the anti-obesity assemblage, neither Ozempic nor any other innovation in anti-obesity technology will have the power to derail the struggle for fat liberation.

Debates over whether it is fatphobic for individuals to take weight loss drugs have distracted fat studies scholars from the fact that any and all growth of the anti-obesity assemblage will intensify fat oppression. There is no upside to new anti-obesity medications. There is no secret exception to the rule that targeting fatness for elimination and working towards that elimination makes the world more hostile to fat people. As I have shown throughout this dissertation, rendering fat people *afflicted* is the *requisite precondition* for selling weight loss

drugs. A world in which hundreds of millions of people are prescribed anti-obesity medications undermines the possibility of a world in which fat people are liberated.

As such, fat activists and fat studies scholars have an obligation to condemn the development, marketing, sale, and prescription of anti-obesity medications. There should be no drugs that are indicated for obesity. This argument should not be made on the basis of risk (that these drugs may have unpleasant side effects), history (that other weight loss drugs have harmed people in the past), or efficacy (that these drugs may not work for everyone or forever). This argument should be made on the grounds that any resource directed towards fighting obesity intensifies the marginalization of fat people. On these grounds, fat activists could lobby the FDA to withdraw all anti-obesity drug indications and to never approve another drug indicated for obesity again. They could protest the inclusion of obesity in the ICD and its use by the CDC and the WHO. The possibilities are numerous. Notably, this assertion is entirely separate from the use of GLP-1 agonists to treat diabetes.[26] I make this point specifically on the grounds that *treating obesity* will inevitably oppress fat people.

I have given fat studies scholars an analytic for uncovering anti-fatness. Armed with knowledge of the anti-obesity assemblage, we can now ask of every discourse, practice, or policy about fatness: "Does this expand or otherwise legitimize the effort to produce a world without fat people?" If the answer is yes, then the matter in question will perpetuate fat oppression and should thereby face resistance. It is now time to begin asking this question, to direct our focus to a structure that has long benefitted from its invisibility, and to make the magnitude of our oppression undeniable. It is time to fight the anti-obesity assemblage. It is high time for fat activists to join the war on obesity – on the side of fat people, against the war itself.

[26] If individuals who take these medications for diabetes or some other condition lose weight while taking them, that should be treated as neutral information.

Appendix A: Search String and Coding Schema for Weight Stigma Research (Chapter 2)

Web of Science Search String

TI=(((fat OR obes* OR overweight OR antifat OR anti-fat) AND (stigma* OR prejudice* OR "discriminate against" OR "discrimination against" OR stereotype* OR "bias against" OR "biased against") OR "weight stigma" OR "weight bias" OR "obesity bias" OR "anti-fat" OR "antifat" OR "nurses' attitudes toward obesity and obese patients scale" OR "nurses' attitudes towards obesity and obese patients scale" OR "Attitudes Toward Obese Persons Scale" OR "Beliefs About Obese Persons Scale" OR "Fat Phobia Scale" OR "Fatphobia Scale" OR "Universal Measure of Bias - Fat" OR "Universal Measure of Bias-Fat") NOT stigmasterol) OR AB=(((fat OR obes* OR overweight OR antifat OR anti-fat) AND (stigma* OR prejudice* OR "discriminate against" OR "discrimination against" OR stereotype* OR "bias against" OR "biased against") OR "weight stigma" OR "weight bias" OR "obesity bias" OR "anti-fat" OR "antifat" OR "nurses' attitudes toward obesity and obese patients scale" OR "nurses' attitudes towards obesity and obese patients scale" OR "Attitudes Toward Obese Persons Scale" OR "Beliefs About Obese Persons Scale" OR "Fat Phobia Scale" OR "Fatphobia Scale" OR "Universal Measure of Bias - Fat" OR "Universal Measure of Bias-Fat") NOT stigmasterol)

Notes on search string:

- Used "weight bias" rather than "weight" AND "bias" due to too many irrelevant results
- Did not include "attitudes" as a separate term due to too many irrelevant results

Full Codebook and Coding Instructions

2 coding categories:

1. Enabling Obesity Elimination
2. Not Enabling Obesity Elimination

How to code

1. Assume text is *not enabling obesity elimination* until finding evidence to the contrary
2. Check abstract for evidence of *enabling obesity elimination* category
    - If you find evidence of *enabling obesity elimination*, use the drop down in the right-most column to code the item and proceed to the next item
3. If you do not find evidence of *enabling obesity elimination* in the abstract, proceed to the introduction and conclusion of the article
    - If you find evidence of *enabling obesity elimination*, use the drop down in the right-most column to code the item and proceed to the next item
    - If you do not find evidence per the coding scheme, use the drop down in the right-most column to code the item *not enabling obesity elimination* and proceed to the next item

Note: the term weight stigma is used in the following criteria to include weight bias, obesity stigma, obesity bias, obesity prejudice, weight-based discrimination, anti-fat bias, anti-fat attitudes, fat stigma, etc.

Criteria for "Enabling Obesity Elimination" category in Article Abstract

If the abstract of an article does any of the following, code the article as *enabling obesity elimination*

1. States that overweight/obesity is a disease
2. Portrays obesity as an epidemic and/or public health problem
3. Portrays obesity as burdensome on individuals, organizations, institutions, and/or society
4. Discusses the relationship between higher weight and negative health outcomes without centering stigma as a mediator
5. Portrays obesity, rather than a social force, as the cause of weight stigma
6. Discusses weight gain and/or barriers to weight loss at the individual or population level
7. Discusses weight stigma as driver of or risk factor for higher weight
8. Discusses weight stigma as a barrier to anti-obesity efforts at the individual, medical, public health, and/or policy level
    - Discusses reluctance of health professionals to engage in anti-obesity interventions, including counseling patients on weight loss, referrals (or lack thereof) to bariatrics, and/or prescribing weight loss medications, programs, other interventions, etc.
    - Includes self-directed anti-obesity efforts (i.e. weight loss efforts)
9. Calls for more anti-obesity education or research
10. Calls for more resources to be devoted to anti-obesity efforts [including recommending anti-obesity interventions]
11. Describes a study that measures weight loss or gain as an outcome of the research

Criteria for "Enabling Obesity Elimination" in Article Intro/Conclusion

If any of the following are mentioned even once in the introduction, discussion, or conclusion of an article, code the article as *enabling obesity elimination*

12. Characterizes weight stigma as a barrier to anti-obesity efforts at the individual, medical, public health, and/or policy level
    - Discusses reluctance of health professionals to engage in anti-obesity interventions, including counseling patients on weight loss, referrals (or lack thereof) to bariatrics, and/or prescribing weight loss medications, programs, other interventions, etc.
    - Includes self-directed anti-obesity efforts (i.e. weight loss efforts)
13. Calls for more anti-obesity education or research
14. Calls for more resources to be devoted to anti-obesity efforts [including recommending anti-obesity interventions]
15. Calls for intervening on weight stigma to reduce obesity

If any of the following are mentioned

- even once in the first two paragraphs
- even once in the conclusion/final paragraph
- or are discussed (in any combination) for three or more sentences / or are discussed in any 3 sentences throughout the full introduction, discussion, and conclusion

code the article as *enabling obesity elimination*:

16. Obesity is an epidemic and/or public health problem
17. Obesity is burdensome on individuals, organizations, institutions, and/or society
18. The relationship between higher weight and negative health outcomes without centering stigma as a mediator
19. Obesity, rather than a social force, is the cause of weight stigma
20. Weight stigma is driver of or risk factor for higher weight
21. Weight gain and/or barriers to weight loss at the individual or population level

Appendix B: Corpus of Weight Stigma Interventions (Chapter 3)

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
1	Barra & Singh Hernandez (2018) "Too Big to Be Seen: Weight-Based Discrimination Among Nursing Students" *Nursing Forum*	103 nursing students Seton Hall University, College of Nursing, South Orange, New Jersey, USA	Weekly didactic education 15 weeks
2	Berman & Hegel (2017) "Weight Bias Education for Medical School Faculty: Workshop and Assessment" *Journal of Nutrition Education and Behavior*	Medical school faculty in occupational medicine, psychiatry, weight and wellness, cancer control, and medicine Geisel School of Medicine at Dartmouth, Lebanon, NH, USA	Didactic education 1 hour lecture during grand rounds or faculty meeting
3	Burke (2018) Stop the Stigma! Eliminating Implicit and Explicit Bias Toward Adult Obese Women Receiving Gynecological Care: A Quality Improvement Project to Cultivate Empathy and Increase Knowledge of Best Practices *Dissertation, University of Massachusetts, Amherst*	12 practicing Health Professionals at an OB/GYN clinic University of Massachusetts, Amherst College of Nursing, Amhurst, MA, USA	Didactic education including Rudd Center "Weight Bias in Healthcare" video 1-hour lunchtime session

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
4	Cook et al. (2021) "Management of Obesity During Pregnancy and Periconception: Case-Based Learning for OB/GYN Clerkships" *MedEdPORTAL*	20 third year medical students School of Medicine, University of South Carolina, Columbia, SC, USA	Didactic education Vignettes Discussion 30 minutes of preparation, 60-minute in-person or remote seminar and discussion
5	Cotugna & Mallick (2010) "Following a Calorie-Restricted Diet May Help in Reducing Healthcare Students' Fat-Phobia" *Journal of Community Health*	40 dietetics and health promotion or health behavior science major students Department of Health, Nutrition & Exercise Sciences, University of Delaware, Newark, DE, USA	1 week simulation (low calorie diet)
6	Essel et al. (2022) "Discovering the Roots: A Qualitative Analysis of Medical Students Exploring Their Unconscious Obesity Bias" *Teaching and Learning in Medicine*	188 second-year medical students The George Washington University School of Medicine and Health Sciences, Washington DC, USA	Implicit Association Test and written reflection
7	Farooqi (2022) Decreasing Weight Bias to Improve Outcomes and the Patient-Provider Relationship *Dissertation, The University of Arizona*	1 DO, 1 MD, 2 FNPs The Graduate College, the University of Arizona, Tucson, AZ, USA	Didactic education 30-minute lunch session

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
8	Finbow (2019) The Student Body Project: Evaluating A Multi-Strategy Weight Bias Reduction Intervention With Food And Nutrition Students In Nova Scotia, Canada *Thesis, Mount Saint Vincent University*	22 dietetics students Mount Saint Vincent University, Halifax, Nova Scotia, Canada	Workshop including viewing performance "Balancing the Scales" 3 hours
9	Fitterman-Harris & Vander Wal (2021) "Weight Bias Reduction Among First-Year Medical Students: A Quasi-Randomized, Controlled Trial" *Clinical Obesity*	48 first-year medical students Department of Psychology, Saint Louis University, St. Louis, Missouri, USA	Didactic education including Weight of the Nation segment Part of Behavioural Medicine and Health course
10	Flinchum (2020) A Multifactorial Intervention to Reduce Weight Bias in Healthcare Providers *Dissertation, Valparaiso University*	42 nurses and medical staff College of Nursing and Health Professions of Valparaiso University, Valparaiso, IN, USA	Didactic education session including Rudd Center "Weight Bias in Healthcare" video 25 minutes
11	Frick (2007) In-Service Prompting Healthcare Workers' Awareness Of Fat /Size Bias: A Pilot Study *Dissertation, Antioch University New England*	37 HPs and nursing students Department of Clinical Psychology, Antioch University New England, Keene, NH, USA	Didactic education lecture 1 hour

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
12	Gajewski (2023) "Effects Of Weight Bias Training On Student Nurse Empathy: A Quasi-Experimental Study" *Nurse Education in Practice*	121 Nursing students School of Nursing, Oakland University, Rochester, MI, USA	Didactic education, simulation with standardized patient in fat suit Part of Health Assessment course lab
13	Geller & Watkins (2018) "Addressing Medical Students' Negative Bias Toward Patients With Obesity Through Ethics Education" *AMA Journal of Ethics*	677 first-year medical students Johns Hopkins University School of Medicine, Baltimore, MD, USA	Ethics session, small group discussion and clips from 2 *House* episodes, 90 minutes, part of Obesity, Nutrition, and Behavior Change course
14	Ghartey (2019) Effects of Bariatric Sensitivity Training on Medical Intermediate Care Unit Nurses *Dissertation, Chatham University*	34 nurses Chatham University, Pittsburgh, PA, USA	Didactic education and discussion, including Rudd Center "Weight Bias in Healthcare" video 1 hour
15	Hales et al. (2018) "A Qualitative Study to Explore the Impact of Simulating Extreme Obesity on Health Care Professionals` Attitudes and Perceptions" *Ostomy Wound Management*	6 RNs & 1 physiotherapist Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington, Newtown, Wellington, New Zealand	Fat suit simulation 3 hours

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
16	Hunter et al. (2018) "Exploring Student Nurses' Attitudes Towards Those Who Are Obese and Whether These Attitudes Change Following A Simulated Activity" *Nurse Education Today*	29 nursing students Nursing Division, School of Health Sciences, City, University of London, United Kingdom	Fat suit simulation 30 minutes
17	Isom (2020) The Effect of an Educational Video Intervention on Knowledge of Obesity and Weight Bias in Dietetic Interns: A Mixed Methods Analysis *Dissertation, Simmons University*	70 dietetics interns Simmons College School of Nursing and Health Sciences, Boston, MA, USA	Didactic education session, including Rudd Center "Weight Bias in Healthcare" video 8 hour session, 60 minute lunchtime intervention
18	Kushner et al. (2014) "An Obesity Educational Intervention for Medical Students Addressing Weight Bias And Communication Skills Using Standardized Patients" *BMC Medical Education*	127 first-year medical students Northwestern University Feinberg School of Medicine, Chicago, IL, USA	Didactic education, simulation (SP in fat suit) Fall semester Communication Skills unit
19	Ladwig (2023) "Fostering Weight Status Understanding Among Exercise Science and Health Students by Simulating Common Physical Activities With Additional Body Mass" *Advances in Physiology Education*	9 exercise science & health students Purdue University Northwest, Hammond, IN, USA	Didactic education, simulation (weighted vest) 2 75-minute class meetings, 40 minute simulation

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
20	Luig et al. (2020) "Improving Obesity Management Training in Family Medicine: Multi-Methods Evaluation Of The 5AsT-MD Pilot Course" *BMC Medical Education*	42 family medicine residents University of Alberta, Edmonton, Canada	Didactic education medical education workshop, simulation (fat suit), simulation (SP), clinical practice 2 day workshop, 15 minute simulation
21	Marcum (2009) Effectiveness of Obesity Sensitivity Education on Changing Attitudes and Beliefs of Nurses and Nursing Students *Dissertation, College of Saint Mary*	101 nurses, nursing students, nursing instructors College of Saint Mary, Omaha, NE, USA	Didactic education, online module including Rudd Center "Weight Bias in Healthcare" video Self-paced
22	Matharu et al. (2014) "Reducing Obesity Prejudice in Medical Education" *Education for Health*	63 medical students UC Davis, UC Irvine, Mayo Clinic USA	Dramatic reading and discussion 1 hour
23	Molloy et al. (2016) Molloy et al. (2023) (reviews 2016 article) "Using Trigger Films as a Bariatric Sensitivity Intervention: Improving Nursing Students' Attitudes and Beliefs About Caring for Obese Patients" *Nurse Educator*	70 nursing students School of Nursing, Duke University, Durham, North Carolina, USA	Viewing of trigger films and discussion 1 hour

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
26	Moto et al. (2020) "A Web-Based Training Approach to Impacting Providers' Attitudes Toward Obesity Care" *Online Journal of Nursing Informatics*	22 mixed health professionals Troy University School of Nursing, Montgomery, AL, USA	Didactic education: self-paced online modules (Rudd Center) 8 weeks
24	Nestorowicz & Saks (2021) "Addressing Bias Toward Overweight Patients: a Training Program for First-Year Medical Students" *Medical Science Educator*	24 first year medical students Rutgers Robert Wood Johnson Medical School, Piscataway, NJ, USA	Didactic education, including Rudd Center "Weight Bias in Healthcare" video, discussion, museum visits 3 months
25	O'Reilly (2018) A Case Study Of The BalancedView Course: Addressing Weight Stigma Among Health Care Providers In British Columbia *Dissertation, University of British Columbia*	249 mixed health professionals The University of British Columbia, Vancouver, Canada	Didactic education, self-paced online modules 2-3 hours to complete

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
27	Oliver et al. (2020) Oliver et al. (2021) 2020: "Weight Sensitivity Training Among Undergraduate Nursing Students" *Journal of Nursing Education* 2021: "Reflective Journaling Of Nursing Students On Weight Bias" *Nurse Education Today*	125 third year nursing students Villanova University, Villanova, PA, USA	Didactic education including Rudd Center "Weight Bias in Healthcare" video, reflective journaling Embedded in semester-long course curriculum
28	Oliver et al. (2022) "Development of a Weight Bias Reduction Intervention for Third-Year Nursing Students" *Clinical Obesity*	99 third-year nursing students Villanova University, Villanova, PA, USA	Didactic education including Rudd Center "Weight Bias in Healthcare" video, reflective journaling Embedded in semester-long course curriculum
29	Persky & Eccleston (2011) "Impact of Genetic Causal Information on Medical Students' Clinical Encounters with an Obese Virtual Patient: Health Promotion and Social Stigma" *Annals of Behavioral Medicine*	39 third- and fourth-year medical students Recruited from Washington DC and Baltimore, MD, USA	Reading, simulation (VR standardized patient) 1 hour

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
30	Poustchi et al. (2013) "Brief Intervention Effective in Reducing Weight Bias in Medical Students" *Family Medicine*	64 second- and third-year medical students UMDNJ-Robert Wood Johnson Medical School, Piscataway, NJ, USA	Didactic education, including Rudd Center "Weight Bias in Healthcare" video, discussion <1 hour
31	Price et al. (2017) "An Innovative, Arts-Based Approach to Interprofessional Education" *Health & Interprofessional Practice*	335 health professions students and faculty Dalhousie University, Halifax, Nova Scotia, Canada	Workshop including viewing performance "Balancing the Scales" 3 hours
32	Quirk (2017) Weight Bias: Investigating the Impact of an Empathy-Evoking Intervention in Reducing Mental Health Professionals' Anti-Fat Attitudes *Dissertation, City University of London*	65 mental health professionals City, University of London, United Kingdom	Viewing of Rudd Center "Weight Bias in Healthcare" video 5 minutes
33	Renold et al. (2023) "The Effect of a Multifaceted Intervention Including Classroom Education and Bariatric Weight Suit Use on Medical Students' Attitudes Towards Patients With Obesity" *Obesity Facts*	79 third- and fourth-year medical students University of Zurich, Zurich, Switzerland	Didactic education course, simulation (fat suit) 8-week course, 30 minute simulation

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
34	Roberts et al. (2011) Teaching Medical Students About Obesity: A Pilot Program to Address an Unmet Need Through Longitudinal Relationships With Bariatric Surgery Patients *Surgical Innovation*	4 third-year medical students Harvard Medical School, Boston, MA, USA	Direct contact with bariatric patients, didactic education, reflective journaling 1 year
35	Rote et al. (2018) "Development and Assessment of a Course to Reduce Weight Bias in Undergraduate Health Promotion Students" *Pedagogy in Health Promotion*	21 health and wellness majors The University of North Carolina at Asheville, Asheville, NC, USA	Didactic education Full semester course, Body Fat and Body Image
36	Rukavina et al. (2008) "A Service Learning Based Intervention to Change Attitudes Toward Obese Individuals In Kinesiology Pre-Professionals" *Social Psychology of Education*	95 kinesiology pre-professionals The Ohio State University, Columbus, OH, USA	Didactic education, simulation (role play), direct contact Semester-long test and measurement class, 1 afternoon direct contact
37	Setchell et al. (2017) "Addressing Weight Stigma in Physiotherapy: Development Of A Theory-Driven Approach to (Re)Thinking Weight-Related Interactions" *Physiotherapy Theory and Practice*	8 physiotherapists The University of Queensland, Brisbane, Australia	Readings and discussion/reflection 3 months

Table 3: Corpus of Weight Stigma Interventions

	Authors (Year) **Title** **Publication**	**Intervention Population** **Location**	**Format & Duration**
38	Swift et al. (2013) "Are Anti-Stigma Films a Useful Strategy for Reducing Weight Bias Among Trainee Healthcare Professionals? Results of a Pilot Randomized Control Trial" *Obesity Facts*	22 dietetic and medical students The University of Nottingham, Sutton Bonington Campus, Loughborough, UK	Didactic education: 2 Rudd Center videos – "Weight Bias in Healthcare" and "Weight Prejudice Myths & Facts" 1 hour
39	Tanner (2017) An Educational Intervention to Increase Awareness Of Weight Bias In Nursing Students *Dissertation, University of Alabama*	45 nursing students The Graduate School of the University of Alabama, Tuscaloosa, AL, USA	Didactic education session including Rudd Center "Weight Bias in Healthcare" video 20 minutes
40	Wijayatunga et al. (2019) "The Effects of a Teaching Intervention on Weight Bias Among Kinesiology Undergraduate Students" *International Journal of Obesity*	33 kinesiology students Texas Tech University, Lubbock, TX, USA	Didactic education, "Weight of the Nation" clip, role play Embedded in semester-long course
41	Williams (2022) Evaluation of a Pilot Program to Increase Healthcare Professionals Awareness of the Effects of Weight Bias: A Doctor of Nursing Practice Scholarly Project *Dissertation, University of Virginia*	10 health professionals School of Nursing, University of Virginia, Charlottesville, VA, USA	Self-study modules including "Weight of the Nation" clip 7 weeks

Appendix C: Corpus of Weight Stigma Intervention Materials (Chapter 3)

Table 4: Corpus of Materials Used in Weight Stigma Interventions with Health Professionals

Intervention	**Medium**	**Resource (Year)**	**Link/Source**
Barra & Singh-Hernandez (2018)	News Media	Fire Service Called in 50 Times to Winch Fat People Out (The Telegraph, 2012)	https://www.telegraph.co.uk/news/health/news/9587979/Fire-service-called-in-50-times-to-winch-fat-people-out.html
Barra & Singh-Hernandez (2018)	News Media	Too Fat to Fly: Did This Man Need Three Seats? (ABC News, 2009)	http://abcnews.go.com/Travel/BusinessTraveler/obese -passengers-fat-fat-fly-american-airlines/story?id=9249954
Barra & Singh-Hernandez (2018)	Image	MRI Scans of Obese and Thin Women	https://www.sciencephoto.com/set/2126/healthcare-mri-scans-of-obe%20se-and-thin-women
Berman & Hegel (2017)	Lecture Slides	Size-Based Bias and Discrimination in Obesity Care: *Our Patients Deserve Better!* (2017)	Article Supplement
Burke (2018)	Lecture Outline	Stop the Stigma! Eliminating Implicit and Explicit Bias Toward Adult Obese Women Receiving Gynecological Care (2018)	Dissertation Appendix E
Burke (2018); Flinchum (2020); Ghartey (2019); Isom (2020); Marcum (2009); Nestorowicz & Saks (2021); Oliver et al. (2020) & Oliver et al. (2021); Oliver et al. (2022); O'Reilly (2016); Poustchi et al.	Video (Educational)	Weight Bias in Health Care (2009) – The Rudd Center for Food Policy and Obesity	https://youtu.be/lZLzHFgE0AQ

Table 4: Corpus of Materials Used in Weight Stigma Interventions with Health Professionals

Intervention	Medium	Resource (Year)	Link/Source
(2013); Quirk (2017); Swift et al. (2013); Tanner (2017)			
Cook et al. (2021)	Article	ACOG Practice Bulletin No. 105: Bariatric Surgery and Pregnancy (2009)	https://doi.org/10.1097/AOG.0b013e3181ac0544
Cook et al. (2021)	Clinical Practice Guidelines	Pharmacological Management of Obesity: An Endocrine Society Clinical Practice Guideline (2015)	https://doi.org/10.1210/jc.2014-3415
Farooqi (2022)	Lecture Slides	Using Sensitive Communication in Weight-Related Conversations to Improve Patient Outcomes (2022)	Dissertation Appendix E
Finbow (2019); Price et al. (2017)	Video (Dramatic Performance)	*Blame, Shame, and Lack of Support*: A Multilevel Study on Obesity Management (dramatic adaptation) (2013)	https://youtu.be/LVX4_s5IP3g
Fitterman-Harris & Vander Wal (2021); Williams (2022)	Video (Educational)	*The Weight of the Nation*: Stigma - The Human Cost of Obesity (2012)	https://youtu.be/4Ow1uiWcn4c
Flinchum (2020)	Clinical Practice Guidelines	Guidelines for Providing Safe, Sensitive and Compassionate Communication and Care to Patients with Overweight and Obesity	Dissertation Appendix H
Flinchum (2020)	Script	Opinion Leader/Exemplar Script	Dissertation Appendix G
Frick (2007)	Lecture Slides	Challenge to Change: Antifat Bias in Healthcare	Dissertation Appendix D
Gajewski (2023)	Clinical Practice Guidelines	Weight Bias in Healthcare: A Guide for Healthcare Providers Working with	https://www.obesityaction.org/wp-ontent/uploads/Weight_

Table 4: Corpus of Materials Used in Weight Stigma Interventions with Health Professionals

Intervention	Medium	Resource (Year)	Link/Source
		Individuals Affected by Obesity	Bias_in_healthcare_4_12_17.pdf
Gajewski (2023)	Video (Educational)	Breaking Bias | Sarah Bramblette | TEDxNSU (2014)	https://youtu.be/1_XuwM844bY
Gajewski (2023)	Standardized Patient Script	Simulation Script: Tom Carter is a 28-year-old male admitted with a diagnosis of uncontrolled HTN	Personal Communication
Geller & Watkins (2018)	Television Episode	*House*: Heavy (S1 E16)	N/A
Geller & Watkins (2018)	Television Episode	*House*: Que Sera Sera (S3 E6)	N/A
Kushner et al. (2014)	Article	Memoirs of an Obese Physician (2010)	https://doi.org/10.7326/0003-4819-153-10-201011160-00017
Kushner et al. (2014)	Clinical Practice Guidelines	Talking About Weight with Your Patients (2011)	http://www.ama-assn.org/resources/doc/public-health/talking-aboutweight-kushner.pdf
Marcum (2009)	Lecture Slides	Obesity Sensitivity Education	Dissertation Appendix L
Matharu et al. (2014)	Script	*The Most Massive Woman Wins* (1998)	N/A
Moto et al. (2020)	Online Modules	Preventing Weight Bias Toolkit (2017)	http://www.uconnruddcenter.org/resources/bias_toolkit/index.html.
O'Reilly (2018)	Online Modules	BalancedView Modules	https://balancedviewbc.ca/
Persky & Eccleston (2011)	Article Excerpt	Modern Science Versus the Stigma of Obesity (2004)	https://www.nature.com/articles/nm0604-563
Persky & Eccleston (2011)	Article Excerpt	The Etiology of Obesity: Relative Contribution of Metabolic Factors, Diet, and Physical Activity (1998)	https://doi.org/10.1016/S0002-9343(98)00190-9

Table 4: Corpus of Materials Used in Weight Stigma Interventions with Health Professionals

Intervention	Medium	Resource (Year)	Link/Source
Rote et al. (2018)	Book	*Why We Get Fat* (Taubes 2011)	N/A
Rote et al. (2018)	Book	*The Obesity Paradox* (Lavie 2014)	N/A
Rote et al. (2018)	Book	*A Big Fat Crisis* (Cohen 2013)	N/A
Rote et al. (2018); Wijayatunga et al. (2019)	Video (Educational)	*The Weight of the Nation* (2012)	https://youtu.be/-pEkCbqN4uo
Setchell et al. (2017)	Article	Physiotherapists Demonstrate Weight Stigma: A Cross-Sectional Survey of Australian Physiotherapists (2014)	https://doi.org/10.1016/j.jphys.2014.06.020
Setchell et al. (2017)	Article	Weight Stigma in Physiotherapy Practice: Insights From Patient Perceptions of Interactions With Physiotherapists (2015)	https://doi.org/10.1016/j.math.2015.04.001
Setchell et al. (2017)	Article	Physical Therapists' Ways of Talking About Overweight And Obesity: Clinical Implications (2016)	https://doi.org/10.2522/ptj.20150286
Swift et al. (2013)	Video (Educational)	Weight Prejudice: Myths & Facts (2009) – The Rudd Center for Food Policy and Obesity	https://youtu.be/92rWQ-OIb1Y
Wijayatunga et al. (2019)	Video (Educational)	*Why are Thin People Not Fat?*	Part 1: https://vimeo.com/188835636; Part 2: https://vimeo.com/188837113
Wijayatunga et al. (2019)	Roleplay Script	Communication Efficacy Around Body Composition-Group Assignment	Article Supplement 2
Wijayatunga et al. (2019)	Lecture Slides	Body Composition: 1	Article Supplement 1

Table 4: Corpus of Materials Used in Weight Stigma Interventions with Health Professionals

Intervention	Medium	Resource (Year)	Link/Source
Williams (2022)	Clinical Practice Guidelines	NAAFA Guidelines for Healthcare Providers with Fat Clients	https://static1.squarespace.com/static/5e7be2c55ceb261b71eadde2/t/605d0b09af80014b16bbb2cd/1616710410284/2020+Guidelines+for+Healthcare+Providers.pdf
Williams (2022)	Fictional Story	"Eva's Story"	Dissertation Appendix F

Table 5: Additional Documentation of Weight Stigma Interventions with Health Professionals

Intervention	Medium	Resource (Year)	Link/Source
Barra & Singh-Hernandez (2018)	Lecture Slides	Too Big to be Seen: Weight Based Discrimination Amongst Student Nurses	http://blogs.shu.edu/rrd/files/2021/04/2021_Barra.pdf
Hales et al. (2018)	Lecture Slides	Simulating Size Study Findings	https://www.bariatricmanagementinnovation.org/files/1488924875783.pdf
Hales et al. (2018)	User Manual	Bari-suit® User Manual	https://www.benmormedical.co.uk/wp-content/uploads/2019/01/bari-suit%C2%AE-User-Manual.pdf
Hunter et al. (2018)	Video (Intervention Demonstration)	Use of empathy suits at City University London	https://youtu.be/tqvm00Tc-T8
Molloy et al. (2016)	Lecture Slides	Using Trigger Films as a Bariatric Sensitivity Intervention to Improve Nursing Students' Attitudes and Beliefs	https://sigma.nursingrepository.org/handle/10755/621799

Table 5: Additional Documentation of Weight Stigma Interventions with Health Professionals

Intervention	Medium	Resource (Year)	Link/Source
Oliver et al. (2020/21/22)	Lecture Slides	Strategies for Reducing Weight Bias in Education and within Healthcare: Steps Towards Change	https://www1.villanova.edu/content/dam/villanova/nursing/documents/cope-webinars/TOliver%20PPT%2012-7-21%20FINAL%20for%20participants.pdf
Oliver et al. (2020/21/22)	Video (Recorded Presentation)	COPE Webinar, Dec 2021: Strategies for Reducing Weight Bias in Education and within Healthcare	https://youtu.be/WSeRv38hYbk
Price et al. (2017)	Video (Recorded Presentation)	Balancing the Scales: Promoting Healthy Weight Management without Blame or Shame	https://youtu.be/KXq-BGePK8w
Renold et al. (2023)	Video (Intervention Demonstration)	Supplementary Material for: The effect of a multifaceted intervention including classroom education and bariatric weight suit use on medical students' attitudes towards patients with obesity.	https://doi.org/10.6084/m9.figshare.22347217.v1

Appendix D: Detailed Information on Fat Suit Weight Stigma Interventions (Chapter 3)

Table 5: Weight Stigma Interventions with Health Professionals Involving Fat Suits

Study/Location	Participants/ Suit Details	Intervention Procedure	Fat Suit Protocol
Hales et al. (2018) University of Otago, Wellington, Wellington, New Zealand	*n* = 7 Six Registered Nurses and One Registered Physiotherapist Benmor Medical bari-suit®[a] 7.5 kg (20 lbs)	1. Questionnaire: 5 open-ended questions that focused on perceived difficulties a person with obesity may face on a daily basis, during exercise, and when engaging with health care services; perceived feelings when in public places; and what health care professionals should know or try to find out from people with obesity. 2. 20–40-minute interview 3. Fat suit experience 4. Second interview while wearing the suit	2-3 Hours Walking up and down stairs, tying shoelaces, taking public transport, visiting a café, or going food shopping in a large metropolitan supermarket
Hunter et al. (2018)[b] School of Health Sciences, City, University of London, England, United Kingdom	*n* = 29 Second Year Nursing Students Benmor Medical bari-suit®[c] 12-15 kg (26-33 lbs)	1. NATOOPS survey 2. Fat suit experience 3. NATOOPS survey 4. Focus group interview	30 Minutes Everyday activities such as tying shoe laces and using public toilet facilities
Ladwig (2023) Integrative Physiology and Health Sciences Center, Purdue University Northwest, Indiana, USA	*n* = 9 Exercise Science and Health major undergraduate students RUNmax Adjustable Weighted Vest 16 and 32 lbs	1. Day 1: 75-minute didactic lecture on affective responses to physical activity at different physiological intensities and how these experiences influence activity adoption and adherence; summary of difficulties practitioners may encounter while attempting to foster pleasure among both overweight and sedentary clients.	Performed twice, first with 16 lbs and second with 32 lbs Activity 1: walked to a chair, removed both shoes, sat down on the chair, put their shoes back on, and retied their shoes while remaining seated.

Table 5: Weight Stigma Interventions with Health Professionals Involving Fat Suits

Study/Location	Participants/ Suit Details	Intervention Procedure	Fat Suit Protocol
		2. Day 2: 15 minutes - weight status understanding worksheet (BMI calculations at current weight, +16 lbs, and +32 lbs; "thought experiment" to imagine activity at +16 lbs and +32 lbs). 3. Fat suit experience 4. Review worksheet from pre-fat suit experience, document unexpected experiences and how they might approach activity promotion differently among overweight clients based on what they had just experienced	Activity 2: Briskly walk down and back 100 foot hallway; run down and back 100 foot hallway. Activity 3: Climb and descend 3 flights of stairs.
Luig et al. (2020) University of Alberta, Edmonton, Canada	*n* = 42 First Year Family Medicine Residents XXL-Rehab Bariatric Suit 6.5 kg (14 lbs)	8 – 11 hours over 2 days 1. Interactive, discussion-based lectures covering: 1) the complex etiology of obesity and its chronicity, 2) an introduction to the 5A's of Obesity Management and the 5AsT approach, 3) assessment and management of obesity in pediatrics 4) prevention, pregnancy and postpartum, 5) management of obesity, including lifestyle changes, medications and bariatric surgery. 2. Fat suit experience 3. One page narrative reflection on their experience wearing the suit. 4. At the next session, residents discuss their experiences and reflections in small groups facilitated by expert preceptors. 5. Standardized patient interviews: Residents	≤15 Minutes Tasks of daily living, i.e., getting dressed, cleaning the apartment, getting out of bed, making the bed, in a "Smart Condo" owned by the university[d]

Table 5: Weight Stigma Interventions with Health Professionals Involving Fat Suits

Study/Location	Participants/ Suit Details	Intervention Procedure	Fat Suit Protocol
		demonstrate their use of the 5A's by practicing with standardized patients. 6. Debrief in small groups including preceptor, standardized patient, and peers. 7. In-clinic practice: Residents practice the newly acquired skills and knowledge with one of their own patients in clinic. 8. Residents reflect on their experience in a one-page narrative, which they debrief with their preceptor.	
Renold et al. (2023) University of Zurich, Zurich, Switzerland	*n* = 79 Third and fourth year medical students Unknown 7 kg (15 lbs)	8-week course 1. NEW Attitudes Scale 2. 8 course sessions with 2 interactive lectures (2h each) on epidemiological, medical, physiological, and psychological aspects of obesity. The course included a live surgery transmission of a laparoscopic Roux-en-Y gastric bypass procedure from the operating theatre to the classroom with narration of the operating surgeon. 3. Fat suit experience 4. Class presentation on fat suit experience 5. NEW Attitudes Scale	≥ 30 Minutes Everyday activities in public: taking the bus or tram, walking in crowded areas, clothes shopping, interacting with sellers, going to a restaurant, or to a fitness consultation. Groups of three; one student took photos and video while others wore suit,

Note. The primary function of the suits was to increase the wearer's size. I am including the weight of the suits here as a reference for how much they may have additionally strained their wearers beyond their enlarging function.

[a] The authors do not specify which suit was used for the intervention in the article. An image of the suit was found in a 2017 presentation by the first and second authors (Hales & Gray, 2017).

[b] This article was retracted in 2022 (Hunter et al., 2023).

[c] The authors do not specify which suit was used for the intervention in the article. An image of the suit was found in a 2014 blog post by the first and second authors (Hunter & Rawlings-Anderson, 2014).

[d] Information about the smart condo can be found on the university website (University of Alberta, n.d.).

Appendix E: Weight Stigma Interventions that Occurred During Anti-Obesity Training (Chapter 3)

Table 6: Weight Stigma Interventions that Occurred During Anti-Obesity Training

Study/Participants	**Obesity Education**	**Weight Stigma Component**
Isom (2020) Dissertation, PhD in Health Professions Education Simmons University, Boston, MA, USA 27 Dietetics Interns	Beth Israel Deaconess Medical Center **Joint Dietetic Internship Class Obesity Day** **9:30 – 9:45:** Welcome **9:45 – 10:00:** Weight Bias Study - overview/instructions **10:00 - 10:45:** Surgical Options for Treating Obesity, Edward A. Hatchigian, MD, Medical Director, Weight Loss Surgery Program, Bariatric Surgery Program, Department of Surgery, BIDMC **11:00 – 12:00:** Getting Your Clients to Do What They Know..., Kerri Hawkins, MS, RD, LDN, cPT, Family Practice Group, The Sagov Center for Family Medicine **12:00 – 1:00:** Lunch (Weight Bias Intervention) **1:00 – 2:00:** Nutrition Practice Standards for the Bariatric Patient, Emma G. Samuels, MS, RD, LDN, Bariatric Dietitian, Bariatric Surgery Program, BIDMC **2:00 – 3:00:** Medical Management of Obesity Florencia Halperin, MD, Medical Director, Program for Weight Management, Co-Director, Center for Weight Management and Metabolic Surgery, Brigham and Women's Hospital **3:00 – 3:30:** Evaluations and Weight Bias Study wrap-up	Intervention group: Screening of Rudd Center "Weight Bias in Healthcare" during lunch. After the video, intervention group discussed their experiences working with patients with obesity. Discussion Questions: 1. Can you share a time that you had a similar experience as the health providers and/or patient in this video? 2. If you observed this behavior in a healthcare setting, was any action taken either by you, a supervisor, another patient, etc…)? 3. What kind of strategies do you think healthcare providers can use to ensure sensitive, compassionate care that is free of weight bias?
Luig (2020)	**5AsT-MD course**: 5As of Obesity Management™"(ASK, ASSESS, ADVISE,	

Table 6: Weight Stigma Interventions that Occurred During Anti-Obesity Training

Study/Participants	Obesity Education	Weight Stigma Component
University of Alberta, Edmonton, Canada 42 Family Medicine Residents	AGREE, ASSIST) to support primary care obesity conversations. Fall cohort: 11 hours over 2 days. Spring cohort: 8 hours over 2 days. **Interactive, discussion-based lectures covering**: 1. the complex etiology of obesity and its chronicity 2. an introduction to the 5A's of Obesity Management and the 5AsT approach 3. assessment and management of obesity in pediatrics 4. prevention, pregnancy and postpartum 5. management of obesity, including lifestyle changes, medications and bariatric surgery **Empathy suit experience:** residents are given an opportunity to wear a empathy suit, which simulates a body size in the obesity class. Learners experienced the incumberance of obesity spending approximately 15 min in a Smart Condo executing tasks of daily living (i.e., getting dressed, cleaning the apartment, getting out of bed, making the bed). **Residents complete a one page narrative reflection** on their experience wearing the suit. At the next session, residents **discuss their experiences** and reflections in small groups facilitated by expert preceptors **Standardized patient interviews:** Residents demonstrate their use of the 5A's by practicing with standardized patients. Patient cases were designed to focus on specific parts of the 5A's (i.e., ASK, ASSESS, ADVISE, AGREE, ASSIST) and to allow residents to practice the skills and tools they have learned. **Residents debrief in small groups**, which include their preceptor, the standardized patient, and their peers.	15-minute Bariatric Empathy Suit experience.

Table 6: Weight Stigma Interventions that Occurred During Anti-Obesity Training

Study/Participants	Obesity Education	Weight Stigma Component
	In-clinic practice: Residents practice the newly acquired skills and knowledge with one of their own patients in clinic. Residents reflect on their experience in a one-page narrative, which they debrief with their preceptor.	
Renold et al. (2023) University of Zurich, Zurich, Switzerland 79 3rd & 4th-year medical students	**Full Semester Clinical Elective Course "Obesity and Related Diseases." Learning Objectives:** 1. The students understand the genetic, biological, and pathophysiological causes of obesity. 2. The students will gain insight into the physiological mechanisms of eating behavior and why we often do not eat what we should. 3. The students know the different forms of conservative and surgical therapy for obesity and their chances of success. 4. The students learn through the gamification task how much obesity limits the quality of life and how stigmatizing our society's treatment of the disease and those affected is. **Week 1:** Introduction: Stigma, Genes and Environment, Physiology of Eating Behavior, Appetite Control **Week 2:** Obesity related comorbidities, Preoperative Bariatric Assessment **Week 3:** Post-bariatric medical and surgical follow-up, Physiology of Eating Behavior, Gut hormones **Week 4:** Psychologic aspects of patients with obesity, Obesity Prevention, **Week 5:** Ingestive behavior in Obesity, Obesity in the Childhood	• Week 1 Lecture Learning Objective: To discuss common prejudices against patients with obesity • Week 7 Lecture Learning Objective: Discuss stigmatization of patients with obesity as part of ethics discussion • ≥ 30 Minutes Bariatric Weighted Suit experience in groups of 3. Everyday activities in public: taking the bus or tram, walking in crowded areas, clothes shopping, interacting with sellers, going to a restaurant, or to a fitness consultation.

Table 6: Weight Stigma Interventions that Occurred During Anti-Obesity Training

Study/Participants	Obesity Education	Weight Stigma Component
	Week 6: Bariatric-metabolic Surgery, Post-bariatric Physiology **Week 7:** Medical obesity treatments, Ethical questions in the treatment of Obesity **Week 8:** Transmission of Live Laparoscopic Roux-en-Y Gastric Bypass Surgery, Plenary Discussion: Experiences in the Bariatric weight suit Group Presentations	

Appendix F: Novo Nordisk's Weight Stigma Media Network (Chapter 4)

Table 7: Media Products Made by Novo Nordisk Directly

Website Title	**Description**	**Media Products**	**Selected Figures**
It's Bigger Than Me - Queen Latifah Ad Series	Website and campaign designed to spread the message that obesity is a chronic and misunderstood health condition with struggles and impacts that go beyond weight.	Diagnosis Stigma Body Talk: The Self-Hate Sitcom SIU: Shame Investigation Unit Let's Talk – An Honest Conversation	Queen Latifah
It's Bigger Than Me Live	It's Bigger Than Me Live was a three-city tour designed to encourage and empower honest conversations about obesity. With Queen Latifah as our host and a panel of experts by her side, they discussed the complexitities behind this disease and its impact on our society, bodies, and minds.	(not coded because these were live events) New York Houston Los Angeles	Olivia Affuso, Professor and Associate Scientist, University of Alabama Nutrition Obesity Research Center and Center for Exercise Medicine Brooke Burke, Author, actress and TV personality Dr. Michelle Toussaint, Clinical Health Psychologist, National Center for Weight and Wellness Dr. Angela Golden, Author and Owner, NP Obesity Treatment Clinic, Arizona 88 payments totaling $72,287.22 from NN
It's Bigger Than Me - Time to Talk/It's Bigger Than Me Series	Redefining Obesity: Obesity is a complex disease, and managing it requires a real understanding of the multiple factors that	Episode 1: My Body Isn't My Identity Episode 2: From Fear to	Yvette Nicole Brown, Actress Katie Sturino, CEO of Megababe, Fat Influencer

Table 7: Media Products Made by Novo Nordisk Directly

Website Title	Description	Media Products	Selected Figures
	contribute to it. That's why actress Yvette Nicole Brown, alongside people living with obesity and health care providers, are ready to unpack the reality of living with this disease. Because loving ourselves can and should include safeguarding our health and managing our weight.	Action: Approaching Obesity With Your Doctor Episode 3: Defending Your Right to Lose Weight Episode 4: Feeling Like a Failure: The Journey of Living with Obesity	Ashlee Marie Preston, Social Justice Influencer Anna O'Brien, Fat Influencer Lisa S., Novo Nordisk patient ambassador Dr. Tiffany Lowe-Clayton, DO • 139 payments totaling $121,286.30 from NN Dr. Deborah Horn, DO, MPH, MFOMA • 372 payments totaling $478,100.26 from NN Inc • 44 payments totaling $118,729.95 from NN AS Dr. Scott Kahan, MD, MPH
It's Bigger Than Me – Inclusive Obesity Care Initiative	Become an Ally for Inclusive Obesity Care: Obesity is a chronic but treatable disease, but for people living with obesity, there's more to managing it than we can see. With approximately 2 out of 5 adults in the United States living with obesity, it's important that they feel seen and heard when seeking help from a health care provider. But sometimes, the fear of being judged may stop many from doing so.	Supporting a Brighter Future for Obesity Care	Queen Latifah Dr. Sandra Sobel, MD • 8 payments totaling $7,270.88 from NN Dr. Craig Primack, MD, Obesity Medicine Specialist • 111 payments totaling $58,366.20 from NN

Table 7: Media Products Made by Novo Nordisk Directly

Website Title	Description	Media Products	Selected Figures
	That's why we're on a mission to reduce bias and stigma for people living with obesity.		
Truth About Weight	Losing weight and maintaining it is hard because of how the body responds when you lose weight. Many people lose weight at first, only to see it return. A health care provider can help you explore weight-management options. And reducing your weight may help improve certain risk factors for heart disease. patient facing	N/A	Reneé, Novo Nordisk patient ambassador Patty Nece, Novo Nordisk patient ambassador Lisa S., Novo Nordisk patient ambassador Donna Kasznel, Novo Nordisk patient ambassador
Rethink Obesity	Provider facing website with information about obesity disease progression, metabolic adaptations, diagnosing obesity, initiating a plan, advocacy and resources, and obesity treatment modules. Addressing weight bias page listed under diagnosing obesity.	A Day in the Life of a Patient with Obesity Donna's personal experience with weight management	Donna Kasznel, Novo Nordisk patient ambassador

Table 8: Media from Organizations Sponsored by Novo Nordisk

Organization Name/ Connection to Novo Nordisk	**Organization Description**	**Organization Media Products**	**Selected Figures**
Obesity Action Coalition/ Chairman's Council Platinum Donors - Contributing more than $100,000 annually to OAC's general operating efforts	The Obesity Action Coalition OAC is a more than 80,000 member-strong 501c3 National nonprofit organization. As one of the nation's leading voices on obesity, our core focuses are to raise awareness and improve access to the prevention and treatment of obesity, provide science-based education on obesity and its treatments, fight to eliminate weight bias and discrimination, elevate the conversation of weight and its impact on health and offer a community of support for the individual affected.	**Fresh Perspectives Series** • Eliminating Bias and Empowering Patients • Can You Be Body Positive and Still Want to Lose Weight? • The Whale: Brendan Fraser talks with OAC • An Honest Conversation About The Whale • Overcoming Internalized Weight Bias **Obesity Care Week** • Weight Bias **Stop Weight Bias Campaign** • Campaign Launch • Let's Stop Weight Bias in Children • Let's Stop Weight Bias in Healthcare • Let's Stop Weight Bias in the Workplace • Let's Stop Weight Bias Together • Profiles: Ted, Patty, Amber, Nikki, Faith • Paying it Forward: An Interview with Novo Nordisk	Ted Kyle, former pharmaceutical employee, former OAC Chairman, creator of ConscienHealth website and blog Patty Nece, JD, Immediate Past OAC Chair Joseph Nadglowski, President and CEO James Zervios, Vice President and Chief of Staff Yvonne Bryant, senior director, consumer marketing lead at Novo Nordisk Sarah Bramblette, Lipedema, Lymphedema, & Obesity Patient Advocate (@Born2lbFat)

Table 8: Media from Organizations Sponsored by Novo Nordisk

Organization Name/ Connection to Novo Nordisk	Organization Description	Organization Media Products	Selected Figures
		• OAC Interviews Queen Latifah	
The Creative Coalition/ Creative Coalition, including On the Edge Podcast, explicitly sponsored by Novo Nordisk.	A nonprofit advocacy group consisting of writers, actors, producers, directors, agents, designers and lawyers from the entertainment world	Grey's Anatomy Episode - Living in a House Divided **On the Edge Podcast** • Episode 3 – Yvette Nicole Brown: Family First • Episode 6 - Chandra Wilson: From The Broadway Boards To SAG Awards • Episode 8 - Grey's Anatomy Cast Members: Breaking Through With Television **Public Service Announcements** • If you told me… • Artists Using Their Voices: COVID-19 and Obesity PSA	Robin Bronk, CEO, The Creative Coalition Jacqueline Donabedian, Director of Medical Research, Grey's Anatomy, Jamie Denbo, Writer/Co-Executive Producer, Grey's Anatomy Chandra Wilson, Zaiver Sinnett, Chris Carmack, BokHee An, Grey's Anatomy Kiley Donovan, Executive Producer, Station 19, Boris Kodjoe, Station 19 Nicholas Gonzalez, The Good Doctor S. Epatha Merkerson, Steven Weber, Chicago Med Yvette Nicole Brown, Novo Nordisk Ambassador Tim Daly, Madam Secretary

Table 8: Media from Organizations Sponsored by Novo Nordisk

Organization Name/ Connection to Novo Nordisk	Organization Description	Organization Media Products	Selected Figures
			Dean Norris, Breaking Bad, Claws Tamara Tunie, Law and Order: Special Victims Unit Judy Gold, Better Things
AMC Sundance TV 9.14 Pictures Wavemaker Global/ Series explicitly sponsored by Novo Nordisk	Thick Skin follows the lives of four women in Philadelphia as they pursue professional success, face challenging relationships with their parents and search for love.	Thick Skin Documentary • 1: The Burden of Weight Stigma in Modern Society • 2: Overcoming Bias to Set Goals • 3: Fighting back against a body shaming world • 4: Building a better world Thick Skin Video Extras with Model Alex Frankel • Empathy • Fat Shaming • Toxic Diet Culture • Weight Loss	Ashley, a baker Queen, fat burlesque performer Lexi, singer/actor, the Fat Ingenue Susanne Johnson, nurse and health at every size influencer Alex Frankel, plus size model Dr. J David Prologo, Obesity Medicine Specialist
STOP Obesity Alliance/ Novo Nordisk is a corporate member, $25,000	The Strategies to Overcome and Prevent STOP Obesity Alliance is made up of a diverse group of business, consumer, government, advocacy, and health organizations dedicated to reversing the obesity epidemic in the United States. Drawing on the	Fast Facts – Weight Bias and Stigma	William Dietz, MD, PhD, Director Dr. Scott Kahan, MD, MPH, Medical Director

Table 8: Media from Organizations Sponsored by Novo Nordisk

Organization Name/ Connection to Novo Nordisk	Organization Description	Organization Media Products	Selected Figures
	strengths of the collaborative, STOP conducts research, makes policy recommendations, and develops hands-on tools for providers, advocacy groups, policymakers, and consumers.		
Media Empathy Foundation/ Report was developed and executed by the media empathy foundation and made possible thanks to the support of Novo Nordisk inc.	The Media Empathy Foundation is a 501c3 nonprofit organization. Our mission is to reduce health stigma by promoting empathy, compassion and inclusivity in all forms of media. Media has the power to shape public perceptions, bridge divides, and inspire change by challenging common stereotypes and biases associated with stigmatized health conditions.	Spotlight on Weight Stigma Panel Discussion The Media Empathy Report	Deborah Roberts, Senior National Affairs Correspondent for ABC News Mike Paseornek Founder, Lionsgate Motion Picture Production David Sloan Senior Executive Producer ABC Primetime Jeff Mahshie Creative Director, Donna Karan Orlando Reece VP/Category Development Officer, TelevisaUnivision Dr. Fatima Cody Stanford Dr. Rebecca Puhl Patricia Nece OAC

Table 8: Media from Organizations Sponsored by Novo Nordisk

Organization Name/ Connection to Novo Nordisk	**Organization Description**	**Organization Media Products**	**Selected Figures**
Vox Creative/ This advertising content was produced in collaboration between Vox Creative and our sponsor Novo Nordisk, without involvement from Vox Media editorial staff.	We are a creative collective within Vox Media that connects brands and audiences through the things that really matter to them…Together with our partners, we shine a spotlight on the untold stories: the voices, ideas, and talents that reflect our audience's dynamic world. We believe in empowering the personal identities of our people, including but not limited to race, gender, ability, sexuality, beliefs, culture, age, and body type.	Why is weight discrimination still legal? The (not so) ancient history of weight stigma The global spread of weight stigma How weight stigma in the doctor's office harms patients	Dr. Jennifer Shinall, Law Professor, Vanderbilt University Dr. Fatima Cody Stanford, Obesity Medicine Specialist, Harvard Medical School Dr. Alexandra Brewis, Arizona State University, Author of *Fat in Four Cultures* Dr. Asher Larmie, Fat Activist Influencer
The DEI Shift Podcast/ Sponsored by the American College of Physicians with a grant from Novo Nordisk	Our mission is to create a podcast series on diversity, equity, and inclusion (D.E.I.) in medicine that sparks discussion and provides practice-changing data and stories for a physician, student, allied health professional, and health care leader audience. We hope that listeners will be able to gain useful information to improve their practices and environments, to gain empathy, cultural competency, and	Obesity Management Mini-Series • Episode 1- Defining Obesity, Challenging Weight Bias	Dr. Fatima Cody Stanford Sanika Walimbe, undergraduate student, UCSD Cognitive Science Dr. Brittäne Parker, Internal Medicine Hospitalist

Table 8: Media from Organizations Sponsored by Novo Nordisk

Organization Name/ Connection to Novo Nordisk	Organization Description	Organization Media Products	Selected Figures
	humility, and to learn more about emerging D.E.I. concepts.		
Mediflix/ Film sponsored by Novo Nordisk	The trusted, inspiring and "Edutaining" Video Streaming Platform that helps patients, families and caregivers chart the health journey they have ahead. Healthcare has never been more central to our daily lives. Even with the vast amount of information available publicly, navigating to find credible, relevant, and understandable resources is frustrating and often inaccessible to the average person. Mediflix provides accurate information, access to the best knowledge and engagement from world-class medical institutions and practitioners with personalized information.	More Than What We See: An Obesity Journey | Parts 1 and 2	Dana Rosser Dr. James "Butch" Rosser Dr. Lou Aronne, MD, Obesity and Weight Management Specialist • 136 payments totaling $56,020.14 from NN Dr. Philip R Schauer, bariatric surgeon • 5 payments totaling $16,095.64 from NN AS • 11 payments totaling $11,965.04 from NN Inc

Table 9: Novo Nordisk-Sponsored Weight Stigma Thought Leaders

Name/Connection to Novo Nordisk	**Description**	**Media Products**
Anna O'Brien, Fat Influencer moniker Glitter and Lazers/ Paid speaker	Glitter and Lazers serves you plus size fashion, world travel, and interior design with a punch of personality and a dose of humor. On this channel you'll find plus size fashion hauls, honest reviews, home decor tips, interior decorating ideas, how tos, diy tips, look books, travel vlogs, vacations inspiration, outfit inspiration and a whole lot of real talk.	Sponsored Video – My Biggest Health Update Yet - Join me as I discuss the latest in my health journey. In this candid, and hopefully empowering video, I share my story, struggles, and triumphs that played crucial roles in my path to wellness. I highlight the pivotal importance of finding the right doctor. This is not just a tale of overcoming personal hurdles, but a testament to the power of perseverance. Whether you're on a similar journey or just seeking inspiration for your own life, I hope my story helps you realize that your wellbeing is always worth fighting for, and the right guide can make all the difference.
Fatima Cody Stanford/ Paid speaker and consultant 59 payments totaling $69,234.37 2020 article reported she gives 200 media interviews per year. 2021 article reported she gives 150 lectures per year.	Fatima Cody Stanford, MD, MPH, MPA, FAAP, FACP, FTOS is an obesity medicine physician scientist, educator, and policy maker at Massachusetts General Hospital and Harvard Medical School. She is a national and international sought after expert in obesity medicine who bridges the intersection of medicine, public health, policy, and disparities.	Stigma hampers care for people with excess weight and diabetes
Robert Kushner/ Paid speaker and consultant Novo Nordisk Inc 112 payments totaling $200,902.66 Novo Nordisk AS	Dr. Robert Kushner has a long, distinguished career as one of the most highly respected weight management experts in the world. He is Medical Director of the Center for Lifestyle Medicine at Northwestern Medicine in	Medscape inDiscussion Obesity Podcast • How to Challenge Obesity Bias and Stigma in Healthcare (with Joe Nadglowsky)

Table 9: Novo Nordisk-Sponsored Weight Stigma Thought Leaders

Name/Connection to Novo Nordisk	Description	Media Products
73 payments totaling $180,515.13	Chicago, Professor of Medicine and Medical Education, Northwestern University Feinberg School of Medicine, Past President of The Obesity Society and a founder of the American Board of Obesity Medicine (ABOM) that certifies physicians in the care of patients with obesity.	
Karl Nadolsky/ Paid speaker and consultant 249 payments totaling $4,386.24	Dr. Karl Nadolsky is a clinical endocrinologist & obesity specialist at Holland Hospital in Holland, MI, and clinical assistant professor of medicine at Michigan State University. He developed and served as director of the Diabetes, Obesity & Metabolic Institute and was faculty for the endocrinology fellowship program at Walter Reed National Military Medical Center, Bethesda until separating from the US Navy in 2017 after 9 years of service.	American Association of Clinical Endocrinology Annual Meeting • Address weight bias as a complication of obesity • New AACE Statement Tries to Fight Weight Bias and Stigma
Rebecca Puhl, Ph.D. discloses a relationship with WW International (research grant funding recipient) and Novo Nordisk (consultant).	Dr. Rebecca Puhl is Deputy Director for the Rudd Center for Food Policy & Health and Professor in the Department of Human Development and Family Sciences at UConn. Dr. Puhl is responsible for identifying and coordinating research and policy efforts aimed at reducing weight stigma and discrimination.	Media Empathy Foundation
Scott Kahan/	Dr. Scott Kahan is the Director of the National Center for	It's Bigger Than Me videos

Table 9: Novo Nordisk-Sponsored Weight Stigma Thought Leaders

Name/Connection to Novo Nordisk	Description	Media Products
Paid speaker and consultant 172 payments totaling $150,002.86	Weight and Wellness. He is a physician trained in both clinical medicine and public health. He serves on the faculties of the Johns Hopkins Bloomberg School of Public Health, the George Washington University School of Medicine, and the George Washington University School of Public Health and Health Services.	

Appendix G: Novo Nordisk Media Corpus (Chapter 4)

Table 10: Corpus of Novo Nordisk Produced/Sponsored Media

Category/ Organization/ Person	**Title**	**Link**	**Date**
OAC – Fresh Perspectives	Eliminating Bias and Empowering Patients - Fresh Perspectives	https://youtu.be/rHN4G-3bKMo?si=60tD1JZwCYgvDqvU	May 17, 2023
OAC – Fresh Perspectives	Can You Be Body Positive and Still Want to Lose Weight? - Fresh Perspectives	https://youtu.be/BwYSoGymZTw?si=VI7BXg-rNIBdRRGH	Jun 14, 2023
OAC – Fresh Perspectives	The Whale: Brendan Fraser talks with OAC	https://youtu.be/-Ka4jLFrWVc?si=pPzTXgFl8qzezS31	Feb 17, 2023
OAC – Fresh Perspectives	An Honest Conversation About “The Whale” // Fresh Perspectives	https://youtu.be/FXcik2xfPOM?si=gZzBPL-yfQxF6xjx	Jan 11, 2023
OAC – Fresh Perspectives	Overcoming Internalized Weight Bias // Fresh Perspectives // Nikki Massie	https://youtu.be/HMyxzFjytH4?si=1pWyNisnCbaKBy4s	Oct 31, 2022
OAC – Obesity Care Week	OCW2022 - Weight Bias	https://youtu.be/RaRBmR4y4fg?si=5aTHQLuSUo-i0Yma	Mar 10, 2022
OAC – Stop Weight Bias	Stop Weight Bias Campaign Launch	https://youtu.be/BhwSNT5wY-Y?si=XahLmXWGEqz_KwFz	Jan 20, 2021
OAC – Stop Weight Bias	Let’s Stop Weight Bias in Children	https://youtu.be/u5exCxK1O3Y?si=t5CAU5lFIgW7VJ78	Jan 14, 2021
OAC – Stop Weight Bias	Let’s Stop Weight Bias! – National PSA	https://youtu.be/hSbTMxBWgVg?si=XJqCClkTOVSClDBv	Jan 14, 2021
OAC – Stop Weight Bias	Let’s Stop Weight Bias in Healthcare	https://youtu.be/PrL5Vq8bhrk?si=pVqW6xzNYTWuUmKY	Jan 14, 2021

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Category/ Organization/ Person	**Title**	**Link**	**Date**
OAC – Stop Weight Bias	Let's Stop Weight Bias Together	https://youtu.be/P14i1EpDyyo?si=S9nkqSfCISCiQp29	Jan 14, 2021
OAC – Stop Weight Bias	Let's Stop Weight Bias in the Workplace	https://youtu.be/4VkIMHKZyGY?si=NT3MtYEfPL2Cvi41	Jan 14, 2021
OAC – Stop Weight Bias	Paying it Forward: An Interview with Novo Nordisk	https://stopweightbias.com/paying-it-forward-an-interview-with-novo-nordisk/	Jun 14, 2021
OAC – Stop Weight Bias	Patty	https://youtu.be/ay23zLd5K7Y?si=GSimiwwWoD0BzPwu https://stopweightbias.com/voices-and-experiences/meet-patty/	Jun 24, 2021
OAC – Stop Weight Bias	Ted	https://youtu.be/6ODm9uXEI7k?si=1x_mj8nqF6-yeTLo https://stopweightbias.com/voices-and-experiences/meet-ted/	Jun 24, 2021
OAC – Stop Weight Bias	Nikki	https://youtu.be/3zZ2znc6D-A?si=UaIXfo6-9lF5FvtN https://stopweightbias.com/voices-and-experiences/meet-nikki/	Jun 24, 2021
OAC – Stop Weight Bias	Faith	https://youtu.be/pVObpdznVY8?si=CLltXrFtAQTInhmK https://stopweightbias.com/voices-and-experiences/meet-faith/	Jun 24, 2021
OAC – Stop Weight Bias	Amber	https://youtu.be/W8oBYG2rna8?si=usKrlmP_1W7iYsEV	Jun 24, 2021

Table 10: Corpus of Novo Nordisk Produced/Sponsored Media

Category/ Organization/ Person	Title	Link	Date
		https://stopweightbias.com/voices-and-experiences/meet-amber/	
OAC/It's Bigger Than Me	OAC Interviews Queen Latifah	https://youtu.be/tSCDZiWSlmo?si=n4jrxDjMwQbLt2gf	Oct 27, 2021
Novo Nordisk - It's Bigger Than Me	Episode 1: My Body Isn't My Identity	https://youtu.be/HbBZSOYHGRM?si=YhkMdiynfS7vKDFN	Apr 5, 2023
Novo Nordisk - It's Bigger Than Me	Episode 2: From Fear to Action: Approaching Obesity With Your Doctor	https://www.youtube.com/watch?v=qg0PF0J7O3o	Apr 5, 2023
Novo Nordisk - It's Bigger Than Me	Episode 3: Defending Your Right to Lose Weight	https://youtu.be/Qv6Zmw3Hc3o?si=W0XSFWNkW2beA-X-	Apr 5, 2023
Novo Nordisk - It's Bigger Than Me	Episode 4: Feeling Like a Failure: The Journey of Living with Obesity	https://youtu.be/M8Xb6v58h5U?si=fFOqopqyxjyMH4or	Apr 5, 2023
Novo Nordisk - It's Bigger Than Me	Supporting a Brighter Future for Inclusive Obesity Care	https://youtu.be/1Io_jtP74rk?si=2esYnf5dOCp8Mi5_	August 31, 2023
Novo Nordisk - It's Bigger Than Me [taken down]	Diagnosis Stigma	Saved on computer	2021
Novo Nordisk - It's Bigger Than Me [taken down]	Body Talk: The Self-Hate Sitcom	Saved on computer	2021
Novo Nordisk - It's Bigger Than Me [taken down]	SIU – Shame Investigation Unit	Saved on computer	2021
Novo Nordisk - It's Bigger Than Me [taken down]	Let's Talk – An Honest Conversation	Saved on computer	2021

Table 10: Corpus of Novo Nordisk Produced/Sponsored Media

Category/ Organization/ Person	**Title**	**Link**	**Date**
Novo Nordisk - Rethink Obesity (HCPs)	A Day in the Life of a Patient with Obesity	https://www.obesitycompetencies.gwu.edu/article/322?_sft_competency=weight-bias	2017
Novo Nordisk - Rethink Obesity (HCPs)	Donna's personal experience with weight management	https://www.rethinkobesity.com/diagnosing-obesity/addressing-weight-bias.html	2017?
Glitter and Lasers (Anna O'Brien)	MY BIGGEST HEALTH UPDATE YET!!!	https://youtu.be/uziM_43hf7k?si=JgoLUeJfYx5rneVd	September 6, 2023
Thick Skin - AMC	1: The Burden of Weight Stigma in Modern Society	https://youtu.be/w7HyMsfb-EY	September 18, 2023
Thick Skin - AMC	2: Overcoming Bias to Set Goals	https://www.youtube.com/watch?v=HTxwS2VcV6M	September 18, 2023
Thick Skin - AMC	3: Fighting back against a body shaming world	https://youtu.be/FgBL1Ebn-MI?si=iEaSh_uqqGO_J9vu	September 18, 2023
Thick Skin - AMC	4: Building a better world	https://youtu.be/ruiCgMl2sp8?si=-PdcfyyxW5tYPKSY	September 18, 2023
Thick Skin Video Extra	Empathy	https://www.sundancetv.com/shows/thick-skin/videos/empathy--1063341	September 18, 2023
Thick Skin Video Extra	Fat Shaming	https://www.sundancetv.com/shows/thick-skin/videos/fat-shaming--1063344	September 18, 2023
Thick Skin Video Extra	Weight Loss	https://www.sundancetv.com/shows/thick-skin/videos/weight-loss--1063342	September 18, 2023
Thick Skin Video Extra	Toxic Diet Culture	https://www.sundancetv.com/shows/thick-	September 18, 2023

Table 10: Corpus of Novo Nordisk Produced/Sponsored Media

Category/ Organization/ Person	Title	Link	Date
		skin/videos/toxic-diet-culture--1063343	
Vox Creative	Why is weight discrimination still legal?	https://next.voxcreative.com/ad/23298808/why-is-weight-discrimination-still-legal	Sep 23, 2022
Vox Creative	The (not so) ancient history of weight stigma	https://www.vox.com/ad/23274653/the-not-so-ancient-history-of-weight-stigma	Sep 23, 2022
Vox Creative	The global spread of weight stigma	https://www.vox.com/ad/23292474/the-global-spread-of-weight-stigma	Sep 23, 2022
Vox Creative	How weight stigma in the doctor's office harms patients	https://www.vox.com/ad/23180916/weight-stigma-doctor-healthcare-patient-harm	Sep 23, 2022
The DEI Shift	Obesity Management Mini-Series: Episode 1- Defining Obesity, Challenging Weight Bias	https://www.thedeishift.com/obesitymanagement-1-526336.html	N/A
Grey's Anatomy	Living in a House Divided	https://tvshowtranscripts.ourboard.org/viewtopic.php?f=11&t=51605 https://greysanatomy.fandom.com/wiki/Living_In_a_House_Divided	March 3, 2022
On the Edge with the Creative Coalition	Episode 8 - Grey's Anatomy Cast Members: "Breaking Through With Television"	https://www.spreaker.com/user/11313090/060722-ote	June 7, 2022
On the Edge with the Creative Coalition	Episode 6 - Chandra Wilson: "From The Broadway Boards To SAG Awards"	https://podcasts.apple.com/us/podcast/episode-6-chandra-wilson-from-the-broadway-boards-	March 3, 2022

Table 10: Corpus of Novo Nordisk Produced/Sponsored Media

Category/ Organization/ Person	Title	Link	Date
		to/id1569926884?i=1000552808567	
On the Edge with the Creative Coalition	Episode 3 – Yvette Nicole Brown: “Family First"	https://www.spreaker.com/user/11313090/episode-3-yvette-nicole-brown-family-fir	October 19, 2021
The Creative Coalition	Artists Using Their Voices: COVID-19 and Obesity PSA	https://youtu.be/mrFcAZn_sfE?si=JuXm1192R6db_PHn	Sep 17, 2020
The Creative Coalition	“If You Told Me...” (60 Second Cut)	https://youtu.be/5qTZQGEj6U?si=R9BWCplUBXjerk27	Dec 16, 2021
Mediflix Documentary	More Than What We See An Obesity Journey Parts 1 and 2	https://www.mediflix.com/video/obesity-part1?utm_source=today https://www.mediflix.com/collections/483/video/obesity-part2	Feb 10, 2022
STOP Obesity Alliance	Fast Fact – Weight Bias and Stigma	https://stop.publichealth.gwu.edu/fast-facts/weight-bias-stigma	February 26, 2020
American Association of Clinical Endocrinology Annual Meeting	Address weight bias as a complication of obesity	https://www.healio.com/news/endocrinology/20230505/video-address-weight-bias-as-a-complication-of-obesity	May 05, 2023
Medscape	New AACE Statement Tries to Fight Weight Bias and Stigma	https://www.medscape.com/viewarticle/991569	May 04, 2023
Endocrine Today	Stigma hampers care for people with excess weight and diabetes	https://www.healio.com/news/endocrinology/20220813/video-stigma-hampers-care-for-people-with-excess-weight-and-diabetes	August 13, 2022

Table 10: Corpus of Novo Nordisk Produced/Sponsored Media

Category/ Organization/ Person	**Title**	**Link**	**Date**
Medscape inDiscussion Obesity Podcast	How to Challenge Obesity Bias and Stigma in Healthcare	https://www.medscape.com/viewarticle/982630	April 05, 2023
Media Empathy Foundation	Spotlight on Weight Stigma Panel Discussion	https://vimeo.com/733204510	June 29, 2022
Media Empathy Foundation	The Media Empathy Report	https://www.mediaempathy.org/wp-content/uploads/The-Media-Empathy-Report-2022-06-24.pdf	
Media Empathy Foundation	An Overview of Weight Stigma and its Harm	https://www.mediaempathy.org/weight-stigma/	July 25, 2022

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