Obesity: Culture, Family, Individual
A qualitative study of Fat in Youth

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Then you will walk your way safely and not injure your foot. When you walk, your stride will be unconstricted; If you run, you will not stumble...

- Proverbs, 3:23; 4:12
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Introduction

Background

Long before the onslaught of “the global obesity epidemic”, one of the pioneers in research on paediatric adiposity, Hilde Bruch, postulated that youngsters undertaking treatment to “normalize” their bodily condition, exhibit striking similarities. In her view, fat kids not only resemble each other in physical appearance, but also in their slow and awkward movements, their great interest in food, even in their total personality development and the way they handle their interpersonal relationships (quoted in Gard & Wright, 2005: 74).¹ Fundamentally, this thesis argues differently. Having spent time in leisure, individually, with a group of patients in a treatment programme for paediatric overweight issues in Norway, I have experienced youngsters involved in treatment for obesity as a highly diverse lot.² With reference to the kids I met during the course of my research, I might draw the following generalizing, introductory picture: Figuratively, some of these large youngsters may be said to move through life awkwardly, even as, mechanically, the very structures of their bodies compel them to do so calculatedly.³ To such a patient corporeality itself, i.e. the very being-in-a-body, often comes across as a stressor, and body-size and shape make for strong impediments to many social aspects of life, including various ability to participate in physical activities. Though a minority, some patients in the treatment programme would seem to engage in life with more flair; occasionally even

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¹ In a discussion such as the present, choice of words is of seminal importance. I agree that “seemingly wellmeaning euphemisms like ‘heavy’, ‘plump’, ‘husky’, and so forth put a false positive spin on a negative view of fatness. ‘Overweight’ is inherently anti-fat” (Wann, 2009: XII). Also, “Whereas fat can be considered, at least in part, to be a physical or visceral phenomenon, ‘weight’, ‘overweight’ and ‘obesity’ cannot. They are social arbitraries, measures constructed in the thinking of people such as researchers, doctors and risk assessors at insurance companies for whom indices of the body mass type were originally designed” (Evans et al, 2008, p. 41) With those disclaimers, I use “obese” and “obesity” as neutral biological terms, and “fat” and other more descriptive terms as reflection of mind-sets or the like (like “fat-kid”).

² Differences in personality have been documented between treatment-seeking obese and obese individuals not enrolled in treatment (Stunkard & Wadden, 1992; see also e.g. Fitzgibbon, Stolley & Kirschenbaum, 1993; Decaluwe, Braet, Moens & Van Vlierberghe, 2006; Wooley & Wooley, 1984; Kolotkin, Crosby & Williams, 2002).

³ In a similar sense to how doctors and physiologists are prone to “calculate” with the closest possible accuracy the variables of intake and output towards predicting the future weight loss of patients (Gard & Wright, 2005, p. 39).
flamboyance. This second type of patient – perhaps typically the male teenager – can be said to present their large bodies as conferring largely positive characteristics, like physical strength. Such an individual might report little calamity from his obesity and perhaps even appear to feel genuinely unencumbered by issues of weight and girth. Among the youngsters I interacted with, some claim to live exemplary lives (and resent the assumptions they know people make about them as fat kids4). There are those, too, who readily concur with their diagnosed disinclination towards activity; whereas a number might be described as spontaneously energetic in their bodily comportment (which, truth be told, surprised me somewhat). These grounds alone may suffice to license caution in conceptualizing (Norwegian) obese youngsters as birds of a feather.

**Paediatric Adiposity**

I highlight the following points as central to the arguments developed in this thesis. Obesity results from extremely complicated mechanisms and processes, biological and social, in and outside human control. In childhood obesity, symptomatically speaking, a host of variations, both social and biological, has been established between the sexes.5 Ethnicity too is known to have important clinical impact. In terms of paediatric treatment, “no approved pharmacological or surgical approaches exist” (Flynn et al, 2006). Overall, being healthy, or rather, achieving health – is a task which befalls the individual child/patient directly (but more of that anon). Beyond medical ramifications, in the following I make clear that to be a young obesity patient is to be engaged in a process to alter many fundamental aspects of one’s being – well beyond the thermodynamic matrix energy in/energy out. A working definition of successful treatment might be radical alteration by conscious means of one’s personality and life circumstances as well neurotransmitters and cellular-level biology. Against this picture, for the vast majority of obesity patients, patently, half-measures simply will not do; you must as it were, buy the whole packet. (Even though, as we shall see, all out dedication is often not enough.) It is noteworthy that a condition which other than

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4 Petersen and Lupton (2000, p. 51), among others, argue that, “people who are somewhat overweight are deemed archetypal candidates for heart disease, and are subject to anxiety and to discriminatory remarks from others […] Many people regard negatively the actions of neglecting one’s health by failing to engage in health-protective behaviours, such as taking regular exercise or controlling one’s weight”.

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gluttony and inertia is taken by society to bespeak a lack of selfcontrol – in fact requires the most thorough self-regulation if hope of lasting, radical weight loss is entertained.

Focus

The overarching aim of the present research has been to uncover and describe what it means to live life as a large youngster and to be involved in treatment – which is to say, to allow discursive space to the patient perspective. The “meaning” children and young people infuse to obesity can presumably be surmised in part from “the events, situations, experiences, and actions they are involved with or engage in […], including cognition, affect, intentions and anything else…”, as well as “the particular context within which the participants act, and the influence that this context has on their actions” (Maxwell, 2005, p. 22). Though this may have yielded “only a few banalities (ibid, p. 81), my goal has obviously been textured and rich descriptions – of «a phenomenon as it is concretely lived» (Finlay, 2009, p. 6), i.e. childhood obesity. That is, to draw from the articulations contained in the children's range of daily life, both in terms of A) societal mechanisms and B) «embodied, experiential meanings (ibid.). The term “lived experience” is a specific philosophical term; my use of it is informed by a phenomenological perspective on the relation between body and world. I use «lived experience», however, with a caveat: My approach is in effect perhaps best described as “sympathetic to the child's perspective”, since, for reasons explained later, I have had to rely on siblings, parents, other adults, as well as previous research, in my attempt to construct a composite picture.

On a purely anecdotal basis, when discussing obesity many people are quick to offer up some remark to the effect that this or that acquaintance, “is fat surely because he eats all the time…” Like every good lie, proverbially, prejudice often has a kernel of truth and even a qualitative approach to adolescent adiposity cannot hope to dismantle all preconceptions about fat people. In terms of research aims, this project set out to look critically at Norwegian society’s perceptions of fat people; to question what functions fat prejudice serve, so to speak, and scrutinize how such perceptions influence young people in treatment for obesity. I describe and analyse a set of individuals’ experiences of a
limited set of phenomena – which will allow me, in broad strokes, to say something about what it might mean to be an obese youngster in treatment in Norway today.  

Somehow, obesity discourses seem to carry special resonance in Norway, the geographical focal point of the research. I say this even though in Norway, by way of introducing this setting, very large people are a highly distinct and infrequent sight; the “morbidly obese” constitute a tiny demographic minority (though socio-economic and geographical variation has been posited). The “obesity epidemic” is certainly not everywhere readily evident. In Norway a national ethos of “an active lifestyle”, with the call of nature and the great outdoors, is supposedly cultivated in every Norwegian from birth, and it is not beyond significance that this explanation featured dominantly in the way both Norwegians and Pakistanis interviewed in this project perceive “Norwegian values”. If this should be true, there is something almost in-built in Norwegians that says “obesity is bad!” This obviously doesn’t make it any easier to be afflicted by the condition. To put it differently, expectedly, to be an obese child/adolescent in Norway is in many ways bound to be a lonely experience.

I do not focus on children at risk of being overweight; not on prevention of obesity in individuals or populations; not even on treatment or “body-normalization” per se. The focus is on lived experience in terms of movement, consumption, identity, and other relevant factors in the lives of individual youngsters whose obesity issues are acknowledged. Acknowledged, that is – somehow, by the participant and her parents; by definition, by the school nurse who more than twelve months past referred the youngster to the programme; and certainly, by the treatment staff there (if also, not to

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6 This may be said to be important in as much as, “Current weight-loss schema help to naturalize a fatness discourse that not only represents large people in offensively stereotyped ways but also fails to integrate people’s lived experience as gendered, situated bodies in an inequitable world” (Evans et al., 2008, p. 53; quotes Aphramor, 2005, p. 315).

7 According to recent research, among Norwegian children between the ages two and nineteen, 13.8 % are now overweight, while 2.3% are classified as obese (Juliusson et al, 2011). Though extant knowledge is lacking, the number of involved in formal obesity treatment cannot be very large in total. Globally, paediatric obesity is said to have increased “2·3-fold to 3·3-fold over about 25 years in the USA, 2·0-fold to 2·8-fold over 10 years in England, and 3·9-fold over 18 years in Egypt” (Ebbeling, Pawlak & Ludwig, 2002).

8 This alludes to a recent statement: “The ability of parents to recognize weight deviations in their children is important for the management of emerging weight problems in children (Juliusson et al, 2011).
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forget, by the public). This means that my data represents not only a very small population, but also a potentially biased segment of young people with overweight issues in Norway. At the same time, participants in the project sprawl the spectrum in terms of gender, age, and degree of obesity, and the data probably mirrors reasonably well the larger body of patients (specifically in terms of age, treatment history, BMI, but also “commitment”) in the treatment programme at the time of the project.

Core Research Formulations

There is a vast corpus of scientific publications on social and biological aspects of paediatric obesity; there are numerous branches to this knowledge – childhood obesity is certainly multifaceted and in the following discussion I have had to make delineations regarding topical focus. Topics discussed have been chosen on the basis of importance to the lives of participants and as crystallized topically from the data material. This thesis focuses more on physical activity than consumption, for instance, because I observed more of the former than the latter activity among participants. The reason why the discussion has wound up in that particular direction – not taking into account that there is not ample precedence to draw on in terms of patientperspective qualitative research on paediatric obesity, and the fact that the present project has been exploratory throughout – is that the methodology used, the nature of our interaction, proved to facilitate a focus on physical activity. The data garnered through the research process opens for discussions and descriptions of experiences and phenomena which influence all paediatric obesity patients and others with bearing only in particular circumstances. The patient perspective in paediatric obesity has not been explored to full. Against this reality – with weight loss the holy grail of obesity research, the ultimate focus of nearly all commentary on “the global epidemic” – qualitative methodology guided by the discipline of medical anthropology can perhaps contribute to on-going discourses by questioning some of the things we take for granted in society’s relentless focus on illness/disease and well-being/health in the issue of body

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9 I believe the acknowledgement of obesity as a “problem”, had slanted several of the youngsters towards a certain health-awareness – and, in some, actually reinforcing society’s stigma. Thus perhaps making the child anxious to somehow conform to what I’ve called treatment rhetoric. Obese youngsters not involved in treatment might see things entirely differently.
weight. Because, due to the dense moral nature of the subject matter, it is still necessary to pose critical questions.\[10\]

An overarching question ties this thesis together, a common theme running through the three papers: *How is the cultural repertoire of the industrialized West attuned to express vital experiences in obese children’s reality?* As it turns out, to the participants in this project, many social encounters testify to what I came to recognize as a “lack of adequate signs and symbols” (Middelthon & Colapiatro, 2005). This might warrant attention in that, in this case, “members of society have recourse to only one opinion on a basic human experience” (Wann, 2009, p. X). The research process has uncovered something of a void in our symbolic representations; the morality of obesity (too gluttonous, too slovenly: Ancient cardinal sins) can be said to be infused with the ontological power to override any other understanding of the bodily condition. *What is it, then, with fatness as a social entity – in the industrialized West – that effectively eclipses or renders mute alternative modes of expression?*

I argue that obesity discolours or disturbs, as it were, any other message about an individual, signalling or beaming out an exhaustive and exclusive set of negative characteristics. I uncover similarities between obesity as a stigmatised identity marker and heroin dependency, in that it “covers” or “corners” – monopolises – the whole of one’s social existence. In other words, an obese individual all but becomes his fat. In the present cultural setting, there simply are no good ways to conceptualize being obese. This is intuitive to most people, most of all obese people themselves. A second theme running through the discussion, then, is *how obesity makes for an overriding, total identity.*

Finally, a stated aim of the research project has been to identify coping mechanisms available to youngsters in terms of managing a presumed stigmatized identity. And, as an extension of this, how public health discourses impact on population groups whose behaviour is deemed to run counter to the modern prescriptions of health, of which the obese will be seen to be at the pinnacle. The aetiology of obesity is often tied to factors which, intuitively, are likely to vary between ethno-cultural populations. Even the whole question of large bodies – whether they in essence are so undesirable, is known

\[10\] As Evans et al (2008, p. 47-48) puts it: “Social, cultural, psychological and economic complexities of obesity and health are reduced to the identification of a weight problem and its panacea – weight loss and eating ‘proper’ food […] The moral, evaluative and regulative overtones […] are barely disguised.”
A Note on Literature & Layout of the Text

In as far as I have chosen to adopt a broadest possible approach to the literature, I have not prioritized keeping strictly abreast on all clinical references. Some sources I quote are dated, even old. Particularly in regard to health and mechanical matters in obesity I have found it necessary on occasion to look to sources from before obesity became a globalized problem. Why? In my personal opinion – heavily influenced by the findings of Wright & Gard and others in the burgeoning critical fat studies tradition – clear moral implications guide or colour much of the present debate on obesity. I venture to speculate that the issue of morality has had growing influence on debates and research, coincidental to the increasing global incidence of obesity. As pertaining to the patient perspective, the result is that much of the debate has been slanted towards the imperative of weight loss, glossing over other perspectives. Throughout, my intention has been to draw out the most possible nuance to highlight the plight of obese children and I solicit patience if this has resulted in reliance on some perhaps seemingly outdated sources.

Structurally, the text of the thesis is divided into two main parts, preceded by this introduction and followed by the three included papers. 11 The first part of the thesis is a summary of the extant knowledge on some aspects of childhood obesity of importance to a paediatric focus. The primary aim of this part is to establish the discursive universe, the features of the landscape, as it were, it being integral to the purposes of this project to map the terrain in terms of the ideas that meet obese children as minors, patients, sons and daughters, peers and members of society. Knowledge about medical and biological aspects, physical activity, body movement, and the prospects of treatment, is important in and of itself in enlightening on social aspects of paediatric obesity. But perhaps more than that, it seems necessary to describe and give a clear picture of the discourses in circulation that children have to rely on in their struggle to

11 The discussion prior to the papers takes up several themes from each of them respectively. In a way, though, the discussion prior to the papers culminates into the richest possible background material for Paper II in particular.
make sense of being fat. Once an appreciation of this landscape is established, one is better equipped to focus on the children moving through it. The second part of the thesis is an exposé on some of the research findings of this project. Focus might be said to be on the three “topological features”: obesity as a social phenomenon; as disease; and body-regulation. Via a debate on obesity and family, the second part commences with a focus on how obese bodies play out in social interaction. This is meant to provide background for a more elaborated discussion on obesity, health and the imperative of treatment. Taken together this enables a thorough investigation of physical activity as a cure for childhood obesity – having by then demonstrated that our moral view of very large bodies, indeed the premises of very nearly all relevant discourses, really make us dim-sighted to the difficulties that this proposition can entail.

The Treatment Programme

The treatment programme from which the participants were recruited is located in a major city in Norway and treats patients with fairly varying BMI (though official requirement for BMI is the 97th centile of weight/height) – from burgeoning weight issues to what is called morbid obesity. The programme admits children and adolescents between the ages 3 and 18 with a majority in school age and a median age of 10.7. Patients hail from different ethnic groups, with 50% being non-Norwegian and there is an alleged over-representation of Pakistani youngsters. At the time of the present research, the treatment programme had around 300 patients; there was a waiting list of about six months to join. 21% of patients drop out before the first year consultation. A majority of patients live in parts of the city with relatively lower socio-economic indicators. Patients are inducted into the treatment programme by referral by respective school nurses. Treatment consists of periodical consultations at the centre – more frequently during the first year of enrolment – where children and parents are given lifestyle advice, have blood samples drawn and tests administered. In addition, patients are encouraged to participate in exercise through the training component of the
programme, offered as integral to the treatment. As an indication of the relative “success” of the programme vis-à-vis its treatment aims, as made clear by treatment staff - “Very few patients actually ‘graduated’. It’s a long term perspective”.

Treatment staff pointed out that many participants and parents likely have a rather skewed understanding of the treatment philosophy, in that many believe that “the treatment programme is one thing and the exercise component another – while this is really one project! I wonder how pleased they are with the treatment if all they do here is come and talk...” Apparently, there is a marked problem with patients failing to meet up for the scheduled consultations; as one staff member put it:

That likely reflects the attitude many of them have. I am sure many would prefer to have a wonderpill they could take to get slim and then continue with the same lifestyle...They know what is healthy and not – it's not that! Sometimes it is enough just to listen to what they have to say, with a sympathetic ear; to reassure them that obesity is difficult and that they're not lazy and stupid. Many have eating disorders in the sense that food represents so much more than just nourishment. When they start in the programme, we note their ‘four day-diet’. It often looks good on paper, but they don't report everything they eat – they lie about their consumption...!

**Research Participants**

Fifteen young patients (not counting family members) were eventually recruited to participate; eight ethnic Norwegians and seven Norwegian-Pakistanis. I introduce the principal participants below. Their participation in the project ranged from a single conversation at the treatment centre to twelve meetings over several months in many social settings, with the core of participants volunteering about four afternoons each. Each participant was given pseudonyms and all data was collected under assumed rubrics, like in the following:

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12 This exercise component was carried out as part of several research projects attached to the treatment programme. The intention was to offer a social environment where kids could meet and move with people with similar issues under guidance from friendly adults, beyond the importance placed on actual participation in physical activity in terms of health benefits. The component was terminated, at the prearranged date, during the course of the present research.
**Berit** is a young Norwegian girl (12) whose body makes it difficult for her to “do things”, as she says, because she is “so big”. Berit – and her mother, **Turid** (and especially the two of them together) – became a central source of input to the project, not least because of her willingness to participate over a prolonged period of six months. We interacted in a very varied set of circumstances and social scenarios, from playing bowling, mini-golf and other assorted leisure activities of her choice, to eating, strolling, shopping, and even doing physical exercise. Her fairly rich input pertains to social aspects in terms of her relations to peers and wider society, but also in relation to food, physical activity and treatment in general, and very importantly, as to the “ergonomic” peculiarities of obese bodies. As I elaborate below and in the paper, in her case, these ergonomics are such that, likely, the hindrance to her movement in some situations stems from the particular combination of distribution of fat tissue, probably the texture of those tissues, as well as actual size, height and width of her body (*Paper II*). Berit told me outright how she hates being fat and wishes she was thin; I thought of her as having committed herself to following the treatment program and live by the spirit of its rules in order to achieve this aim, even though she knows full well the sacrifice this demands in real life. I got to understand that Berit habitually displays what I’d call incredible self-control in many areas of her life – specifically, she told me of one episode in school when she had endured what must have been incredible pain in order to avoid drawing attention to her person in a class scenario. I mention this intimate factoid here both to give an impression of this young girl's mode of being in the world and the degree to which her being bodily different centres her attention and her thoughts. Despite her sometimes introvert outlook, I took the twelve “sessions” she volunteered time for, to indicate her developing a quantum of confidence in me (as shared by her mother). Even so, admittedly, our conversations were not always fluid and smooth. Though her verbal and interactive input is textured and the material on her is relatively substantial, it will be seen that her perspective sometimes subsumed or disappeared a little into her mother's presence; I have at times relied on Turid's input both to facilitate conversation but also to expand on topics Berit was reluctant to discuss very much in depth. In total, her participation itself and the topics her case manifested, yielded sufficiently interesting insight into several pertinent topics, and particularly with relevance to obesity and ergonomic challenges, that her case was deemed an ideal candidate for a more prolonged debate in form of an individual paper. Finally, beyond the quality of her input and our interaction, Berit's case, her circumstances, are such that they might throw light on issues that are of particular
interest only to some obese individuals and some that will enlighten on the experiences of many very large children, more generally.

**Ulrik** (14) is a rough-and-ready Norwegian youngster who projects primarily positive sides to being “fat”, as he puts it, and who displayed no discernible interest in changing his life (*Paper I*). But his participation in the project, prodded along by his volunteer ‘Big-Brother’ **Karl** (who himself is a survivor of obesity surgery and therefore has vested interests and forceful arguments vis-à-vis Ulrik's rather recalcitrant attitude to the question at hand) – helped highlight some of the more complex mechanisms at play in adolescent obesity. Bodily, Ulrik appears a fairly solid individual, with the bulk of his weight collated on his torso and upper body; though in ways which does not seem to impede his movement, as will be clear from empirical descriptions. Commanding impressive upper-body strength makes him an apt bowling-player; being both precise in his movements and forceful, allows him to send the ball in a straight trajectory and scoring “strikes” time and again. His skilful manoeuvring and agile handling of his body in this scenario is a far cry from other participants and the picture the obese body-type might normally conjure. Ulrik participated in five afternoon encounters in a bowling-alley over several weeks, during which conversations were pursued; and on several occasions more thorough in-depth interviews were done in more private settings in the alley after games. This gave Karl the opportunity to adopt a more direct approach without it being embarrassing to Ulrik in the sight of other kids in the venue, forcing Ulrik to reflect on his behaviour and his participation in treatment. (Karl himself participated in several follow-up interviews were he expounded on his own experiences as an obese child and adult and also spoke more in depth about his project concerning Ulrik and the challenges thereto.) Ulrik would probably not identify very much personally with the topical focus of the research and other than the actual activities, which he said he enjoyed, he was probably fairly bored with and did not really understand the point of my irritating questions or, or deep down, his participation in the project for that matter (though, as elaborated above, that was obviously voluntary and subject to his discretion). Nonetheless, Ulrik's case was chosen for more in-depth study, both because his participation did yield qualitative and nuanced data – sufficiently so I thought, to warrant his own paper – but also because his case is capable of challenging some fixed perceptions on how obese children move through the world and I therefore call on his particulars, in a sense, to throw light on the more general regarding childhood obesity.
Razzaq (14) is a jovial Pakistani boy who does seem to wish he was thin, though he has more or less accepted his fate, as it were – and he is not overly held back socially by his body status; he participates in leisure activities, cricket sometimes, with other boys, he dances at the club and he is not loath to talk to girls. But he is not too concerned with why he’s not getting there in terms of weigh loss (Paper III). He applies his own distinct logic to the whole question of health and change. He engages in exercise through the treatment programme, even though the bulkiness and low gravity point of his body shape – judging by his facial expressions and affectations, general bodily mannerisms when doing something active – apparently make physical activity exceedingly strenuous. (Movement is even more complicated for his sister, Parveen). In terms of his size, it seemed clear that five additional kilo would scarcely make much of difference, as he pointed out, effectively, in a non-verbal manner during a conversation. Razzaq’s dimensions certainly does him no favours in terms of manoeuvrability, which was clear both to the trainers in the exercise-training where he participated, and to me during our games of bowling. Razzaq, though strong, has somewhat depressed body-coordination and motor skills and he chucks the bowling-ball rather than making a smooth, angled movement, or he sees fit to employ both hands to lug the ball forward from between his legs in a similar fashion to Berit. His comportment when exertive might suggest he was not exposed to a lot of physical activity in early childhood; but he tells me he used to play field hockey on a team, but quit when it became boring. He doesn't seem to have anything against physical activity as such, as his comment (in the paper) on the ardour of his gym class versus that of the exercise programme shows. Incidentally, Razzaq told me he aspires to become a truck driver, though he later retracted this plan on account that, “Truck driving is bad! You sit down all day long. That is not good for your health” – indicating with statements like this that he is after all steeped in dominant discourses. Beyond providing insight into body movement, Razzaq was also instrumental in highlighting alleged cultural mechanisms among Norwegian-Pakistanis whereat large(r) bodies are/have been subject positive connotations and may also provide obstruction to change, especially since family life is often integral to both the “problem” and the “solution”. Razzaq seemed to appreciate the leisure activities we did together, over a period of several months, like bowling and billiards, and as I claim in the paper, we developed a frank tone and friendly rapport (though see Maxwell, 2005, p. 83) between us which greatly aided the research process.
Hafsha (15) & Aisha (13) are a pair of sisters who display a somewhat different approach to being Pakistani and large than does Razzaq. For them, their ethnic identity only underscores the urgency they have learned through the programme, regarding the inherent hazards to health from obesity tied to “being Pakistani”. Somewhat ironically, they could be poster-children for the treatment program – in that they have heard the message and appear ready to pursue it (Paper III). Together with their father, Mustapha, and other members of their family, we did various activities and I was even invited into their home for dinner on several occasions to discuss pertinent issues in a family setting. Among the things we spoke about was the use of hijab (“dupati”, in their Punjabi word for it), whether that makes movement in terms of participation in physical activity difficult – which they vehemently denied, though conceding that other forms of head covers might cause such obstruction.

The two sisters on the one hand, and Razzaq on the other, have been made the mainstay of a more detailed discussion in the paper. Their input and also their attitude in a sense complement each other, enlighten on different aspects of being fat and belonging to this ethnic group. That is in terms of gender, their respective overall attitudes to change, and their families involvement in the process. In addition, both sibling pairs (including Parveen) made for very interested participants, willing to contribute much in the discussions.

Kim (17) is a young adult who in more ways than one feels imprisoned by his body’s massive physicality, which he decries as beyond the fault of his own behaviour. All his life – this is his firm stance – he has lived by a regime focused on health, food and exercise. Kim is an articulate young adult; conversations with him followed more conventional interview format (though done while strolling). I call on Kim quite extensively in the following discussion, because his life illustrates many issues facing many obese young people and he also is “good to think with” in terms of some of the more particular experiences encountered by some individuals. We met for several conversations over several weeks and Kim provided key-informant input on how to address the young participants on these sensitive issues.

Peter (14) is a Norwegian lad who does not appear overly encumbered by being of a large body. He told me that being inducted into the treatment programme had not felt out of place for him since he had long been aware of his body status. Though he obviously has a measure of extra weight, this is perhaps not the main reason why he
reports being bullied at his “special school”, where he dorms. Being fat is in his view one of many issues that play out in the life of a teenager, but when it comes to changing his behaviour to accommodate the prescriptions of the treatment program, he pointed to structural difficulties like having to eat in the cafeteria at school where the options are perhaps not the healthiest, as he would say. Peter participated in three afternoon sessions and then ended his involvement in the research.

Tareq (13) is a Pakistani boy whose obesity seems to have taken a toll on his life and specifically in the way he relates to his surroundings. The victim of bullying, he has had to change schools, to a “special school”, which necessitates daily transport in a taxi. Tareq doesn't often leave his house to do things outside; he tells me, he has no friends. Moreover, he seems to have taken up many of society's ideas about body-fat, in that he is able to articulate theories as to why people become fat, how to achieve weight loss and the like, and body-fat would seem to be the lens through which he gauges many everyday concerns. At the same time, he is also keen to downplay his own obesity, insisting on being “big boned”, “large”, rather than other epithets. He is interested in the topic of obesity almost on an academic level, though this might be his way of deflecting attention from his own problems and concerns in this regard. I took this to indicate Tareq's rather precocious personality; he poses all sorts of question to reciprocate mine, like what have I done together with the other kids and am I going to develop a pill, is that the purpose of the research? Regarding his own life, he was willing to say something about his eating habits and food preferences. As per our initial agreement, following his own spontaneous suggestion, Tareq participated in four afternoon sessions over a couple of months, playing billiards and bowling etc.. This enabled discussions on many issues centred on physical activity, food and health in relation to obesity, combined with observational insight into his way of engaging his social surroundings.

Espen (7), a Norwegian boy, was the youngest participant in the research, who, with his mother, participated in two encounters in a bowling-alley. His overweight issues might be described as burgeoning. Espen is a lively child; he participates in weekly karate lessons in addition to the exercise training through the treatment programme – he “needs to” in order to release some of his need for constant spontaneous movement. He is the type to throw his hands up in the air or do a karate punch, gesticulate with his hands, face and whole body, and generally flicker about. Espen was described by his mother as “hungry all the time, he is always on about food!” I give an impression of his
Obesity and minority

being-in-the-world below, as an ingress to Methods. Though his verbal input was limited, his mother made clear that his motor-skills and sense of balance are a bit off and he therefore profits greatly from his karate lessons. Espen's weight related issues come across as highly complex and his example illustrates just how complicated and biologically “hampered” change and body-regulation can be as a social endeavour.

Natasja (14) is a Norwegian girl who participated in one initial tape-recorded conversation at the treatment centre and another afternoon in a bowling-alley. She told me she had first “noticed in the mirror” that she “is fat”; in terms of obesity, she seems primarily preoccupied with not fitting into clothes and having a different appearance than other girls her age. But she was also concerned with the ergonomics of living a large body, for instance that gym in school and other exertive situations cause her some embarrassment, making her feel “left out sometimes”. Especially when spending time with her friends, who are slim.

Though Maimuna's (9) participation in the project was limited to the initial, tape-recorded conversation at the treatment centre – she had articulated ideas as to what “being overweight” entails, especially socially. Her participation also helped clarify the need for a more adjusted methodological approach (see below). Maimuna seemed to sense that the topic under inquiry might be considered sensitive in wider society.

School Nurses, Home Ec. & Phys. Ed.-Teachers

An auxiliary source of empirical data was obtained from the enrolment of a total of fifteen physical education- and home economics teachers and school-nurses from assorted major-city school districts, where the prevalence rates of overweight/obesity is known to vary according to socio-economic factors. (This point was taken into account in the planning process, but also turned out to be a major concern among the school-personnel themselves.) School-personnel were invited to participate through letters sent to the various schools, and they often seemed to volunteer for conversations as an expression of interest in the topic at hand. Input from schoolpersonnel forms a backdrop to the lives of the youngsters, which I in the following draw on as one of many sources of obesity discourses. However, I hope to publish findings from the interviews conducted with school-personnel in a paper focused on obesity discourse and gym in school.
Synopsis of Empirical Material

• Thematically, the material consists of a fairly broad spectrum of topics, dependant on the circumstances of each participant – such as: Challenges to eating right; thoughts on “being active” and engaging in physical activity; hassles and worries with being large, such as the ergonomic dimension and the fear of getting sick; sometimes, more positive sides to the experience, such as “personal strength”; personal characteristics and “selfcontrol”; the need for treatment and the realization of being obese.

• A core of key participants have contributed disproportionally to the material.

• The depth of communication and the resultant ethnographic material in each case was highly situational and varied.

• The more textured input stems from verbal data based on repeat conversations in (relatively) comfortable surroundings, and the interactive observations made possible by this mode of communication.

• Conversational input was supplemented with observations of body-movement and personal demeanour in varied and numerous social situations.

• Input from the participants is combined with what amounts to my own analysis and commentary on the empirical material, based inter alia on comparison with input from other sources.

• This basis is moderately sufficient in meeting the aims of the present project.

• Even so, I think the material has produced qualitative insight into at least a few “lived experiences” among young obese Norwegians.

• Input from the school personnel has provided invaluable ethnographic background material, which has helped enlighten on the expectations of society and experiences of the young patients.

Extended Abstracts of Included Papers

Paper I:

In contemporary Western discourse, good health is the moral duty of the individual. Seeing how obesity must result from either ignorance or lack of willpower – the condition surely encapsulates the antithesis of the moral individual. This moral perspective tends to blur what living massive bodies mean to individuals, since willpower is not necessarily at the heart of their own understanding of being large. The
discussion is centred on a case study of a Norwegian adolescent, “Ulrik”, who is presently enrolled as patient in a treatment programme for paediatric obesity. “Lifestyle change” is a central element of the treatment philosophy there, meant to make individual patients and their families able to “master” or “cope with” issues like eating and exercise in ways that may induce benefits to health and hopefully weight loss.

The aim of the paper is to afford a chance to look beyond the generalizing prejudice – though Ulrik “confirms” many of these – as pertains to obese individuals. These, I argue, result in very meagre scope for making sense of obesity. The major concern of the paper is ultimately to draw attention to Ulrik's idiosyncratic way of moving through the world of obesity; to point to peculiarities in order to throw light on the general. As such, I have not developed a unifying theoretical superstructure but rely on a more descriptive exposition of the concerns that play into Ulrik's dealing with the treatment programme on the one hand and life as a large lad on the other. However, the discussion is guided by theoretical input from the Foucauldian school of governmentality and subsidiary to this Deborah Lupton's conceptualization of health-ism, which help make sense of how individuals are made to feel responsible for own health and are expected to subject themselves to mechanisms whereby they, ultimately, become “self-governed”. Ulrik though is seemingly rather far from this ideal, but it is interesting to note the length he has to go to fend off as it were the pressure to conform.

Similarly, in extension to this is a notion often running through commentary on obesity, that knowledge itself engenders change (see e.g. Murtagh, Dixey & Rudolf, 2006) – a theoretical point of view which easily produces oversight of individual-level issues in health-related behaviour. What I take from this is complimentary with Valverde's concept of “diseases of the will”. Taken together such a perspective might point to some of the reasons why Ulrik stresses a disparate understanding of obese bodies and why he seems reluctant to succumb to the pressures to change his behaviours and attempt to conform bodily.

The paper is the product of a series of afternoons spent together in a bowling-alley, where Ulrik and I were accompanied by several people known to him – a research methodology ensuring both conversational input as well as the opportunity to engage Ulrik informally and observe his engagement with and place in the world. This constitutes the modus operandi of interaction with a wider group of participants in the research project, a form of interaction which has resulted in insight into different topics
and themes relating to obesity and personal differences in the obese childhood experience. An advantage to such an operational approach is that topical focus can easily be adjusted to the circumstances of the individual participant – giving scope to let each child focus on what is important to them. By way of contrast, young girls in the sample would often demonstrate through our interaction an entirely different outlook that does Ulrik. The methodological mode proved particularly fruitful in Ulrik's case, because, by virtue of being a teenage male with a tough-guy attitude, Ulrik underlined that he is not wont to discuss his feelings and such (and likely less so with a male researcher). Doing things together allowed me to pose questions in a more informal manner, more attuned to his way of communicating.

In a wider sense, for Ulrik, this whole thematic pursuit, obesity, seemed an embarrassment to him in as much as “being a patient” comes across as “weak” and talking about obesity is to him in a sense worse than being obese. Even so, despite Ulrik's resistance to the topic, his limited interest in talking about it – he clearly enjoyed taking part in the activities we did together, and our interaction provided valuable insight into some of the processes that might go into the development and treatment of childhood obesity. Karl is the boy's more or less self-appointed “lifestyle coach” and his presence contributed supremely to the dynamics of our interaction. Having personally experienced much of what Ulrik goes through (Karl provided retrospective insight into the life experience of obese children in his own right), as well as having had to undertake “life-saving obesity surgery” – Karl has access to set of rather hard-hitting arguments. Ulrik evidently had a lot of respect for his mentor, and between them, their form of personal communication opened for discussions on topics Ulrik would probably have skirted had the two of us been alone. Besides, I certainly wanted, as an anthropologist, not to be seen trying to influence his behaviour (he is more or less bombarded as it is with a message that being fat is dangerous) which means I had to strive to balance several concerns in our communication. During our activity, I would pose Ulrik a question; in keeping with his ultimately cavalier and trivializing attitude to the issue of obesity (and perhaps in his life more generally), Ulrik would often attempt to laugh away my question or try to dismiss me derisively (a “tough teen”, Bassett et al., 2008). Karl would partake in these conversations; sometimes he would see fit to confront Ulrik's attitude, “take him by the collar”, make him reflect on my query with reference to his own life. Under immense pressure to accept a more mainstream understanding of his obese body, sure enough, there were
moments during our interaction were Ulrik’s demeanour betrayed that Karl’s no-holds-barred style of health campaign was seeping through. An important argument I make: Everyday life is obviously something else entirely.

A backdrop to the paper is that beyond actual weight, Ulrik faces other social issues and challenges, among which is an “obesogenic load” at home, including what might seem to be a lax or permissive parenting style from his single mother. Beyond having to pay much mind to “eating right/less” and “doing more”, these circumstances in Ulrik’s life contribute to making change all the more complicated. How then does this self-declared “fat-boy” grapple hegemonic understandings of his bodily dimensions? Ulrik, for one, seems keen to give off the impression of being unfazed by the whole being-fat-is-bad shebang. He is ever careful to avoid embarrassment, meaning being seen as “lame” or “weak,” not so much “fat”. To his mind this is intimately connected to the idea that he can “beat up anyone at school who says I’m fat”. It might perhaps be suggested that Ulrik’s rotund bodily state, with his extra layer of muscle and fat, provides him with an emotional cover, a shield – both at home and vis-a-vis his peers. Even as the concept “health” comes a bit more to the fore for him when pressed on the issue, to Ulrik, as I present the case, being large means being strong. This ultimately, I argue, is something of a hindrance to his full-hearted embrace of the aims of treatment. A boy with social issues at home and a free reign to indulge in behaviour which is certainly contrary to the advice given through the programme, coupled with a teenage embarrassment with all things weak or girly, Ulrik may be seen to have seized upon a comforting element in his body-type which connects the other dots. As a simile for his behaviour, he drinks custard from a carton not because he wants to be fat; he simply “likes the taste” – it’s only that no-one stops his indulgence. Besides that, he might take some comfort from his consumption vis-à-vis his home issues; likely he often just doesn’t “stop to think”, as he puts it. But ultimately, being fat is tolerable and even attractive to him since he can literally throw a punch whenever his version is challenged (treatment rhetoric doesn’t seem to reach through much, since he labels all that under “weak”). Social issues, strong teenage boy, reluctance to change, are therefore interrelated keywords playing into each other in his case. While the patient perspective often seems overlooked in obesity discourses, it is my contention that in obesity, one should strive to understand the circumstances of the individual. The paper may therefore be of interest to professionals concerned with how the notion of “healthy
lifestyle” impacts on modern society and particularly to those who fall outside of its norms as it were.

**Paper II:**

In contemporary obesity discourse, physical activity is routinely portrayed as essential regarding weight regulation. This axiom tends to neglect that health-enhancing exercise may involve categorically different sets of corporeal experiences for obese individuals than for people of other weight categories. Rather, to observers and themselves, obese people are fundamentally lazy – the moral aspects of this have long been debated. Less attention has been paid to how Western cultural signs and symbols inadequately distinguish how obese bodies are variously adapted to execute given bodily movement. Based on a case study of a Norwegian paediatric obesity patient, “Berit”, the paper uncovers how a young girl has to accommodate her corporeal structure when undertaking many forms of physical activity. Berit is under all sorts of pressure to lose weight and with exercise at the heart of many endeavours to regulate obese children’s bodies, she is certainly familiar with the impetus. She herself is keen to participate in strenuous activities inasmuch as slimming is her greatest dream. However, she can't convey in words what performing the series of tasks involved in that proposition means for her. This traps her in a very bad place indeed: Prodded to move, yet restricted in movement, she is effectively unable to extricate herself from her bodily constrains. The paper derives from input from conversations with her alone and with her and her mother together, combined with notes taken while observing her activity and movement in different capacities and circumstances over time.

An overall aim of this paper is to throw light on Berit's being in the world as a young girl and obesity patient, and in a sense to draw attention to the notion that “the body”, as recognized by Western civilization, is not one thing, its not the body. I advance the line of reasoning that embodying a particular configuration of an obese body can make certain forms of body movement burdensome. This is a situation made worse by the fact that available symbolic representations often fail to do such bodily reality justice. The discussion may therefore be said to focus on an interplay of somatic and semiotic issues – how phenomenological (to call it that), corporeal concerns and socio-cultural mechanisms collude and collide to make obesity a formidable double burden for some individuals. For Berit, this means that in practice she is routinely expected to participate in activities her body is not very fit to perform.
The paper aims to bring light to this predicament based in the most part on a descriptive analysis. I have found ethnographic analogy useful to advancing my line of argumentation. Previous literature does not offer a solid theoretical framework, I find, to fully elucidate on this cultural state of affairs. However, the argument that our cultural repertoire is ill-equipped or inadequate to make sense of the very-large-body-experience, recalls a definition of “sign” in a Peircian tradition. In as much as a sign can be understood to generate meaning instantaneously, automatically and specifically. To the present purposes, this means that body-fat sends an overriding message to other people, conveying a set of negative characteristics in the individual, including “lazy”, “lacking self-control”, “blameworthy”. This is important to Berit because in social encounters, her side of the story tends to disappear. The effect of which is that we fail to truly grasp this human experience, that is, obesity.

On the other hand, a Feminist critique of the tradition of phenomenology has bearing on the present problem. Represented by Merleau-Ponty, who famously focuses on how being of a human body influences the whole human experience, our perception of the world – the critique (see Embodiment & Phenomenology) pertains to the tendency to advance a view of “the body” as a fixed entity, as a common unit of measure, without much actual attention to how various types of bodies might factor into the whole perceptive experience. Say, how women's bodies might in various circumstances generate different experience than would male bodies. Analogue to this, the obese body is likely to produce meaning in ways that will sometimes be radically removed from a thin person's experience of the same phenomenon.

Taken together these perspectives – obesity as muted sign and obesity as a radically different base of body experience – can at least help highlight the notion that there is ultimately a void in our ability to understand Berit's particular being in the world. A word of caution. It is important to be aware that body fat has the potential to generate other meaning and the message conveyed by obese bodies is to some extent contextual. Obese children are not devoid of all forms of “narrative resistance” (a theme I explore elsewhere) and Berit is, for instance, able to “explain” her dimensions and size with reference to being “big boned”. But this cannot alleviate her precarious figurative (nor literal) balancing-point. Caught in limbo has very real implications in terms of desire, will and ability to participate in physical activity and this, in the long run, inadvertently chips away at her motives for engaging in other health related behaviour. The insight
offered through this exposition may be of some interest to those who in some capacity encourage large adolescents to exercise.

**Paper III:**

Globally, paediatric obesity causes widespread concern, and the role of ethnicity is an important focus. Ethnicity in obesity is the subject of attention in terms of both culture and biology, entities which are seen, on the one hand to be playing into the incidence of obesity, and on the other, to engender various levels of health risks to people of different backgrounds. People from Southeast Asia are often portrayed as being subject to specific hazards from obesity and associated comorbidities, and particularly immigrant groups to the industrialized West from this region are often thought to live by values “conducive” to the development of more corpulent bodies. Investigating how culture can mediate health-related behaviour through ideas about bodies, food, and physical activity, while addressing a notion that the Pakistani community in Norway is particularly conservative and slow to change, this paper points to the centrality of health as a cultural concept and the state of efficacy of public health promotion in contemporary Norwegian society. We discuss two families whose members are patients in a treatment programme for paediatric obesity, based on interaction and conversations over several weeks in different settings.

It should be pointed out that in the text clear parallels emerge between Razzaq and another, Norwegian participant of similar age, body type and feelings about being large (sc. Ulrik, see *Paper I*). Just as there are bound to be “values and concerns other than those related to ethnicity that are sometimes more important in determining food habits” (Nielsen, Krasnik & Holm, 2013) – as far as both these two boys go, this is true to other of their health related behaviour. Lest we sort of fall in the same pit as “the health authorities' reliance on dichotomies in promoting health among immigrant families” (ibid.), we should ultimately assume Razzaq's ethnicity will frequently play a subsidiary role in his world view as a large individual. The same should be said regarding the two sisters: It is important not to be blind-sided by their ethnic identity in this (that is after all only my analytical tool) – to them, other streams of thought may be in the forefront.

**Summary of Thesis/Research**

An independent summary of the main findings of the research on which this thesis rests: I commence on a personal note and continue with a focus on the project's
peculiar interplay between methods, focus and insights. Obesity in children, in the Western world, is a topic steeped in and reflexive of society's wider view of morality. The bodily condition under scrutiny evokes a long list of personal sins in the afflicted. Previous research paints a clear picture that as a society, we tend to think of fat people as responsible for their body-status and its regulation, and hence, ultimately, as deserving of their fate. Moreover, most people who see or think about large individuals, often harbour fairly fixed ideas as to what obesity represents. As a «normalbodied» member of Norwegian society, I must admit (though I've confessed to this in Paper II) to have come to this particular research topic sharing a number of preconceived ideas. This is not stated to excuse this thought set (this is after all how we're all socialized, as I will make clear), only to use my own as a tool to gauge the experience of others. Having said that, from the onset I set out to uncover as close as possible what obesity means in the lives of young patients' and to do so with a sympathetic eye. However, in a sense, I was unaware of the deep-seated nature of my prejudices and the extent to which these were coloured by axiomatic notions about excessive body-fat. I certainly did not grasp that beyond the cellular level, fat is not fat, the same in all contexts and individuals.

**Moral Overtones**

According to a cornerstone argument I make in the thesis, the imperative to slim and maintain body-control that befalls obese individuals, «overrides» people's ability to see fat tissue in any other light. My failure to have thoroughly conceptualized this «bias» even in the project proposal is not strange, given that during the course of the research I came to identify a phenomenon whereat we we may be said to lack the cultural tools to enable such an understanding. In Kvale and Brinkmann's metaphor, for me personally, the research process has been akin to a journey, which has resulted in knowledge and insight but has also changed the traveller (Kvale & Brinkman, 1996).

I ascribe this to the deeply “participatory” nature of the research methodology, viz. in effect, “working collaboratively with research participants to generate knowledge that is useful to the participant as well as the researcher, contributing to personal and social transformation” (Maxwell, 2005, p. 84). This has methodological implications since in a qualitative study such as this, “you are”, as J. A. Maxwell notes, “the research instrument […] and your eyes and ears are your tools to make sense of what is going on” (ibid., p. 79). In my changing, my understanding has changed, and also, likely, what I have chosen to focus on and attempt to describe here. A deeper sympathy for
the complexity of childhood obesity and the plight of fat children, hopefully shine through in the text.

Berit’s day at the mini-golf course (Paper II) captures better than other situations how in obesity ergonomic and symbolic limitations congeal; the episode marks a milestone in the process by which I came to make this realization. Berit’s body showed itself ill-suited to this seemingly straightforward motoric activity. She is herself obviously aware – if wordlessly so – of this depressed «ergonomic ability» (as I call it), expressing a reluctance to participate and referring to her body as «too heavy to bend down all the time». None of us were, however, able to articulate that in actual fact it may be the specifics beyond actual weight of her body which combine to hinder movement. Even having observed her many times – this important realization only dawned on me through later reflection. Berit's mother’s presence that day proved decisive to the dynamics of the scene. That is an important methodological point, because the instance illustrates how important it is to be mindful of the close interplay of family culture and interaction on many of the issues that are held by dominant discourses to «fan the flames» of paediatric obesity: for instance food, consumption and exercise. Therefore the parents' perspective is held to be essentially complimentary to input from the patients themselves and is often treated as such in the following.

One of the most efficient ways I can think of to illustrate the underlying point, that differences between (obese) bodies in a sense get lost in the moral maze of body-regulation – is to mentally juxtapose Berit's lack of agility in this scenario with Ulrik's forceful and nimble handling of the bowling ball, as described in Paper I.

**Limited Ways to Think About Being Fat**

Having observed Ulrik at play, my argument is that he would probably not have given pause if asked to bend his body down similarly, because he knows from experience that his strength really takes away most physical hindrances posed by his bulk to his body's movement. The fat on his body configures, in other words, in a way that would seem to impede less on his life. A seminal discovery in this project is that, though Berit and Ulrik’s bodies probably weigh roughly about the same, the distribution of fat on their bodies and other individual anatomical differences (explored in the papers) – contribute to the difference in their outlook as obese individuals. This whole line of argumentation could only have been developed based on insight accessible through close observation of physical movement combined with attention to conversational
input over time. But beyond anatomy, the heterogeneity of their experiences is also about discursive potential. Where Ulrik can fall back on his physical strength as an asset in the life of a young boy, Berit does not seem to take much solace from the strength that does in fact reside in her very large body (she is well aware additional muscle mass is needed to support additional weight). For her to make sense of her body, she effectively only has access to the same «text book» explanatory models with which her mother and myself understood her behaviour. That is, ultimately – in light of the need to slim.

Both these participants' narratives may be said to revolve around the axis of embodiment, cultural signs, and discursive options. This may be identified as a common thread that runs through the findings of the research, inasmuch as Pakistani children (Paper III) have access to cultural codes which might both mitigate and exasperate, call it that, the effects of current obesity discourses on a young child's status as obese. All told, there are few good ways of making sense of obesity. My material suggests, and this is supported by previous research (e.g. Rowlinson, 2011), that males have access to a somewhat larger repertoire of “narrative resistance” and “coping mechanisms”, like possessing physical strength or being funny – whereby being fat can become more a tolerable social role.

**A Totalising Condition**

Clearly, to be a child or adolescent involved in treatment for obesity means that some process has gone into defining you «overweight» – and at least on some level you likely share this evaluation. Added to that, biologically speaking obesity treatment requires a complete regimen (and even that proposition is dubious, or so I claim in Knowledge Context). Criteria for involvement in the present research included at least twelve months prior involvement in the treatment programme from which the patients were recruited, which is probably why several participants had «internalized» the language of treatment («treatment rhetoric» is the term I use). Given the relative paucity of ways to make sense of obesity for a young patient – it takes fortitude or perhaps disengagement, not to. What the participants in the research project have in common is they're all in a place where body fat, ideally, occupies a large part of their attention. One thing is the prospect of shedding substantial body weight, though, and quite another to be made to identify entirely with this singular issue. For children in treatment, this may contribute to a sort of all-or-nothing-at-all approach to body-regulation. A couple of examples will illustrate.
The two Pakistani sisters discussed at some length (paper III) for instance, portrayed themselves as fully cognisant of wider society's views of large bodies, dangers to health and all, including that fat Pakistanis are «susceptible to extra risks». As a family they appear to have, as a matter of speaking, bought the whole packet, including channelling cultural resources into, in so many words, getting with the program. At the same time, several other participants expressed a notion that being fat, all told, is only one of life's many issues: «It's not like I walk around all day thinking about being fat...!» (I repeat Peter's words here, partly as a reminder that this whole project could ultimately never truly amount to more than an adult's projection of childhood obesity).

**Patient Perspective, Ethnographic Methods**

This thesis has aimed to describe childhood obesity from the patient perspective – which is to say, from an angle which incorporates what this whole bodily process means in the lives of youngsters. Perhaps contribute in some small way to an understanding of why, beyond biology, treatment seldom succeeds. Towards this end, in order to avoid relying exclusively on verbal input directly from the child and the real chance of asking the wrong types of questions in each case, conversational information was supplemented with data obtained through observation of activities partaken in by the participants. Observation of a child's movement during a game, say, often enabled questions pertaining to or related to that activity. Posing questions with limited scope in relation to «being fat» often proved a safe way to circle in on more profound issues.

Even so, the project never intended to rely solely on input from the youngsters themselves. Indeed, in practise, parental and adult participation has been important to my ability to say anything very profound about the deeper meaning of obesity in the lives of the young people involved. Clearly, the final tally of patient participants is not extensive. Parents and other adults did facilitate communication and for better or worse would sometimes “help” answer difficult questions; and their presence often proved instrumental in surmising the perspective of parents' in order to understand more of their children. It should be stated – in a sense to summarize the project – that even when talking whilst engaging in leisure activities, many research encounters were admittedly marked by the slow pace of conversation. This was not, however, uniform. It was often in the company of a parent or some other adult that the most fruitful communication (including interactive observations) was achieved. But that increased input, it should be stated, was sometimes bought at the cost of a child's thorough elaboration on given topics. These are the cons and prons. Overall, parents and other
adults made important contributions and occasionally, in some discussions in the
following, I have depended on input in which the child's own thoughts and sentiments
are perhaps not always in the forefront. This has to do with getting the parents'
perspective forward in order to understand obese children's reality and the discourses
they face, but also reflect methodological limitations in terms of gaining verifiable
insight into children's inner worlds when it comes to obesity and body weight. I see the
parents' perspective as an important supplement to the verbal and non-verbal
information from the young participants. The discourses adults construct around
childhood obesity, whether they be doctors and health personnel in charge of treatment,
physical educators or home economics teachers, or parents, for that matter – constitute
a very important source of information for a child to make sense of his large body.
That is why I would still consider parents' insights complimentary even with a perfect
methodology capable of capturing all aspects of the children's perspective on the issues
at hand.
Methods

Seven-year-old lad at the bowling-alley with Mum and anthropologist: Mid game, the deep-fryer at the reception kitchenette sends out its siren call, an instantly intelligible, alluring message: Heavy scents suddenly waft through the premises, permeating the air about us. The boy asks to be excused and trots off to the little boys’ room. Minutes pass, he doesn’t return. Before long boy is located at the reception-desk, eyeballing the source of his cravings. Mum stands admirably firm against the lad’s vocal desire; the game though is irrevocably dissipated.

Recruitment

Project procedures were approved by three ethical advisory bodies (Norwegian Data Service, Regional Ethics Committee, and the hospital’s ethics board). The project’s recruitment and operational procedures were in part planned but in full carried out in cooperation with the treatment programme (presented below). Hence, I was given permission to recruit participants (in)directly at the treatment centre. This did not include access to medical files or other official documentation. An important premise was that participation in the project should not hamper treatment activity or objectives. Criteria for participation in the research were essentially age between seven and eighteen and a minimum of twelve months prior treatment history in the programme. By bi-ethnic design participants were recruited among “Norwegian-Pakistani” and “ethnic Norwegian” patients.

In terms of recruitment, the following procedure was advised. Patients in the programme are at regular intervals, according to the individual’s treatment plan, called in for consultations at the treatment centre. Treatment staff inform prospective participants (viz. those matching the criteria) about the research project after the normal course of such a consultation. Following which, in order to participate, interested youngsters must actively seek out the office allocated to the project where the researcher on those occasions would be waiting. In this way, any patient so inclined simply slips out the hospital door without ever meeting the researcher. The at times slow pace of recruitment indicates that, indeed, many chose this option. On the other hand, those who did come forward can be assumed to have done so with some level of interest in the research. There is clearly substantial potential for “bias” inherent in this recruitment procedure. This, however, seems justified and even necessitated by the nature of the research focus – and a concern over non-neutral selection should be
outweighed by the notion that the participants have thereby given their true consent to participate. Moreover, in order to be ever mindful, vigilant, of the need to maintain the principle of ongoing «informed consent» in terms of participation, participants being minors etc., in each case the number of meetings was agreed in advance. Furthermore, in the introductory conversation with children and parents we would speak about (and in the information sheet given out, it was explained) how participation could be terminated at any time without consequence to the child's involvement in the treatment programme. Several participants, including the initial two, at some point opted to not prolong their participation.

**Data Collection**

Qualitative approaches can play an important role in research on disease and health care (Fitzpatrick & Boulton, 1996). Initially, this project's proposed modus of generating ethnographic data was (due to ethical considerations) operationally meant to rely on semistructured interviews (Kvale & Brinkman, 1996; Maxwell, 2005) with the young patients and their families at the treatment centre’s premises. During the first two interviews, however, it was felt that the setting and specifically the mode of communication this involved, was not conducive to exploratory conversations on matters tuned towards the young patients’ perspective. I had a feeling this type of setting might induce answers that the children would expect me to be after. I might easily be giving off the impression I was, say, running the treatment programme's errands by checking up on the children's fidelity and stamina in the treatment process. In practice, it was proving difficult to achieve trustful communication during the course of an hour’s conversation. Frankly, I was failing to facilitate open-ended questions and, in deed, answers given seemed to be tied to expectations concerning treatment progress. The presence of parents was felt not to be fruitful. These are complications tied to clinical interviews with children, which is what this amounted to. As other researchers have experienced, “Encouraging a teenager to have a conversation in a semistructured research interview is fraught with difficulties” (Bassett et al., 2008). Conscious of how a young patient too would find the situation encumbering, and due to the clear strains this would pose to whatever resultant data – I felt a new approach was urgent. Clearly, these special research conditions necessitate a methodology which is, a) exploratory, b) flexible enough to accommodate potentially changing circumstances and research foci, and c) sufficiently stimulating to make
research interaction easier. In other words, a more “conversational approach” allowing for “interviewing and analysis as intertwined phases of knowledge construction” (Kvale & Brinkmann, 1996, p. 49). In light of the qualitative nature of the aims of the study, viz. to describe and interpret “not only […] the physical events and behaviour […] but also […] how the participants […] make sense of these, and how their understanding influences their behaviour” (Maxwell, 2005, p. 22), the youngsters must have freer reign to express their side of the issues. A more fruitful interplay between participant, parent and researcher ought also to be fostered. A new approach, including research venue etc., was directed towards creating a setting of confidence with the participant and maximum incentive for each to share their experiences.

Truth be told, at the time I could find very little methodological precedence (as to modus/venue – other than semi-structured interviews) in relevant literature to accommodate the present circumstances (but see e.g. Lindelof et al, 2010). The extant knowledge on childhood obesity appeared largely to have been garnered through quantitative methods, often on population or community level and, crucially, with a view to establish best practise in terms of weight regulation. A better suited methodology was therefore developed through brainstorming with research colleagues. The new approach, we concluded, would have to substantiate a need for non-verbal input and should therefore involve some form of “direct participation” (Pelto & Pelto, 1996). A good idea might therefore be to simply do things together; essentially allowing the kids more play in deciding the locality and mode of research interaction. As elaborated shortly, such a scheme was developed, reducing the hospital premises to a venue for an introductory conversation about the research project. Participant observation (Ellen, 1984; Hilden, 2003; Bryman, 2012) is not a commonly encountered methodology in the study of childhood obesity. As I’ve said I found little research had gone into observing the minutiae of for instance body movement in obese children. My contention moreover is that few, still, seem to have attempted to explore paediatric obesity from a perspective of what might be involved for the children who suffer this condition. The novelty of the methodological approach has been acknowledged through the peer-review process of the three papers.

**Interaction**

A number of the young patients were accompanied by a parent or caregiver, naturally, for consultations at the treatment centre, and many parents came along, at least
initially, for activities as part of the research. Under these new circumstances parents' presence often provided dynamics with important bearing on the direction of the communication and resultant material. Having been told of the idea of doing things together, a second meeting might be arranged at a local bowling-alley or another venue to the youngster’s liking, suitable for leisure activities and (hopefully) conducive to some form of conversation. That second encounter would normally transpire much like any afternoon in a bowling-alley only the routine of the game might be interspersed by questions posed by me in between rounds. The participant might then ideally formulate a response while doing his round; or questions might be asked to a participant and/or parent in a lull in or after the completion of a game.

As it turned out, many participants favoured bowling, though several other activities like minigolf and billiards were found suitable for the project’s purposes; including taking walks, chatting over soft drinks, and even engaging in physical exercise. Such other activities might open for a particular line of question which might be more sensible to broach in another scenario – whereat, by way of example, an offer of a soft drink or a snack in the bowling-alley, might allow for follow-up questions around food or food preferences. Like Peter, who one afternoon first repeatedly declined a soft drink; then, when I went and bought a bottle of sparkling water, he accepted after all – only, “not Diet Coke, that doesn't taste nice!” Seeing that there was no other diet soda just then available, Peter decided to have a regular Coke. This affords me an obvious cue to ask him whether that is something they condone in the programme. “Sure,” he says – “I drink that!”

In other words, the data includes observations of interaction in many social environments beyond the verbal input generated through conversation. Though structured conversations with children probably often yield less material that with adults in a more traditional interview setting, the informal setting and our mode of interaction probably helped making many of the actual conversations in this project overall relatively communicative and informative. Which is not to say that the insight generated into each participant's lived experience is necessarily vast. The presence of family members during activities, however, often enabled both verbal input from the child, as well as observation of body movement etc. and family interaction. Parents would often prod the child into talking or talking more, or might engage the child in some discussion on a topic, or in some cases even answer the occasional question outright.
During conversations and interactions, I kept a notebook at hand to dot down any remark or observation. I would sometimes minimize the attention given to taking notes, whereas for some participants my note-taking may have been a point of pride. Prior to a «session» I would prepare some few questions in my notepad, and especially if some insight had been achieved on a previous meeting. Something like the following questions prepared for Tareq on one afternoon: “Last time you told me you think of yourself as 'large'. When did you start describing yourself by that term? How are large people different from slim ones, do you think? Are there any bad things with being 'large'” (A fuller list of pre-prepared questions is included as Appendix A.)

I abandoned the tape recorder used during the initial conversations when I started playing bowling with the participants. Beyond “the silencing effect of the tape recorder” (Bassett et al., 2008) tangible in the initial interviews, my feeling was that a recording device is not very effective in capturing the data which, when talking about obesity, often lurks right beneath the surface of the conversation. My feeling is notwithstanding that, even under the best of circumstances, conversations centred on this topic with children especially will often be difficult to sustain over any length of time.

**Methodological Strengths and Limitations**

It may be pointed out that an obvious weakness to the present approach is the absolute dependence on factors like personal chemistry between the participant (and parents) and anthropologist, which is ultimately an expression of the ultra-qualitative nature of the methodology. Perhaps a more fundamental concern is that the potential for garnering insight into the central topic (being fat) and the lives of youngsters more generally from interaction and conversations in this way, albeit over time, is ultimately limited. Nonetheless, beyond the thematic focus on a patient perspective, which I think is an important contribution in its own right to ongoing obesity discourse, a main strength of the project’s approach, as I see it – is precisely the deeply qualitative nature of the input generated, which in a sense is capable of transcending words and expressions. The ingress to the method section, supra, a retouched fieldnote excerpt, is meant to offer a glimpse into how the peculiar form of interaction might generate observations. (Though, the particular episode may seem to confirm some of the more obvious prejudices about obese children: More or less driven by primal urges they are difficult to motivate to activity – that is a purely incidental focus; the point is the
methodology opens for “thicker descriptions”, more so than conventional interviews). I would argue by comparison that a semi-structured interview angle in childhood obesity research, where a standard set of say eight questions is posed (e.g. Lofrano-Prado et al, 2013), risks missing a qualitative dimension as to how obesity manifests in different ways in the lives of and between individuals.

I see a further strength to the present approach in the inherent flexibility and “reflexivity”, seeing how the researcher must form “part of the social world he or she studies” (Maxwell, 2005, p.82).

The group of key participants, the five or six individuals who contributed the most to the material, took part in several activity sessions some over extended periods of time. Meeting participants consecutively afforded me the opportunity to repeat questions and ask them in different settings. Or a given body-movement might generate an observation, and in turn this might generate a question as to why, when and what, which might result in streams of consciousness in either child or parent. Though closely dependant on factors like personality and personal chemistry, location and other circumstances, like the presence of other people within earshot, etc., this form of communication enabled the articulation of more appropriate questions in each case and otherwise “measure” the mood and mode of interaction.

With a focus on minor patients subject to strict confidentiality issues, the project has been bereft of methodological devices like focus group discussions which have added scope to recent research. «The fact that the groups consisted of close friends made sensitive topics easier to discuss compared to a normal in-depth single interview» (Lindelof, Vinther Nielsen & Pedersen, 2010). To be mindful of and convey a focus on the patients' own perspective, I collected no anthropometric measurements and recorded no BMI (except what was said in conversation). I tried to avoid asking «too grown-up» questions (see ex. Tareq's demeanour). The kind of topics we discussed between us and the level of interference I wished to lay bare in each case was ultimately dependent on how I felt the child in question might be suited to «handle» the particular inquiry. Beyond that, a paramount ethical principle throughout has been not to add stones to the treatment-burden. More rigorous lines of questioning might have been pursued, though, I feel at the cost of this concern.

Moreover, recruitment to the project was not hugely successful in terms of sheer numbers. In addition, I was aware that many of the situations from which the material
is developed, were not optimized by the researcher (me) in terms of scope and depth of
the communication. (Given overall focus, setting, ethical limitations and concerns over
implications for treatment – that was perhaps to be expected). I state this as a kind of
delineation of focus, essentially saying that the project in practice has dealt with what I
might call everyday issues.

To expand on potentially sparse input from the patients, to elucidate on the context and
understanding of obesity in Norwegian society, I found it pertinent to gain insight into
the wider culture that obese children inhabit by interviewing a set of school personnel.
(I hope to explore their input in an unpublished article). Other than that, I
supplemented the ethnographic material generated by interaction and conversations
with patients, parents and treatment staff, with extensive review of medical and social
research on many aspects of obesity. I have brought to bear an analysis of this material
based on a sympathetic eye towards what being fat means to the individual. This is a
perspective which has seldom been explored in obesity research. Though this take was
developed after perusal of a vast body of research on paediatric obesity, a description
like ‘sympathetic’ might obviously represent a potential source of bias – conversely, I
did come to the present research with preconceived ideas, even though these have been
modified by the very research process. As stated, in retrospect I see I very much shared
in the same prejudice with everyone else that the thesis might be said to be trying to
debunk.

But in researching the literature on paediatric obesity, it seemed to me that very little
effort has gone into understanding what the bodily condition might actually involve for
any particular child (see Rees et al, 2009). In the place of more «rigorous methods»,
perhaps a strength of my methodology is the access it has provided to, hopefully, «rich
data [...] rooted in children’s perspectives» (ibid.) and thus qualitative insight into
given points of interest from the vantage of the young patients themselves.13 Even so,
clearly, uncovering the inner worlds of young obesity patients is an undertaking often
fraught with challenges. My orientation towards “thick descriptions” (Geertz, 1973)
has been marred, I am aware, by practical limitations inherent in the methodology
employed (and the pedagogical skills of the researcher). And, in the final tally, the

\footnote{Snethen & Broome (2011) point out information on children’s perspectives of obesity is limited. Though
their approach may be similar, their perspective differs somewhat from mine.}
insights I have gained through interacting and speaking with the participants, no doubt represent mere glimpses into their lives.

Validation of Results

As introduced above, my ability to achieve this aim notwithstanding, through my research I have hoped to dismantle some generalizations as pertains to fat children. The intention has been to draw out peculiarities as well as some general experience. However, the small size of the sample is scarcely very commensurate with transferability of insights. Like Karl points out, there are bound to be fundamental differences between someone like Berit's and someone like Ulrik's experiences (which is part of the reason why I chose to focus on these two individuals in separate papers). I therefore set the course towards describing the “lived experiences” (see below) of individuals, rather than attempt to primarily draft an elaborate analytical framework to enable more concrete validation of “results”. My access to figurative proof-texts, rather, is anchored in an ability to replicate and reformulate questions and inquiries over time, sometimes spanning months. The strength of this approach is validated by Maxwell in stating that “repeated observations and interviews, as well as the sustained presence of the researcher in the setting studied, can help rule out spurious associations and premature theories” (Maxwell, 2005, p. 110). If also, admittedly, “trading generalizability and comparability for internal validity and contextual understanding” (ibid., p. 80). Certainly, I have endeavoured to avoid generalizations as to the transferability of the material and the conclusions drawn.

Files were obviously kept, throughout, allowing collation of material under different subject headings (like The Body; Physical Activity; Food & Consumption; Family; Gym in School; Personal Characteristics, etc.) and pertaining to each of the youngsters. This gave me tools to juxtapose and cross-reference the input from each participant. This content analysis was conducted by a single researcher, which is tantamount to a likely source of misinterpretation. To counterweight this in a way, as methodological device and also analytically, I consciously 'accepted' the words of the participants at face value, following the flow of their reasoning (though there is such a thing as reading between the lines) and paid close attention to the context and setting wherein words were uttered.
Beyond that, any comparison I draw between participants (or other sources) is meant to be purely descriptive; but then again, the whole material is in truth based heavily on my own experience and analysis of the phenomena under scrutiny. The absence of more thorough measures to “validate” the qualitative data is an admitted limitation and flaw, inasmuch as, being the observer, given the peculiar nature of this particular material – *I am* its very ‘conduit’. I will have gotten many things wrong, missed out on much too. Moreover, the number and heterogeneity of the participants contributed to a focus on specific themes available to immediate observation and potentially discussion. The effect is that what I am positioned to say about the lives of these youngsters may not reflect how they see the circumstances themselves, and the topics I bring up may be removed from each individual's understanding. Even so, overall, I think the material has benefited hugely from taking seriously the participants' perspective. I'd hope the insight this has generated might go some way to compensate for the mentioned methodological challenges.

**Ethical Considerations**

There are obvious ethical dimensions to the present endeavour, ethnographic research on a socially stigmatised group. But since, in addition, the focus here is on minor and minority patients recruited through a treatment setting, the project has been subject to a set of formal ethical research restrictions and considerations, approved by officiating bodies and ethics review boards. The project's recruitment procedures and modus of interaction with participants were approved by three individual ethics bodies on hospital and national levels (see above). Consent has been a major concern throughout the operational stages of the project. This has in part stemmed from a realisation that the theme of the research might, at any moment, very well be perceived as shameful or “lame” by a youngster, who might then wish to quit the project. It was therefore important as a means of focusing on the ethical issue of informed consent, to stress vis-à-vis the participants that they could terminate their involvement at any time and were free not to talk about any subject they might deem private or the like. Beyond that, the extent of involvement for each participant was agreed on the first encounter so at to avoid a child should feel pressure to prolong their involvement (the exception being Berit whose participation was more open-ended from the beginning).
I was fully conscious that participation in a project with the present focus might influence, that is, accentuate, a youngster’s worries around health and risks, and thus add to already burdensome psycho-social issues connected with weight. Also, there might be a social component to this in as much as a child could feel increasingly alienated by being subjected to a first-and-foremost focus on “being fat”. There was an academic unease in the project as to whether a focus on weight might add to feelings of shame and stigma in some individuals; as in My fatness is all anyone ever cares about - they never see the real me...

Another ethical aspect which gave pause during the planning of the project was the possibility of youngsters having a fat-identity “confirmed”, for lack of a better term, by participation in the research. By which I mean that, conceivably, participation might induce some kind of complacency; that the young person might pick up on the researcher’s “acceptance” as something more comfortable than the presumed clinical focus of the treatment programme. This might in some way be detrimental to the child’s focus etc., and thus very much in breach of the cooperation extended to me by the treatment programme. On the other hand, a potentially positive side effect of participation (perhaps for the more mature youngsters) might be the possibility of candid conversation with a non-judging adult in a neutral environment (those were the aims anyway). Therefore, throughout my interaction with the participants, I was mindful that it was not the prerogative of the project to contribute to treatment aims as such; certainly not to help “scare” the kids “straight”. Beyond that, both parents and youngsters often expressed hope, during the first encounters at the treatment centre, that participation in a research project on weight issues might in fact contribute to both awareness around pertinent issues and provide an outlet for physical activity etc. Personally, I felt that the premise of participation, namely leisure activities of the individual’s choice, provided incentive for the participant to maintain interest in the project by making it fun.

Writing about ethical aspects of the research, one particular episode springs to mind, which I render here with apologies to Berit, only to illustrate the extreme need to tread cautiously through this delicate academic terrain. In brief, from a data input perspective, Berit had to date proved one of the more interesting participants enrolled in the research and beyond that, one of the more dedicated in terms of commitment to participation. Speaking to her motivation, Berit had by no means an easy time being large; on the contrary, I felt that she and her mother were willing to participate in the
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project despite the social problems that obesity caused in Berit's life and the concern this caused to her mother. I felt that both daughter and mother wished to participate in order to throw light on the plight of obese children in Norway, and, secondarily, in order to get some "inspiration" for their own endeavours. One dreary autumn afternoon, Berit, her mother Turid, and I had made an appointment for us to meet up for bowling after school. Turid was to join us later at the bowling-alley, with the understanding that this would give the two of us time to talk – maybe more freely without Turid being there. Upon our meeting, however, it was immediately apparent to me that Berit had had a worse day than usual at school and her frame of mind did not seem conducive to talk. On a previous occasion she had told me (as had her mother) about being bullied at school; soon I gathered, by her manner of posture and her facial expression, that she was presently suffering the psychological consequence of such unwanted attention. After the longest tortured while in silence between us – standing on the pavement in the drizzle, her eyes cast down and voice all choked up; she’s miserable and I never felt more helpless – the oppressive sadness of the scenario only resolves when we, painstakingly, make it to the alley.

Naturally, we did not pursue a deep conversation about being large just then. But the incident did grimly illustrate, or at least allude to, how being large may influence the everyday life of a youngster. The ethical conundrum I grappled in and after the scenario was related to Berit's continued participation in the project. In retrospective, this exchange with Berit underscores the importance of the research, though, to the lives of the participants themselves. The project was indeed always about the participants' perspective – which is ultimately often overlooked in obesity research and popular coverage of the topic. It was important to me to try and make the best of Berit’s bad day – as heart-rending as I experienced the scenario – and to maintain the channels of communication between us, despite seriously pondering Berit's further participation in the project. Later, Berit herself did not think the episode grounds for quitting. All told, I felt that Berit enjoyed the various games and leisure activities we did together through the project. Being able to voice her own personal concerns occasionally without her mother there, I think was an important part of her experience; and more than that, I felt that she saw participation as a means to bring understanding to her situation, that she appreciated the particular focus of the research. In keeping with our agreement as to her involvement in the research project, after a series of
afternoons over a period of six months, Berit and I reached the common understanding
that she had now reached the end of her participation.
Analytical Framework

According to Gard, “scholars are most effective when they’re able to infiltrate and exploit a range of theoretical and ideological traditions...” (Gard, 2008: 42). With an aim to contribute to our understanding of “the lived body [as] a site of discursive struggle” (Fullager, 2008: 109) – preparing for and during the research, I adopted the widest possible approach to understanding paediatric obesity as a socio-cultural phenomenon, including papers on the hazards to health, interventions, bio-facts etc., and social theories on body-shape, consumption, risk, etc. In terms of the social sciences, I have not subscribed to any overarching theoretical umbrella or school of thought. The discussion is informed by complimentary input from several traditions.

For instance, Deborah Lupton’s (and others’) ideas on public health and health-ism have helped highlight how nearly all participants expressed “knowing” society’s view of obesity and being “aware” of what is expected of them in terms of behaviour towards “normalization”.14 Valverde’s concept of “diseases of the will” lends a fruitful complimentary perspective, since, according to previous research, though not all my participants would agree, obese youth often think of themselves, too, as weak-willed and lacking self-control. Call it internalizing wider society's views. I have found some feminist authors capable of throwing light on how society constructs mechanisms whereby bodies come to be regulated.15 There is a touch of this in queer theory as well. I have looked to the theoretical body on phenomenology and embodiment, Merleau-Ponty and Bourdieu, naturally, to help keep in mind how the condition in question is both a matter of “being in bodies” and “being in culture”. I have found Sign-, stigma-, and minority theory to aid in the discussion of how these concepts intersect, which is to say interrelational aspects like obesity being an overriding identity-marker, and even the “culture/ethnic dimension” in obesity (since culture might influence consumption, activity, body-type preferences, and other such factors). In short, I have allowed myself

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15 Susan Orbach’s *Fat is a Feminist Issue* represents a figurative *ultima thune* in this regard, a work which I found to have limited direct bearing on present-day obesity among Norwegian children. Gremillion and Popenoe discuss issues highly pertinent to the present focus. 16 Like DaCosta’s *The Autobiography of a Brown Buffalo* – for input on obesity among Chicanos.
to draw on any theoretical perspective (and ethnographic analogy\textsuperscript{16}) which might throw light on the experience of living life as a large-bodied youngster in modern Western society. I give an overview of how these schools of thought have helped steer me through some of the phenomena facing obese children.

**Embodiment & Phenomenology**

In Western civilization there has arguably been generally limited focus on the obese bodily experience – other than this body’s profound alteration. We shall see that several participants' sometimes problematic mode of being-in-the-body suffer under a consequential lack of cultural signs and cultural understanding. Even the French tradition of Phenomenology, in its interest in analysing what *being in bodies* contributes to the human experience, has arguably not paid thorough attention to how various *types* of bodies might play out as an experiential factor. I argue thus with support in recent critique of the traditional phenomenological school of philosophy, as exemplified by Merleau-Ponty. It has been pointed out that this thinker’s failure to elaborate on the significance of gender, for instance, in a person’s experiences, resulted in a masculinist bias and other «blind spots which his philosophy has produced» (Smiet, 2012; Groven, Engelsrud & Råheim, 2012). The former author alleges that although Merleau-Ponty did emphasize that ‘the body’ by definition is ‘my body’, and thereby underlined the inevitable ‘mine-ness’ of experience, his school of thought, Smiet argues, in fact «overlooked the specific bodily characteristics that shaped his own experience». Merleau-Ponty’s point of departure, Smiet posits, is the young, male, able, and white body:

> It was this specific body, and these specific embodied experiences, that serve as the general model for embodied being-in-the-world. In this way, [...] while claiming to describe the universal structures of experience and the general characteristics of embodiment, Merleau-Ponty’s phenomenology of the body actually described a very specific body and a very specific type of experience (Smiet, 2012).

This theoretical perspective has proved very useful to explaining how «the ergonomics of obesity» tend to disappear from view – and this is because, I argue, related discourses on the human body in the Western canon has effectively failed to prepare us to what the obese body experience might entail. I have looked to phenomenology as a
resource in my investigation – to be mindful of the «lived experience» angle inherent in this tradition, but also to keep in mind «the blind spots» it inadvertently also represents. Because, as I argue in Paper II, these blind spots in the scientific focus on «the body», is by extension, certainly reflected in the narrow popular definition of what the body is and does. Central to my line of argumentation in the paper and the following, this has contributed to our inability to thoroughly distinguish between «how it feels to be thin» and «how it feels to be fat» (Smiet, 2012). The paper explores empirically a situation where this “gap” in our cultural repertoire has very negative effect on Berit’s experience.

However, in as much as phenomenology attempts “to give a direct description of our experience as it is, without taking account of its psychological origin and the causal explanations which the scientist, the historian or the sociologists may be able to provide” (Merlau-Ponty, 1945/2002, p. Vii), this type of perspective might not accommodate to full the purposes of the present wider focus. In this regard, Evans, Davies & Rich (2009) have argued that, if

We are to address the agency of ‘the body’ in cultural reproduction and better understand how the corporeal realities of children influence their sense of position, value and self, then we will need to deal with both the ‘physical’ and the ‘phenomenal’ universes of discourse, and the ‘somatic mediations’ of lived experience.

The subject matter under scrutiny is highly complex and interwoven, and the ethnographic methodology employed here and the resultant material is, as explained above, by no means sufficient to describe in general the lived experiences of obese young people in Norway today. These circumstances have necessitated an eclectic approach to the problem.

**Critical Fat Studies**

Researchers, health workers and the rest of us ought to be aware of the biological complexity of childhood and adolescent obesity; there is certainly enough research to establish that as fact. No less so, critical fat studies is an academic discipline very much needed to decipher the axioms – call it, “conceptual blind-spots” (Wann, 2009:
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XI) – of the “global obesity epidemic”.16 (The size-acceptance movement is the political equivalent). Inspirational to the present line of inquiry, among others Sobal & Maurer have posed important pioneering questions regarding the hazards to health from childhood obesity. Gard & Wright have authored a very influential title to which I am indebted. John Evans et al., Rail et al., and Harjunen are examples of other authors who analyse the effects obesity discourses have on our understanding of large bodies, a central topic in the thesis. This school of thought draws heavily on the Foucauldian perspective of *governmentality*, from which spring the ideas *bio-power* and *bio-pedagogy*. These conceptual tools have proved useful to help explain many issues in the lives of the young patients in this study, for instance how many patients think it’s their *duty* to slim.17

**Body-regulation: Bio-Power & Bio-Pedagogy**

In a Foucauldian tradition, contemporary Western society has been called “somatic” (Turner, 1992; Foucault, 1988), hallmarks of which are the regulation, surveillance and monitoring of human bodies – and as “permeated by health-ism” (Petersen & Lupton, 1996, p. 25). The individual body has become the site, as is often pointed, where “discipline and control are physically expressed”, and body regulation is now a central tenet (Lupton, 2003). Body management has become important in socially differentiating people and symbolizes the triumph of culture over nature (Lupton, 1996, p. 64). This certainly rings true to other times and places18 – it is something of a truism that “civilisation […] relentlessly *writes* this body, seeking its total destruction by its transfiguration into a cultural object” (Butler 1990, pp. 169-70). It is only that, in

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16 The discipline “requires scepticism about weight-related beliefs that are popular, powerful, and prejudicial. This scepticism is currently rare, even taboo […] members of a society have recourse to *only one opinion* on a basic human experience, that is precisely the discourse and the experience that should attract intellectual curiosity” (Wann, 2009, p. X).

17 Quoting Halse (2007) Evans et al (2008, p. 57) write that “personal responsibility for one’s weight is constituted as both care for one’s self *and* for others and therefore as a moral and ethical duty to wider society […] Within the culture of weightism one is expected to become the ‘virtuous bio-citizen’ by ensuring that one’s weight is within the BMI ‘norm’ […] New health discourses associated with the moral imperative to regulate one’s weight asserts an obligation towards oneself and a social responsibility towards others in a ‘moral economy of virtue’.”

18 Popone, 2004; the Saharawaghs of Sahara would agree to Lupton’s assessment of the place of body-management in culture, even as they hold the *obese* female form as the ultimate expression of precisely the same virtues.
the present social setting, “the notion of individual responsibility for one’s health has translated into the notion of self-responsibility for one’s lifestyle” (Rail, 2009, p. 146).

Treatment for paediatric obesity, essentially, rests on the individual assuming responsibility for her own body-normalisation by adopting values and praxis, “a lifestyle”, considered more beneficial to health and thereby, in this sense, becoming more “proper citizens”. The Foucauldian perspective of Governmentality, and more specifically the concepts of bio-power and bio-pedagogy, is in this sense bound to be enlightening to a study of modern paediatric obesity. This has anyway proved an important theoretical perspective in the analysis of the present material; well-nigh every participant somehow expressed on some level, certainly when pushed, feeling responsible for adopting behaviour more aligned with the aims of the treatment programme. In this sense, I have taken bio-power (expounded in Paper III), to represent those technologies that «regulate populations and govern the body», and «advance the ultimate goal of producing functional bodies that can be improved and transformed. But most importantly, that internalise the duty to do so and become self-disciplining» (Foucault, 1977). Whereas, biopedagogy emphasizes the «ways in which the powerful but subversive, value-laden production of knowledge that targets bodies function in a disciplinary and regulatory way, governing bodies and populations ‘in the name of health’ and producing functional bodies when one internalises such body improvement duties and makes ‘autonomous’ choices in accordance with hegemonic norms, social and moral expectations and expert advice» (Wright, 2009). The concept of «proper citizen» is especially poignant to the discussion of obesity among Pakistanis in Norway, but applies to any patient facing the prescriptions of treatment, because the inherent aim of that endeavour is to promote body-regulative behaviour which qualifies for «proper citizenship» in this way.

**Fat & Sign Theory**

Even in Norway, being fat will not be *all terrible at all times*. Sometimes being fat might involve a feeling of “comfort”, “happiness”, “independence” or “strength” (as we shall see in Ulrik's case) – the papers indicate other interpretive possibilities on a personal level. This obviously underscores the complicated nature of obesity and, potentially, its regulation, seeing that being fat differs from a cancer diagnosis in that it is much more complicated to, in a word, expunge one’s *personality* or components thereof. I make the point repeatedly that obesity might be different things to different
Obesity and minority

people. However, in mainstream modern Western culture, “excessive body-fat” is the equivalent of sign (representamen) in the American Pragmatist C.S. Peirce’s terminology, of which the interpretant often is “slovenly”, “stupid”, “sick”, “socioeconomically challenged” and the like. 19 The semantic repertoire is certainly limited, though the interpretation of body fat as a sign is bound to be contextual and obesity in children sometimes induces different connotations than the ones specified; like perhaps «victim», «bad parents», or even “Pakistani” or “minority”, as argued in the discussion on findings. That is why obesity might induce slightly variable reactions if seen in a child or an adult, in a female or in a Pakistani. What is anyway clear is that such is the force of the signal transmitted by obese bodies – and read into them by the public, the media, public health and the rest of Western industrialised society – as to blur almost all other information. Well neigh all thoughts expressed, emotions betrayed, and actions committed by the obese individual, will automatically be understood by the observer in the acrimonious light of the body from whence they issue. Hence, we tend to think «lazy», rather than «ergonomically challenged» and (as I exemplify below, in relation to Kim and Berit's experiences) every bar of chocolate in the hand of an obese individual we take as proof positive of a lack of self-control (if also «bad parenting» and a limited negative repertoire).

In this way, furthermore, body-fat assumes the function of a metonym for the totality of the person. Or more precisely, in any given social encounter, the obese body (or parts of it) becomes a synecdoche – which is to say, “a part [taken] for the whole” (pars pro toto) – for the individual. 20 The adipose tissue is the instantly intelligible “signal” – viz.

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19 Laura Kipnis (1998) calls body-fat, “a predictor of downward mobility”. Cameron, Norgan and Ellison (2006: XXIV) point to the “unexplained association between lower social group at birth and adult obesity in industrialised countries” – a correspondence established by a host of research. Internationally there has been ample social scientific focus on links between socio-economic status and prevalence of obesity in demographic subgroups (Dounchis, Hayden & Wilfley, 2001). In Norway, a notion of higher prevalence of obesity among people of lower socio-economic strata resonates with the language of official discourses. In terms of popular perceptions, on an anecdotal basis, it is probably true to say that in some social scenarios, obese individuals will be seen as “socioeconomically disadvantaged”. Beyond that, the association was not made by the youngsters or family members in this project, and the thread was not pursued empirically.

20 I find the exercise of metonymy somewhat reminiscent of Alice’s feline encounter in Wonderland: ‘Well! I’ve often seen a cat without a grin’, thought Alice; ‘but a grin without a cat…!’ (Quoted in Zizek, 2004). Kim had the following insight to add: “As a fat person you have to think a lot about how you present yourself socially to other people. Personally, I smile a lot. You know – to compensate kind
“characterized as calling for an immediate response” (Colapietro, 1993) – of that
communication. Hence, a fat body encodes and encapsulates meaning immediately;
and since there is no refuge from one’s own body, “you can’t pass as slim” (Bell, 1997,
p. 36) – relentlessly so. The heightened focus on weight in Western society, and the
ever sharper responsibility metered out to the individual for his own health status, is in
my opinion likely to contribute to making more unequivocal and lucid, to disambiguate
the signals bodies send out to one other. This must be even more poignant in the case
of the type of body that blatantly announces a lack of self-control, being “bodies outof-
bounds”. 21 In the context of global obesity, this phenomenon has been called
“lipoliteracy” – a word which underscores the notion that we “read” obese bodies in
highly distinct light. We may surmise that to stand out as obese means to personify an
enveloping, all-engrossing identity. Body-fat, then, can be thought of as the filter or the
figurative noise that tampers with – obfuscates – the relaying of other interpersonal
messages. 22 This theoretical vantage I have
found capable of throwing light on many concerns expressed by the participants – in as
much as obesity is a bodily condition which leaves an imprint in the individual no
matter the «coping mechanisms» or «narrative resistance» mustered to deal with it.

**Deviance, Stigma & Coping**

Over the last decades, the moral dimension of body shape and weight has been
extensively explored by the social sciences. It was proposed, even prior to the
onslaught of the global obesity epidemic, that “whether or not a physically deviant
person is derogated will depend on the extent to which that individual can be blamed or
held responsible for his or her appearance” (DeJong, 1980). 23 It is well established that

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21 To use a phrase coined by Braziel and LeBesco, editors of the anthology *Bodies out of Bounds: Fatness and
Transgression*.

22 During the course of my research it was pointed out to me that if my weight had been beyond “the
normal range” this would effectively have precluded my serious scientific, ethnographic study of obesity.

23 On this score, on the one hand: “Western cultures value physical attractiveness, and this value
unequivocally influences how members of the culture think about and behave toward people who vary in
attractiveness” (Jackson, 2006). Whereas, on the other: “Negative stereotypes of obese people include
many people harbour very negative views of individuals who fail to engage in health-
protective behaviours, such as taking regular exercise and other forms of exercising
weight-control (Petersen & Lupton, 2000, p. 51). A plethora of social research report
on the widely accepted belief that, “…to be thin is to be healthy and virtuous, and to be
fat is to
be unhealthy and morally deficient” (Carryer, 2001; Halse, Honey & Boughwood,
2007). Knowing this, in terms of social evaluation, insofar as health and well-being are
often conceptualized through moral lenses, a person’s very character itself is
jeopardized by a perceived shoddy diet and other faulty lifestyle habits (Forth &
Carden-Coyne, 2005). This tendency can perhaps be written down to a notion that fat is
always a loaded category, “a symbol, a mirror we can gaze into to glimpse the things
society tells us are the fairest of them all – and the things society tells us are the
grossest, least fair of them all” (Gross, 2005, p. 122).

In one important sense I think the stigma that accrues from obesity is different from
many other types, in that obese people are expected to redeem themselves through
willed metamorphosis (read: transform their stigma into merit entirely by their own
actions). Inasmuch as the biography of an obese individual is likely to be littered with
negative feed-back experiences from peers and society in general, it is not surprising
that in many cases this induces in the sufferer a very strong and enduring sense of
embodying an anti-ideal (Gilbert & Miles, 2002, p. 10). Beyond that, in parallel to
childhood obesity, it has been pointed out in social research on homosexuality that to
see oneself as belonging to “a negatively loaded category of deviants”, can be a deeply
challenging experience to young people (Andersen & Svendsen, 1997, p. 72; my
translation). The following quote, taken from research on the lived experiences of
Norwegian homosexual youth, inspires theoretical comparison; it is offered at risk of

the views that they are ugly, morally and emotionally impaired, asexual, discontented, weak-willed and
unlikable” (Myers & Rosen, 1998).

24 I find this reminiscent of a phrase used in another context, to describe victims of torture: “his own
body as the agent of his agony” (Scarry, 1985).
stretching the analogy on deviance, and only as a frame to understand obese people’s role in Norwegian society. For effect one might juxtapose the bracketed:

Homosexual youth have to deal with their own and other people’s ‘homophobia’ [which compares to the “lipidophobia” obese people endure], they have few good figures to identify with [a problem equally true to obese kids], they have to relate to coming out [as opposed to, in moral terms, being given one option: Shape up!], and they must manage the stigma of AIDS [or perhaps more accurately the fear of AIDS – where obesity is stigma embodied, stigma-made-flesh]. In this light we think that many lesbian and gay youth are worse off than many other adolescents, because our culture does not recognize homosexual expressions [in direct parallel to those of obese people, as Berit’s day at the mini-golf course might illustrate (Paper II)]. We have posed the question: In which landscape are young people supposed to define themselves as lesbian or gay and possibly come out of the closet? (Andersen & Svendsen, 1997, p. 73).

That last rhetorical question is pertinent to the present line of inquiry, in that, for obese youngsters the “landscape” is, in an even more extended sense, hostile to their mode of being-in-the-world. To either category of deviance the only redemption is impossible conformity. For the obese kid, though, there is no “closet” to exit – only the proverbial couch to get off. This particular analogy on deviance and stigma is enlightening, but to a point and that is primarily because fat people are exclusively, always, and so to speak, inescapably – that is: obviously, obese.

25 The following quote brings out the limit to the analogy. It is difficult to envision a practical guide for health personnel “normalizing” obesity is in this way: “[…] homosexuality should be considered as a variety of human diversity and should not be perceived as a personal idiosyncrasy or any kind of disease […] Enhanced prevalence of stress among lesbian women and gay men […] reflects large intra-group differences. For different reasons, some are vulnerable and others are very robust” (Andersen & Svendsen, 1997: 71). Meanwhile, it also brings to mind Kim’s comment on having grown as a person as a result of his ordeals as obese. “You become better at facing adversity…”

26 Crandall (1994) points to parallels between anti-fat bias and racism, one of three close similarities being “the oldfashioned antipathy toward deviance”. In Paper II I explore another important analogy between obesity and homosexuality in the West: a lack of adequate cultural signs to articulate the social experience. The analogy can be taken further with reference to either condition as “disease”. Medical perceptions of homosexuality have evolved (e.g. Andersen & Svendsen, 1997, p. 71), and is no longer recognized as a diagnosable disease. There is continued reason to examine the exact etiological and nosological nature of obesity.
It is known from previous research that people who feel deviant undertake constant self-evaluation. Such is the force of *the gaze*: “Each individual under its weight will end up by interiorizing to the point that he is his own overseer, each individual thus exercising surveillance over and against himself” (Foucault 1977, p. 155). That is “a callous and contemptible gaze” – since, there really is “no sympathy for the poor” (Vetlesen, 2006; my translation). In a classic of the genre, *Such a Pretty Face* – a title which captures something of obesity as an overriding identity-marker – Marcia Millman makes clear that deviance by its very nature has a tendency to become generalized. 27 She provides a neat summary of the effect this social gaze can have on obese individuals, which has steered the way I have approached the topic:

In every situation they must guess whether or not others view them as deviant […] Each new social contact, each action committed in public, no matter how trivial or superficial, is dominated by the fat person’s concerns about how he or she appears to others. Thus her participation in the world is often tentative and filled with fear of being discovered, labelled as the freak she fears herself to be. I felt like I was taking over the whole room. I could never not be noticed! (Millman, 1980)

Previous research tells us that *fatness* serves as the exclusive focus of interaction: “An overriding quality of the overweight girls’ identity. Obesity clashed with other attributes of the overweight girls, and being obese degraded virtues which were not related to weight” (Kallen, Sussmann & Sobal, 1984, p. 17). Negative encounters must somehow be processed by those whose bodies provoke jeers and stares in public. In this regard, Natalie Allon, a pioneer in the field of childhood obesity, saw the bodily condition as a self-fulfilling prophecy. “Fat people are discriminated against, made to feel they deserve the discrimination, and induced to accept the discrimination as just” (quoted in Sobal, 1984). It is important to be aware many obese people come to internalise society’s anti-fat biases (Brownell & Puhl, 2003), and that – “Unlike other minority group members, overweight individuals do not appear to hold more favourable attitudes toward in-group members” (Wang, Brownell & Wadden, 2004; Crandall, 1994). The theoretical perspective of stigmatized identity and its management was assumed to carry special resonance for the present project. It would seem an obvious choice in this scenario to look to Goffman’s theorization, though

27 “[…] As the stories of fat people vividly demonstrate, being overweight and the interpretations made of it, wind up affecting all of a person’s life, pushing the fat person into a special, marginal relationship to the world” (Millman 1980, p. 72).
much has been written on this subject in relation to obesity. Goffman's idea that a stigmatized identity can become a crutch to lean on (Goffman, 1969, p. 39) is particularly pertinent to the present purposes. This, in the sense that being of an obese body might be turned into an explanation for any of the ills of life: “If only I was thin I would be able to do this or that, or achieve this or that”. Also that the management of a stigmatized identity, being fat, can be handled with reference to one’s culture and ethnicity, as I try to show in my discussion of the Pakistani participants; Yes, being fat is bad, but it’s not my fault...

Those patients who can manage to actually slim need not worry too much about making sense of being fat – and I did informally encounter at least two adolescents (patients, but not participants) during the course of the research, who to all intents and purposes had become thin. Those who can't or won't achieve an altered, improved lifestyle as made concrete by weight loss, will often need to make sense of why. A point I make repeatedly: it is safe to say that these effectively failed patients have a limited repertoire at their disposal of not-all-out condemning cultural signs, to “cope with” this reality.
Summary of Knowledge – Knowledge Context

Obesity is a bodily condition which catches our attention. On a general level, what can be said about life as an obese youngster in the Western, industrial world? This, pretty much: Being fat is bad – perhaps socially as bad as medically. The following discussion has been structured by a three-pronged focus on a) the bodily condition as moral category and “a disease”; b) what this entails in relation to other people; and c) in terms of treatment, viz. lifestyle-change and specifically participation in physical activity. These areas overlap and intertwine. I proceed with a discussion of what is known on these various branches of obesity research. This rather lengthy, multifaceted discussion is meant to prepare the grounds for the later empirically based second part of the thesis. The overview is integral to the development of my argument in as far as it seems vital to understand the discursive universe the young participants face as fat-kids and patients if we can hope to understand something of their life experiences. This is all the more important when the subject matter is such as to complicate communication and the best one can hope for in terms of ethnographic input is to be afforded glimpses into patients’ meaning-worlds. On this basis it is necessary for me to go beyond the empirical input of the (subsets of) participants – beyond my mandate as it were – because this biomedical knowledge context and extant controversies pertaining to obesity in childhood is part of the public domain which socializes the children, parents and health workers who make up the project and the wider population in Norway. I therefore suggest it will be fruitful to lay out this setting before I turn to investigate the room and resources these individuals have to relate to it.

Paediatric obesity as Social Entity

Without delving too far into the historical development of the body/mind dichotomy in Western civilization, what, in this part of the world, is the philosophical position, so to speak, of human bodies? For a general background, poetically, it has been pointed out that the human body provides the “link between a here and a yonder, a now and a future” (Merleau-Ponty, 2001, p. 140). Mauss argued, classically, that “the body is simultaneously both the original object upon which the work of culture is carried out, and the original tool with which that work is achieved” (quoted in Csordas, 1994, p. 6) More recently, the Foucaultian view of the body has been epitomised as, “constantly in the grip of cultural practices” (Bordo, 1996). Elisabeth Grosz, the feminist, sees in the
human body “a writing surface on which messages can be inscribed” (Grosz, 1997, p. 78) – whereas to Pierre Bourdieu, bodies famously make for “the most indisputable materialization of class taste” (Bourdieu, 1984, p. 190). The common denominator: Our “communicative bodies” reveal who we are as individuals (Falk, 1995). Clearly, in essence, our bodies are linked with our sense of identity (Lupton, 2003) – we are, in a word, our bodies (Merleau-Ponty, 2001, p. 140). An analogy: Being as it were both the medium and the message, male bodies among the Yanomamo of the Amazon are said to speak to the premium placed on aggressiveness (“waiteri”) in that particular society (Lock & Scheper-Hughes, 1998). In our part of the world, where body-fat has been called the “crux of contemporary […] culture” (Kiplis, 1996) – here,

The way in which we cultivate our bellies reveals a great deal about our culture generally. The steps we take to feed, manage and sculpt our bellies […] are intimately connected with who we are and what we wish to be (Forth & Carden-Coyne, 2005).

Meanwhile, regarding late capitalist society, an apparent paradoxical feature has been pointed out. A red line running through the public debate on sexuality, Deborah Lupton has argued, is “a tension between the discourses privileging self-expression and satisfaction […] and those emphasising the fearful and potentially fateful consequences” (Lupton, 2003), of those sets of behaviours. The analogy to food, which is closer to the heart of the subject of this thesis: “Society deeply wishes us to over-consume […]”, i.e. portrays consumption in terms of sheer insouciance, “[…yet] savagely punishes all bodily evidence of over-consumption” (Kipnis, 1998, p. 206). In the Western world, slenderness (viz. conformity to hegemonic-though-ideal bodily statistics) has come to incarnate that pinnacle of virtues: Self-control.29 This is something of a keyword in the debate on obesity. Conversely, to be non-fat is a close correlate to “core cultural values” like autonomy, toughness, competitiveness and youth (Locke & Scheper-Hughes, 1998). In brief, the ectomorph (i.e. slender) body-

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28 On a meta-level this thesis is intended to bring to the fore how such a statement, though prescient from one point of view, in a sense belies the multifactorial aetiology of obesity, as well as individual variation, and immense complexity of the physio-biological, and indeed, social processes involved.

29 Below, I expand on several mechanisms whereby many obese people find body normalization extremely hard won. The point here is, ‘won’ by what Foucault might call, “those intentional and voluntary actions by which men not only set themselves rules of conduct, but also seek to transform themselves, to change themselves in their singular being, and to make their life into an oeuvre that carries certain aesthetic values and meets certain stylistic criteria” (Foucault, 1985: 10-11). This has aptly been called the “cult of slenderness”.

type all but pivots the healthy and socially adjusted individual. As a dialectic to the
slim, the message rendered by the “uncontrolled, non-exercised, overweight body”, is
one of “grotesquery and private shame” (Bordo, 1993) – and it paints that individual in
a wholly loathsome light. In Western society, body-fat has taken on the semantic work
of a contrast fluid marking the presence of things undesirable: *pathological tissue.*
Obesity has become “a badge of shame” (Klein, 1996, p. 22), a social liability
(Rothblum, 1992). Taking in dominant discourses, there is little getting away from that
as fact. As we shall see in more detail, many of the young participants told me
“Obesity is bad!” – a statement which indicates the power of obesity discourse in
Norwegian society.

Against this background, obese children in the Western world are known to suffer
social sequelae, discrimination and bias even from peers and other young children,
consequential to their bodily condition. It would be impossible to overlook this focus in
previous research:

“Stigmatization of obesity by children appears to have increased over the last 40 years”
(Latner & Stunkard, 2003). “Obesity related psychopathology – the ultimate price to be
paid by some obese people for the discrimination they suffer” (Braet, Mervielde,
Vandereycken, 1997). “The third theme in the stigmatization of obesity was crime, where
overweight people were held responsible for their own condition and punished for their
offense” (Kallen et al, 1984). “Discrimination against overweight persons may account for
these results” (Gortmaker, Must, Perrin, Sobol & Dietz, 1993). “Our findings offer further
support for the pervasive stigma of obesity and the negative implications of stigmatized
identities” (Carr, 2005). “Significant association with worse academic performance can
contribute to the stigma of overweight as early as the first years of elementary school”
(Datar, Sturm & Magnabosco, 2004).

One illustrative quote may be given at length:

Obesity is a stigmatized disease. One commonly held view is that obese people are lazy
and weakwilled. If fat people just had the willpower, they would push themselves away
from the table and not be obese. This widely held view is shared by the public and by
health professionals alike [...] Many physicians just do not like to see obese patients come
into their offices (Bray, 2006, p. 3; also Mayer, 1968).

It is certainly well established that in childhood and adolescence many obese
individuals suffer according to measures of reduced “Quality-of-Life”, a technical
term. Arif & Rohrer (2006), find in obese patients “lower overall Health Related Quality of Life”, even as, “the association was not significant for the four of the six sub-scales including the physical health domain”. Williams et al (2005) hold that, “the effects of child overweight and obesity on health-related QOL in this community-based sample were significant but smaller than in a clinical sample using the same measure” – whereas, Schwimmer, Burwinkle & Varni (2003) conclude that, “severely obese children and adolescents have lower health-related QOL than children and adolescents who are healthy and similar QOL as those diagnosed as having cancer”. Finally – “a substantial decrease in mental well-being has been found among the very severely obese (BMI ≥40kg/m²) suggesting a threshold effect along the BMI-range where the burden of obesity and co-morbidity add to a decrease in mental well-being” (Adolfsson, 2004, p. 6). This may in large part be due to the way very large people are seen by other people in the Western world, at least (there are notable exceptions). Tellingly, findings typically report that “obese adolescents are at greater risk of mistreatment by peers and may have fewer opportunities to develop intimate romantic relationships; this may contribute to the psychological and health difficulties frequently associated with obesity” (Pearce, Boergers & Prinstein, 2002). Bullying – as I illustrate with references to the “real life” of children below, often entails “major barriers” to participation in physical activity, in gym-class as well as in leisure (Bauer, Yang & Austin, 2004).

Youth in Norway

In order to add to the description of the cultural terrain of a “lipidophobic society”, relating how obese youngsters «fit into» current youth culture in Norway, in terms of say, body image and physical activity, might warrant a few lines. (Though, as my empirical material is not extensive on “youth culture” generally, this is a very superficial impression). In this, I look to the sample of school personnel, who are close observers of the sub-culture of youth, for insight. Above and in the papers I refer to a Norwegian a national ethos calling for an «active lifestyle»; this is often exemplified in Norwegians allegedly being «born with skis», and “hiking in particular is acknowledged as being typical Norwegian” (Vaagbø, 1993; Long, 1993; also Goksøyr, 1997; Eichberg & Loland, 2010; Tordsson, 2010). In as much as this image is known to «all», parents, treatment-staff and the young participants themselves (and not least the Pakistani segment), reflected in conversation awareness of this cultural feature. As certainly did the sample of school personnel I interviewed, whose input illustrates
what, in a sense, is «expected» culturally of Norwegian youth in this regard. This set of teachers saw Norwegian youth in general (beyond socio-demographic differences) as often active in sports in their leisure, in organized and individual capacities. However, the educators often also held the view that participation in organized physical activity has become less prevalent. And the sample of teachers lamented that, in the final analysis, «Kids don't really go out much these days! They don't go out to play like we used to.» (These points are taken up elsewhere). They often articulated, if on a theoretical level, that young people in general have become «more prone to sitting down», which many referred to as «the couch-potato syndrome». Also, there was seeming consensus among the school personnel that, much like their counterparts elsewhere in the world, many Norwegian youth have increased their intake of «unhealthy food» and otherwise adopted lifestyles which they saw as having contributed to alleged increasing prevalence of overweight/obesity in Norway over the last decades.

As a sub-focus, minority girls in particular were a common concern among the sample, specifically how this segment of the population is prone and/or hindered from participating in physical activities, due to what was seen as culturally-based restraints from home. In extension of this, one physical educator spoke about adolescents no longer taking showers after gym-class, with recourse to a familiar explanation to this phenomenon in terms of «a strong social focus on 'the body' and the youngsters' personal need to conform...This pressure is on everyone with a slightly different body, especially girls» This teacher speculated that a recent directive to teachers not to make students shower, had sprung from a heightened awareness regarding the use of Hijab among some minority girls.

What I am driving at by presenting the input from the school personnel (in brief) in this manner, is that there is certainly grounds to argue that Norwegian youngsters of all stripes transverse a culture which is intensely focused on body-conformity (and the activities that are seen as part and parcel to achieving this) but at the same time «tugs in the opposite direction» by providing ample “stimuli” that in effect might counterbalance the cultural ideal summarized as an active lifestyle. There are in other words counter-currents in the surface of the culture. Based on these teachers’ insight, then, the culture of Norwegian youth (including minorities) may be said to contribute to the development of overweight issues in some individuals, while youth, at the same time, find themselves anchored in a wider aesthetic culture where resultant obesity
often carry negative social consequences, in a very real sense making the obese the ultimate “other”.

**Qualitative Studies – Young Obese People's Perspective**

Nearly all that is known scientifically about obese children stems from a body of obesity research largely based on quantitative methodology. Until recently there has been a dearth of qualitative research on how individual young people relate to the phenomena at hand. For instance, a recent review of the UK literature with a similar focus as the present project, i.e. as relevant to “children’s perspectives of obesity, body size, shape and weight” – underlines that “little is known” on the topic (Rees et al, 2009). Pointedly –

> Very overweight children were the focus of a small number of studies; otherwise, views are most likely to have come from children with body sizes within the healthy range […]

Children’s engagement and participation in discussion had only rarely been supported in the included studies, and few study findings had depth or breadth (ibid).

Moreover, it has been pointed out that obesity discourse often reflects the “[assumption] that greater knowledge of factors leading to obesity generates a change of behaviour which finally leads to weight loss” (Lindelof, Vinther Nielsen & Pedersen, 2010). It may be suggested, however, with basis in the extant qualitative literature and the present material, that the underlying mechanisms are often rather more complex.

What also emerges is the degree to which children look to dominant discourses to “make sense” of their bodily status. Existing qualitative research on children's perspectives, often find that obese young people tend to be highly aware of their bodily status and the causal pathways of their condition. One recent work, albeit from Brazil, conclude that, “some blame genetics as responsible for obesity development, others blame unhealthy diets and lifestyles, and others acknowledge the roles of early life experiences and family traditions in the process of obesity development” (Gonçalves et al, 2012). While the recent review of research based on the children's perspective, argues: “They appear most aware about influences on body size when they are themselves very overweight” (Rees et al, 2009). A recent Danish paper finds that obese adolescents, though ashamed of it, “consume large quantities of unhealthy food when alone, feeling sad, bored, hungry or with peers […]” They are often aware, the paper argues, “that these actions increase their weight” and “in order to reduce weight they
need to increase their level of exercise” (Lindelof, Vinther Nielsen & Pedersen, 2010). Previous authors have identified

A discrepancy between (a) the obese population's views on and reasons for their obesity and (b) the more rational perspectives on obesity formulated by the health authorities and operationalized in the traditional intervention strategies (Murtagh, Dixey & Rudolf, 2006).

The latter authors go on to conclude that the acknowledgement by treatment personnel and others of “the complex interplay of social and emotional factors unique to the individual may well promote successful weight control” (ibid.; emphasis added).

There is a level of disagreement between authors employing qualitative methodology as regards to children’s motivation for change. Commentators have noted that “Children, whatever their body size, [do] not emphasize the health implications of being overweight. Instead they [see] – and had experienced – overweight bodies as having problematic social and psychological consequences, including bullying and isolation” (Rees at al, 2009). Others find evidence to support an argument that both boys and girls are primarily motivated by precisely health concerns in their pursuit of weight loss (e.g. Lofrano-Prado et al, 2013). The latter paper finds boys to be more worried by physical fitness and girls being influenced by profound body shame, even as the perceived “absence of self-control was the main barrier to success in obesity therapy for adolescents” (ibid). These findings are aligned with a statement that, “Overall, becoming healthy was the main motivation for weight loss and lack of self-control was the main barrier” (Gonçalves et al, 2012). The perceived lack of self-control is indeed of seminal importance to how young people, parents and others view the obese child; e.g.: “[Though] very overweight children and those who are not overweight had very different ideas about children’s control over their body sizes. [Yet] body size was seen as under the individual's control and children attributed negative characteristics to overweight people” (Rees at al, 2009). A further example might be the postulation of one school nurse in the present project, that –

What these kids are trying to do is like quit smoking or stop doing drugs – it takes self-control, you have to take baby steps – I usually tell them that if they really want to, they can make it. It isn't impossible even though your parents are overweight, too, to change habits at home – it is possible, if they only restrain themselves and show self-control!

Other barriers to maintaining behavioural change children identify include: shortcomings in their own physical abilities, the extended time period required to lose
weight and external restrictions beyond their control (Murtagh, Dixey & Rudolf, 2006). Whereas, the Danish study quoted above points to a “discrepancy between the actual daily level of exercise and the perception of it [as] problematic: a person who believes he/she enjoys a moderate active life might not be as motivated to increase physical activity, compared to the person who perceives him/herself as living a fully sedentary life” (Lindelof, Vinther Nielsen & Pedersen, 2010). This is very much in line with what I argue later. Previous research also underscores the different levels of concern obesity or overweight issues cause in youngsters, ranging “from major concerns impactinding on much of an individual's life to almost no concern, with little relation to actual severity of overweight”. The overall concern with this line of reasoning is that weight-reduction behaviours may be less likely in such circumstances (Smith, Sweeting & Wright, 2013). But perhaps the most important lesson to be had from previous qualitative research to our purposes is that –

unsuccessful lifestyle changes led the adolescents to internalize society's perception of obese people as weak and incapable of taking care of themselves (Lindelof, Vinther Nielsen & Pedersen, 2010).

We might furthermore benefit from an awareness that “behaviour cannot be successfully modified without paying attention to the context surrounding the specific behaviour” (ibid.; emphasis added). This presupposes that an obesity patient's behaviour needs changing in the first place and that such change is desirable – though this is saying nothing about whether behavioural change is capable of producing substantial weight loss – in the individual. Even so, it is claimed, in the final analysis many obese children might benefit from “basic behavioural skills”,

to help the obese population to make healthier choices in everyday life. One example could be that the obese person learns different coping strategies in order to handle peer pressure or avoid emotional eating (ibid.)

The effect on willed weight loss notwithstanding.

**Paediatric Obesity & Health**

The dimension of disease represents a second, though intimately interconnected strand of how obesity is viewed by society at large. Many of the perceptions that circulate regarding obese people as lazy and gluttonous, beyond being ancient sins, have come
to be connected with how such vices influence one's health – which in modern society is upheld as the individual's responsibility as well as an important social marker. It may be assumed that for patients in treatment for obesity, public health discourses on the dangers of being fat are likely to form a backdrop for their motivation beyond a social dimension which, as other research also point out, might include bullying and aesthetic concerns like wishing to “look pretty” or fit into particular clothes. Lofrano-Prado et al (2013) has recently argued that, “A person seeking to lose weight primarily for appearance could have a different set of psychosocial characteristics and expectations than a person whose primary reason is to lose weight to improve health”. It is deemed essential to look into health and Public-Health discourses in relation to obesity more in depth in preparation for how the children weigh these issues.

Disease? Behaviour?

In the clinical literature, obesity is often called “a chronic disease” (Zametkin, Zoon, Klein & Munson, 2004), known to have “potentially devastating consequences” (Ebbeling, Pawlak & Ludwig, 2002) – which “[like diabetes and hypertension]. requires long-term treatment” (Waitman & Aronne, 2006). At the same time, while “food and nutrition” is recognized as “a natural part of the treatment of diseases like [...] obesity” – it must be acknowledged that, “for most people, it will be difficult to achieve lasting weight reduction when one has become overweight” (Departementene, 2007, p. 9, 8; translated, emphasis added). In generalizing terms, the efficacy of non-surgical interventions, across the board, is said to be “limited to a 5 % to 15 % body weight loss in the majority of successful patients, [but this weight loss is enough to induce better health]” (Waitman & Aronne, 2006). The incidence of childhood obesity is known to be fuelled by “broader contextual, structural and cultural forces” (Cameron, Norgan & Ellison, 2006, p. XXII).30 Notwithstanding, in the current climate (or indeed, in light of the Law of Thermodynamics) it is not a radical argument to make in the scientific literature (or

30 It may be pointed out that, internationally, obesity treatment programmes seldom address the “particular needs of subgroups of children and youth,” be it for instance those of ethnic minorities otherwise thought especially vulnerable to an “obesogenic environment” (Flynn et al, 2006). Zieff finds that, “evidence-based medicine (and its counterpart in evidence-based physical activity interventions), does not place an emphasis on patients’ (or participants’) cultural values in determining intervention design or evaluation of effectiveness. In addition, there are few strategies available for considering the
public opinion), that behaviour is likely to play a critical role in the development of many cases of obesity. Indeed, a very common view would be that food and consumption surely must be critical. Bray, for instance, makes the case that, “because approximately 22 Kcal/kg is required to maintain an extra kilogram of body weight in an obese individual, the energy requirements in these patients must increase year by year, with the weight gain being driven by excess energy intake” (Bray, 2006, p. 8). This may seem incontrovertible.

However, scientific objections have been raised as to the emphasis placed, in popular perceptions, media and scientific discourse, on human behaviour in the development of obesity. Many theories have been launched as to why some people may be more prone to obesity than others. Though not at the core of the present line of inquiry, there are well known postulations on issues like thrifty genes and an increasingly “obesogenic” environment, while increased energy-density in foodstuff in general is usually alluded to in terms of increasing incidence of global obesity. Some scholars, however, suggest that obese children do not differ from non-obese in terms of sweet preferences, food choices, and eating styles (Drewnoski, 1997); not even necessarily on levels of energy intake: “Fatter children consume a lower EI relative to their weight than their lean counterparts” (Livingstone & Rennie, 2006, p.102). Almost iconoclastically, commentators have gone so far in this direction as to claim that many obese people in fact have little or no abnormality of behaviour to be corrected by intervention (Wooley & Wooley, 1984). A statement albeit made before the onslaught of the global obesity epidemic.

Meanwhile, it is long known that genetic heritability impacts on the development of obesity in individuals (see Maes, Neale & Eaves, 1997; Faith et al, 1999). Scientific usefulness of interventions applied to populations about whom scholarly evidence is limited or even missing” (Zieff, 2011).

31 "[...] One possibility is that elevated preferences for sweet and high-fat foods and the propensity to binge-eat are behavioural manifestations of the obese phenotype” (Drewnoski, 1997: 302). Drewnowski & Holden-Wiltse (1992) argue, “Increased appetite for palatable foods, especially those rich in dietary sugars and fats, may provide a behavioural mechanism for the development of obesity in susceptible persons”. Whereas Bray (2006) holds, “Epidemiologic data suggests that a high-fat diet is associated with obesity”.

32 Op. cit. cont.: “Efforts [to treat obesity through behaviour modification] have been on the whole, frankly, discouraging” (see below).

33 “An obesotypic gene-pool is often somehow seen to be triggered by an ‘obesogenic’ environment”. E.g. Francis, Lee & Birch, 2003.
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Opinion on heritability ranges roughly from 30 to 70 percent (Rössner, 1998). In real terms, obesity is often an inherited condition and the role of parents in the emergence of childhood obesity is “pervasive”; “obese parents tend to have obese offspring through either genotypic or phenotypic susceptibility” (Cameron, Norgan & Ellison, 2006). From mid-childhood on, parental BMI is “significantly associated” with weight-gain in children (ibid.). The following statements seem to typify this tendency: Obese children are “significantly more likely to have obese parents, than are normal-weight children”, or that “all biological family relations showed highly significant correlations for BMI” (Vogt, 1999; Magnusson & Rasmussen, 2006). I take up the theme of family throughout this thesis.

Morbidity

As Berit’s mother pointed out, the human body requires a certain amount of fat to serve ordinary functions, and I might start off this section with a caveat, a reminder that, “Clearly, extra adipose tissue is not merely a repository of fat: it impacts the body’s internal equilibrium with its ability to secrete a range of molecules that in turn trigger further physiological reactions...not all fat is bad” (Paradis, 2010). Beyond endocrinology, which is largely outside the scope of this inquiry, though instantaneously recognizable by eyesight, obesity is diagnosed clinically by largely convenient parameters like BMI. This holds true in paediatric terms – beyond general difficulties in specifying risk categories in paediatric obesity and the known limitations to this specific method of measure. On top of this, an important clause

34 Contrary, that is, to early childhood. These authors find that in early childhood, weight-gain is more closely associated with the socio-economic status of parents.

35 To be sure, there are reports of contraindicative findings. E.g. in a sample of 36 month-old white children, “the correlation between children’s percentage body fat and parent BMI was significant only between mothers and daughters. Obese parents were no more likely to have a child who was fatter” (Whitaker, Deeks, Baughcum & Specker, 2000)

36 For a critique of BMI, see e.g. Henderson, 2005; Evans, Rich, Davies & Allwood, 2008, p. 13: “BMI is rather less good at determining what can be said about health, particularly children’s health, than some would have us believe. Yet, despite its acknowledged limitations, it continues to play a key role in the politication of health”; and, ibid. p. 42: “…an extremely poor measure for children and adolescents”


38 “Consistently elevated risks of adult obesity are evident for fatter children, although the prediction of adult obesity from child and adolescent adiposity measures is only moderate. Fewer studies could be
should be taken into account: “Even when a threshold has been set for defining the point at which ‘weight’ becomes ‘over-‘, it is another thing entirely to claim that is a problem casually related to a person’s health” (Evans, Rich, Davies & Allwood, 2008, p. 41). Not counting issues with measurement methodology, the medical ramifications of heightened body mass index in children are (as far as I can gather), less clear-cut than with adults. Nevertheless: Seemingly as extensive as the accumulating mediareported list of alternative causes, a veritable avalanche of co-morbidities and sequelae has been linked to paediatric obesity; the list is simply daunting. 39 In obesity, however, substantial variation on all levels (viz. in terms of cause, cure and risk 40) between individuals has been demonstrated.

Risk

The body of literature on obesity and risk to health is vast and I will very superficially mention major interrelated strands of biological variation. This topic is of interest to the present study, because biomedical and public health discourses are easily accessible and are often central to the understanding people have of their own and other people's ailments – and narratives on risk have become part of the everyday context of disease. As will be seen below, the young patients in this study largely share the mainstream understandings of the hazards to health that are said to accrue from being obese. Risks to health in terms of obesity, such as they are, are known to be genderrelative (Slypner, 2008).

39 Ordered alphabetically, reported afflictions include (and counting): “asthma” (Reilly et al, 2003); “Blount’s syndrome” (Dietz, Gross & Kirkpatrick, 1982); “[risk factors for] cardiovascular disease” (Koziel, 2004); “daytime sleepiness” (Tsang et al 2013); “elevated blood pressure, dyslipidemia” (Deckelbaum & Williams, 2001); “fatty infiltration of the liver” (Frelut, Razakarivony, Cathelinau & Navarro, 1995); “[impaired] glucose tolerance” (Slypner, 1998); “[obese pubertal boys often have significant] gynecomastia” (Voors et al, 1981; Slypner, 1998); “hyperinsulinemia” (Regan & Betts, 2006); “neuorocognitive effects” (Rhodes et al. 1995); “obstructive sleep apnoea” (Slypner, 1998); “polycystic ovary syndrome” (Rosenfield, 1990; McCartney et al, 2006); “pseudotumor cerebri” (Dietz, 1998); “[very significant] psychological problems” (Reilly et al, 2003); “type 2 diabetes” (Basit, 2005), which “represents an ominous development, in view of the macrovascular (heart disease, stroke, limb amputation) and microvascular (kidney failure, blindness) sequelae” (Ebbeling, Pawlak & Ludwig, 2002); ad nauseam.

40 It may be noted that in the medical literature, risk in terms of social outcomes is often discussed as prominently as any purely pathological consequences. Such as: “Among the most common sequelae of primary childhood obesity are hypertension, dyslipidemia, back pain and psychosocial problems” (Kiess et al, 2001). And, “childhood obesity has significant adverse effects on health in childhood. Psychological morbidity is likely to be the most widespread health impact in childhood” (Reilly et al, 2003; also, Dietz, 1998).
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1998; Flynn et al, 2006). In this, distribution of fat on the body seems critical (Ross and Janssen, 2007). It is known that in children, as in adults, fat centred on the front, lower torso is a more important independent correlate of certain risk factors than percentage body fat (Daniels et al, 1999). Not devoid of practical significance, visceral-abdominal accumulation of body fat, viz. “excess body fat […] stored in the deep abdominal region” (Tremblay & Doucet, 2000), is typically a male pattern of distribution (Bose, 1996). A second strand of concern in the continuing debate on obesity and risk is ethnicity (which subsumes both biology and culture). “The high rate of obesity in certain ethnic groups as well as in specific subgroups can be explained by the interaction of several culturally and biologically based risk and protective factors” (Adolfsson, 2004; Dounchis, Hayden & Wilfley, 2001; Kumar, 2004). These concerns more or less overlap. The scientific debate on “risk” in relation to obesity often centres specifically on how childhood fatness ‘carries over’ and influences the future weight- and healthstatus of individuals. This tendency is “significant” and obesity in early stages of life is known to be a “key predictor for obesity in adulthood” (Deckelbaum & Williams, 2001). The probability of such an outcome has been specified as 3 to 10 times higher if the child’s weight-for-height is above the 95th centile for their age (Bray, 2006). In the scientific literature, adolescence is known to be a crucial stage of life to countermand the plethora of medical (and social) drawbacks associated with adult obesity. Reportedly, the cut-off point to when paediatric obesity becomes a

41 Flynn et al (2006): “Although the growing prevalence of obesity affects males and females equally, males may be more vulnerable to associated health risks such as cardiovascular disease”, Slypner (1998): “For many children and adolescents with mild obesity, and particularly for females, one can speculate that obesity may not be a great health risk”.

42 See also Armstrong & Welsman, 1997; Atkinson & Walberg-Ranking, 1994; Regan & Betts, 2006; Slypner (1998) holds, “lipid abnormalities of obesity […] are related primarily to the amount of visceral fat.”


44 This weight category is coterminous with the official weight criterion for participation in the treatment programme.
predictor of adult obesity, in males, anyway, has been put at fourteen years of age\(^{45}\) (Wright, Parker, Lamont & Craft, 2001).

However, against this rather grim picture it should be stressed that a growing number of authors are concerned with how medico-scientific and popular discourses have tended towards “overreliance on weight as an indicator of health” (Murray, 2009, p. 81). Along these lines Gard & Wright (and others) have argued firmly that obesity is *not a disease in its own right* – “meaning that if you are fat you are ill” (Gard & Wright, 2005, p. 95). In what might be called a classic work of critical fat studies, Campos et al criticize the “four central claims made by those who are calling for intensifying the war on fat: that obesity is an epidemic; that overweight and obesity are major contributors to mortality; that higher than average adiposity is pathological and a primary direct cause of disease; and that significant long-term weight loss is both medically beneficial and a practical goal (Campos et al. 2006, p. 55). This process of questioning some of the axioms of obesity as a harbinger of ill-health is gaining ground in some quarters and this information is bound to make an impact on how some young people relate to their obese bodily condition. We shall see later how the participants in the project conceptualize being fat as something that is bad for health.

**Paediatric Obesity & Physical Activity**

As established, a perennial and pernicious view of the obese is their laziness. Beyond the aetiological status of the bodily condition, physical activity is often seen as key both to the development and the regulation of obesity. Obese children are often urged to “do more, be more active!” as a way to lose weight. I focus on this strand of obesity treatment here, because the methods employed in this project and the resultant material has proved commensurable with this angle. Below, in Part II of the thesis, I to return in more depth to the scope young obesity patients have to relate to the treatment advice “being active”.

\(^{45}\) In clinical settings, the age category in question is likely to be subject to special pressure to circumvent perpetuation of the condition (Viner & Cole, 2005). Coincidentally, this represents roughly the mean age of the participants in the present project.
Physical Activity in Childhood

An individual’s level of physical activity has been summarized as contingent on: “A) Attitudes, preferences, motivations, and skills related to the behaviour; B) Opportunities or constraints that make the behaviour easier or more difficult to perform; and C) Incentives or disincentives that encourage the desired behaviour relative to competing activities” (Transportation Research Board, 2005, p. 86). It is clear how some of these factors are partially divorced from issues which (to some extent) are amenable to conscious control, such as personal competence, motivation, priority, self-consciousness, and the like – factors which in and of themselves, at least for some, may not have been negligible in instilling a feeling of antipathy towards exertion in the first place; and hence, not unthinkably, towards the very aetiology of one’s overweight. It has been upheld as essential that young people are given opportunity to engage in activities they enjoy and do not perceive as embarrassing (Armstrong & Welsman, 1997; also Hansen, 2005; Bauer, Yang & Austin, 2004). A recent European White Paper makes clear that individuals’ attempts at finding ways to increase physical activity in daily life “should be supported by the development of a physical and social environment that is conducive to such activity” (Commission of the European Communities, 2007). While a Nordic Plan of Action suggests, “solutions to the problems of an unhealthy diet, physical inactivity, and overweight must primarily be found in action at the national or local level [...]” (Nordic council of ministers, 2006). Finally, some time ago a Norwegian anthology predicted that the challenge for health-promoting work will be to increase young people’s access to such activities – since, “most youths depend on a certain degree of organised activity for them to be active” (Vold, 1997; translated). These factors hint at the importance as to the presence of user-friendly amenities within walking distance of communities, in calling on young people of all weight groups to become more physically active.46

It is known that children in general are amongst the most active segments of society (Sallis, 2007; Biddle, Brehm, Verheijden & Hopman-Rock, 2012).47 Yet, “40 % of


47 The latter authors stress that, “Physical activity among children is often reported to be quite high, especially if it assessed using self-report”. The italicized point is explained by the authors by way of a
boys and 60% of girls surveyed were failing to meet a Health Education Authority recommendation that young people should participate in physical activity of at least moderate intensity for one hour per day” (NHS, 2002). Similarly, Nordic recommendations for an hour of moderate to vigorous physical activity daily for children, is assumed not met by “about half the population” (Nordic Council of Ministers, 2006). With regards to Norwegian youngsters, it has been reported that “94% and 81% of grade 4 boys and girls respectively, and 81% and 69% of grade 8 boys and girls respectively, are active twice a week” (Øverby & Frost Andersen, 2002). Children typically perform short bouts of moderate to vigorous activities, but a large share of their activity is done in the lower heart rate zones (Livingstone & Molnár, 2000). Activity levels generally tend to decrease with the onslaught of adolescence. Over time, this biological phenomenon is alleged to contribute to “precipitous” change in activity (Rowland, 2007).

Physical Activity and Obese Children
Obese children are fundamentally seen as lazy (a repeated point) and often think this of themselves or at least other obese children. Being told to be more active is part and parcel of the slimming experience. Given this axiom, the individual's circumstances might easily disappear; this is an area where the potential for frustration is marked and the expectations of the parties involved might differ radically. It is therefore useful to proceed with a firm idea of these expectations.

Obesity is frequently confused with inadequate levels of physical activity (Transportation Research Board, 2005). As Gard and Wright point out, “a number of reviews […] have found the relationship between body weight and physical activity to be inconsistent, unclear or controversial”. Other such studies have deemed that relationship “largely equivocal” (Muecke et al, 1992), “conflicted” (Waxman & Stunkard, 1980), “severely diminished” (Bouchard, Deprés & Tremblay, 1993), or the 

48 However: “the Health Survey for England (National Centre for Social Research and University College London) reports that 70% of boys and 61% of girls achieve recommended levels, and trends appear to be generally stable over time” (Biddle, Brehm, Verheijden & Hopman-Rock, 2012). (see also next note)

49 “…60% to 70% of all children were sufficiently physically active”.

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“correlation is typically quite low” (Westerterp & Goran, 1997). It has proven difficult to draw definitive conclusions, something these authors highlight, with regard to obese children’s level of daily energy expenditure when measured against non-obese peers. So much so that, although it may seem a controversial claim, in terms of aetiology there is no de facto scientific consensus on whether obese children as a group diverge from children in general when it comes to levels of daily total energy expenditure (Gard & Wright, 2005; also e.g. Drewnoski, 1997).

I might briefly summarize the historical range of opinion on this. Needless to say, many authors report findings of “significantly lower” levels of energy expenditure in obese children. More moderate designations of obese children include descriptions like “less physically active” and “reduced activity levels”. Some research has focused on how *obese children expend more calories in executing any given movement* – as exemplified in the title *Physical activity but not energy expenditure is reduced in obese adolescents: a case-control study*. The more radical voices in terms of behavioural aspects of obesity in children have belonged to the camp that claim that “many obese have few abnormalities to correct” (Wooley & Wooley, 1984) – which subsumes a perception of obesity as uncorrelated to levels of physical activity. Or that these do not correlate in either gender: Lien, Kumar & Lien (2007) find no differences in Norwegian obese and non-obese boys in terms of physical activity. Whereas, already many years ago, Waxman & Stunkard (1980) harboured “serious doubt […] that obese children are physically inactive. Only at home, and only when caloric expenditure was ignored, could the obese boys be considered inactive”. A more recent review concludes: “PA was related negatively to child weight status in some studies; however, it was not associated in others. In general, sedentary behaviours were positively associated with weight status. However, gender differences appeared in some studies for each variable” (Prentice-Dunn & Prentice-Dunn, 2012). There is, in
other words, little to establish that obese children as a group are in desperate need of more physical activity, controversial as that claim may seem.

**Physical Activity as Treatment for Obesity**

It is seldom disputed that increased physical activity of all levels of intensity, carries salubrious effect beyond whichever level of resultant weight loss. However, in terms of weight loss specifically, there is on-going debate on the optimal intensity of physical activity interventions as well as on the relative efficacy of diet and/or physical activity versus other combinations of interventions. For instance, Caroline Braet highlights the reduction of energy intake as the most salient feature of many weight treatment programs, but states that physical activity “also contributes” to a negative balance of energy, claiming that this, “may accelerate weight loss and improve maintenance of lost weight” (Braet, 2006; see also Jain, 2005). On the other hand, Epstein (1995) suggests, it seems with reasonable plausibility that, “exercise alone is not sufficient […] The combination of diet plus exercise is more effective for long-term than short-term changes”. There is certainly a tendency to view physical activity as integral to weight-reduction interventions. Like: “Regular physical activity represents one of the key elements in

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56 This school of thought has ancient antecedents: the advice is said to feature in Abu Sina’s Qanun (Carmichael, 1999); “Hippocrates first advised us more than 2000 years ago that exercise—though not too much of it—was good for health” (Paffenbarger, Blair & Lee, 2001).
“voluntary” (e.g. exercise training) forms of energy expenditure.\(^{50}\) This is pertinent to our focus, in as much as obese children have been found to confuse physical activity with “gym membership” and other such organized, high-intensity activity (Lindelof, Vinther Nielsen & Pedersen, 2010). Incidentally, Berit’s mother, Turid, said of her daughter: “It’s important she does things herself – to stay active...the problem’s with the spontaneous activity”. She would seem to agree with Thorburn & Proietto (2000), who argue that spontaneous activity is the major determinant as to how much energy an individual expends during the course of a day.\(^{51}\) This line of reasoning seems supported by the findings of a range of authors. Goran & Poehlman (1992) indicate “voluntary physical activity” has little bearing on total energy expenditure. Deprés (1994) point out that “an exercise program aimed at weight loss must generate a large energy expenditure, and the minimal prescription recommended for improving cardiorespiratory fitness may not be sufficient to substantially reduce adipose tissue”.

Westerterp (1999) finds “no net effect of the exercise training on the activity associated energy expenditure”, while Hill, Drougas & Peters (1994) argue “the effect of exercise on energy expenditure is small”. These may be dated references, but the authors reflect known doubt as to exercise-training being the most effective means of physical activity towards weight-loss amongst already-obese individuals (notwithstanding independent benefits to overall health).

The centrality of spontaneous physical activity appears commensurate with the recommendations offered by Armstrong & Welsman (1997), who emphasise “general lifestyle activities”, such as walking and housework – which, in their estimate stand to “significantly increase” daily levels of energy expenditure. This is in line with Ross & Janssen (2007) in saying, “activities such as walking ‘count’ as physical activity”; Nowica & Flodmark (2007), who attest that “children who walk to school are more active than those who do not”; the Association for the study of obesity, who find that “lifestyle activity and walking can also contribute to weight loss” (ASO, 2012); and, Blair et al (1993), in calling for promotion of “brisk walking”. The latter authors conclude that “building physical activity into lifestyle routines produces more long-

\(^{50}\) On the conflation of the terms “voluntary physical activity” and “exercise training”, see Bouchard, Dépres & Tremblay, 1993.

\(^{51}\) This is also important in as much as “participants often under-report physical activity such as household chores that may be sufficiently vigorous for health benefits” (Zieff, 2011).
term success than do the more structured, less flexible programs”. Bouchard et al (1993) argue along the same lines, that in terms of weight control, the focus should be on what they call “leisuretime physical activity [- as this] is more amenable to voluntary changes in the individual’s discretionary time”. Indeed, Epstein et al (1982) and Epstein et al (1985) conclude that obese children attain weight loss more efficiently through such low-intensity activities as walking, rather than high-intensity exercise, such as organized programs. In any event, it has been postulated that for children and adolescents “exercise training does not influence spontaneous activity” (Westerterp, 1998). And as if to add a complicating twist to the matter, spontaneous activity is said to be “predominantly” determined by such non-conscious factors like genes and metabolism (Thorburn & Proietto, 2000).

Nevertheless, a plethora of studies conclude weight reduction to be attainable through physical activity (or in combination with other strategies); albeit, often as the result of prolonged and intensive interventions, and frequently with moderating designations such as modest, temporary, not clinically significant, or gender-dependent. Certainly not the only one, Zieff (2011) has criticised this overall focus, in saying: “Physical activity in general—and interventions in particular—have also been widely, and generally uncritically, adopted as a panacea in the national and international quest to battle against obesity and associated chronic diseases”. Also, it might be fruitful to be aware of the argument that, “the only clear results on significant weight loss come with surgery” (Paradis, 2010). Moreover, while it might be true for a portion of patients that, “Clinically significant weight loss can be produced by increasing physical activity and decreasing energy intake” (Lofrano-Prado et al, 2013), I believe the present discussion indicates that this in no way is the automatic outcome in each case. And this is an essential part of the argument I make, that though weight-loss is advertised as ensuing from more activity and less intake, this promise is incongruous with the reality and experience of many individuals. To account for relatively modest effects of physical exercise on weight loss, as reported in many cases, it may be pointed out that authors routinely look to compensatory behaviour in the obese subjects – i.e. increased caloric intake or reduced energy expenditure outside organized exercise.\footnote{Bouchard, Deprés; Tremblay, 1993; Blaak, Westerterp, Bar-Or, Wouters, Saris, 1992.} Sometimes this is explained in terms of powerful biological mechanisms (Westerterp, 1998). Or limited weight-loss is attributed partly to what is held to be the insufficiently low
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intensity of the intervention (e.g. Fogelholm & Kukkonen-Harjula, 2000; Atkinson & Walberg-Ranking, 1994). Other non-biological factors are also often alluded to, less charmingly, such as under- and misreporting of energy expenditure etc. While this may be part of the picture, too, in some cases, objectively speaking, it is symptomatic of the way obesity is perceived that blame is apportioned to the victim, rather than attempts being made to question the thermodynamic premises of our understanding.

**Limited Knowledge on What Works**

The more dismal perspective on physical activity as a treatment for obesity decries the results of such endeavours as “discouraging” (or the above “pessimistic”); like: “In general, studies report only a small amount of weight or body fat loss with regular exercise” (Bouchard, Déprés, Tremblay, 1993). With reference to paediatric obesity, this includes statements like, “pre- to post-test changes were significantly different from controls in none of the five young exercise groups”, and “exercise added to diet was not beneficial over diet alone in helping children lose weight” (Kay & Fiatarone Singh, 2006; Jain, 2005). This school includes universal statements like: “treatments rarely cure obesity”; “treatment for childhood obesity remains largely ineffective”; “obese individuals are remarkably resistant to treatment”; “no significant changes in body weight or small changes”; “exercise had no significant effect”; and, “no conclusive explanation for the lack of effect of training in the treatment of obesity has been provided”. Some of these sources are fairly dated. But even as of more recently, pertaining to paediatric obesity treatment in general – in other words, how to become thin – “summarized knowledge is limited” (Helsedirektoratet, 2010). What, then, is known about how obese children think about this? Well, the recent review of qualitative studies cited above, points out, crucially, that “No studies were found, for example, that explicitly asked children what they thought might help them to achieve or maintain a healthy weight” (Rees et al, 2009).

**Variation**

Heterogeneity between obese individuals and differences between obese bodies is an important topical focus in this thesis. Indeed, in this should not be neglected there’s a

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gender dimension to the equation – female bodies are reportedly more resistant to weight reduction efforts. Including so-called sex dimorphism in adipose tissue sensitivity to exercise (Deprés, 1994). Neither should it be overlooked that the effects of exercise are likely to differ significantly in individuals of varying body mass indices. There are established physiological differences between individuals pertaining, crucially, to the energy cost of physical activity (e.g. Hill & Melanson, 1999). Equally important is the long-reported, widespread individual responsiveness to training (Foss, Lampman & Schteingart, 1980). In the same vein, Initial Work Tolerance (i.e. baseline for task execution ability) among obese individuals has long been known to be low and highly variable (Foss et al, 1975). Bouchard et al (1993) suggest that individual bodies are variously resistant to alterations in lipid composition. Armstrong & Welsman (1997) state that, crucially, “some obese subjects remain refractory to any intervention to reduce body mass, suggesting a genetic component to the response or non-response of obese subjects to exercise training”. Furthermore, pertaining to ergonomic ability to execute given body-tasks, great variation can be observed between individual obese bodies in terms of fat distribution, shape and size etc. These factors will clearly be influenced by age and sex. As such, the ability of large individuals to perform the distinct movements involved in exercise can be said to vary substantially. But this is particularly true to higher intensity activities (Berrigan, Simoneau, Tremblay, Hue & Teasdale, 2006). Which, presumably, are the more conducive to weight loss – at least in the short-


55 “The rationale for separating severe obesity from lesser degrees of obesity is that there is evidence that there may be physiological differences. At a BMI of 35, which corresponds to a body weight of about 70% over ideal, adipocyte size reaches a maximum, and further increases in adipose tissue mass are due to adipocyte hyperplasia. There is some evidence that severely obese individuals at this level are different from lean and moderately obese individuals in anatomy, adipocyte metabolism, hormone and substrate physiology and biochemistry, and response to treatment [...]” (Atkinson & Walberg-Ranking, 1994).

56 Viz. according to number versus size of fat cells; i.e. hyperplastic and hypertrophic obesity, respectively (See also Deprés, 1994).


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Saying that interventions promoting PA on average have an impact, a recent review points to “a large level of variability in efficacy between interventions” (Gourlan, Trouilloud & Sarrazin, 2011). In other words, it seems that “further research is needed to determine the optimal dose for interventions and to evaluate the maintenance of intervention effects” (Ibid).

Liveable Treatment?

Needless to say, statistically, a very small percentage, globally, of the people trying to lose substantial weight actually achieve and maintain this aim over time (e.g. Paradis, 2010). The above factors surely contribute to the very high level of long-term attrition post-treatment for non-surgical obesity interventions. This in itself raises the seminal issue of adherence to exercise programmes (Fogelholm & Kukkonen-Harjula, 2000; Rössner, 1998; Stunkard, 1972). Unsurprisingly, this is known to be beset with the same types of problems for children and adults (Epstein, 1995). It must be the accumulative force of such oft-debated problems which at one point caused the realization that – the cure for obesity may be worse than the condition (Schwartz & Puhl, 2003). All together this builds up to a polemical conclusion that more effective methods of obesity treatment is necessary (Atkinson & Walberg-Ranking, 1994; Gordon-Larsen, Adair, Nelson & Popkin, 2004). That statement invites a petitio principii: Are interventions set at a point of intensity commensurate with massively “banting” children’s weight, liveable in practice, in the long-run, for most patients (Parizkova 1982; Epstein et al, 1985)?

An evocative indication of the answer to this may be had from a comparison of adherence to two sets of (US) recommendations for physical activity. Davis, Hodges & Gillham (2006) conclude that the later, more rigorous recommendations “may be difficult to meet even for normal-weight individuals” (italics added). A daily hour of exercise is in so many words beyond the scope of many people, regardless of body-weight – the implication being that this stipulated level of activity will be even more strenuous for someone very large. In the context of obesity, this appears to put the following results to sharp relief: “Weight loss in the order of 0.5 kg per

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59 “Physical activity on its own results in modest weight loss of around 0.5kg-1kg per month, but like other methods of weight loss the amount of weight lost begins to diminish with time.” (ASO, 2012).
See Drenick, Bale, Seltzer & Johnson, 1980; Wadden et al, 1989; Byrne, Cooper & Fairburn, 2003. Added to that, as noted above, “No approved pharmacological or surgical approaches exist to treat childhood obesity” (Zametkin, Zoon, Klein, Munson, 2004). And moreover: “Treatment has basically offered the same tools for decades. The recent development of obesity pharmacotherapy has regressed with — in most countries — only one drug of modest effect available. Bariatric surgery has therefore been considered one of the few solutions in the adult setting and is gaining increasing attention as a treatment option, even in paediatric extreme obesity”(Lagerros & Rössner, 2011).

William Banting (1797-1878): author of the booklet Letter on Corpulence, Addressed to the Public, which popularized weight loss through limited intake and a low-carb diet.

I.e. Institute of Medicine, 2002: “60 minutes of moderate-intensity exercise daily”; Centers for Disease Control and Prevention, American College of Sports Medicine, 1995: “30 minutes of moderate-intensity activity, preferably all days of the week.”

week is achieved in response to exercise performed for between 300 and 400 minutes per week or about 50 min per day” (Armstrong & Welsman, 1997). This effectively underscores that for many already-obese children – and perhaps more so adolescents – the road to bodynormalisation is likely to be arduous, to say the very least. In a review, Flynn et al (2006) argue that “current programmes lead to short-term improvements [in health]”, noting “no adverse effects”. Whereas, my point in this line of argumentation is that, following indications of individual variation in responsiveness to treatment, for many, one negative side effect will be an excruciating gap between expectations (say, become visibly thinner) and actual outcomes of involvement in weight reduction efforts. My overall point in taking this overview discussion towards this conclusion has been to prepare the reader to the notion that an indiscriminate “more physical activity!”, really is advice based on strong (if not scathing) presumptions about a person – and fairly weak science. Beyond that, in the “war on obesity”, this is the field on which children are expected to “charge” (to maintain the military metaphor) all-engrossing social mechanisms and engage and subdue extremely intricate biological processes which are the subject of highly moralising tendencies and presently insufficiently understood. Paul Farmer’s concept of “Blame the victim” rarely rang truer. We shall now have opportunity to witness how these grounds are manoeuvred by some obese Norwegian children.
Discussion of Principal Findings

Fat by Family

I begin this more empirically focused part of the thesis (viz. based on observations and conversational input from the participants in the research) – by pointing out a very significant influence on this bodily condition or disease which to some extent might work to “exculpate” the individual child (though that is not my intention here, per se). This focus is central in much of the literature on childhood obesity.

The working title of the research project on which this thesis rests was intended to reflect how the bodily condition obesity represents the sum of interplay between biogenetic and sociocultural processes and mechanisms, including family influences, and individual factors like behaviour. Science seems to recognize the complexity of the biology of human obesity with ever new research, and we have seen above how heritability is an important focus in quantitative research. Yet, prevailing notions tend to incriminate the individual – as epitomized by his or her behaviour – as the single most influential reason for the “global obesity epidemic”. Meanwhile, in terms of childhood obesity, it is easy to castigate family relations and blame the role of parents in particular as “the cause of the problem”. Conversely, it is easy to see how an encouraging home environment is essential to the problem’s successful resolution. This seems downright intuitive – all told it’s hard to get past “lifestyle” and “lifestyle change” as mere treatment jive. A recent conclusion from qualitative research would seem to capture the importance of families in this, what might be called a two-way process: “If obese individuals are to adopt a healthier lifestyle, they need to have a habitus that can stimulate and generate these healthier habits” (Lindelof, Vinther Nielsen & Pedersen, 2010). On the other hand, Grant and Boersma (2005) show how «cycles of control» might be transmitted intergenerationally, wherein for instance food be used as a tool by parents in their communication with their children. This topical focus is vast and has taken up a large share of research on childhood obesity. The following is not meant to discuss this seminal topic exhaustively, or even give a summary; leaning on previous research, I intend a debate on the contribution of family
in the question of body weight and thereby prepare the reader to the notion that obesity is certainly in part beyond the control of the individual.

**Fat Parents, Fat Kids?**

Obesity is held in the literature to cluster in families; it is clear that beyond the biogenetic information, parents transmit and impart values, knowledge, skills, and praxis patterns to their children, including attitudes towards food and physical activity (e.g. Sallis, 2007; Torsheim, Samdal et al, 2004). So much so, parents’ activity levels have been found to predict children’s risk of obesity (Krahnstoever Davison & Lipps Birch, 2002; Quek, 1993). Knowing this, it seems reasonable to assume that parents’ disdain or encouragement in any aspect of life might colour how a child perceives given phenomena. It has for instance been established that weight criticism by a parent or sibling during physical activity can result in reduced sports enjoyment (Faith et al, 2000). But does parental feedback on activity necessarily reflect only the child’s actual behaviour and personality – might not the child have been influenced by the parent’s already established perceptions? A child with obesity issues, who is “significantly less likely” to be described as active or very active by a parent (Tanasescu et al, 2000) – could over time come to believe the veracity of such a statement. Tellingly, obese children have been found to be more physically active when not in the presence of parents: “Obese boys were less active than their brothers in the home, but just as active as their peers at school [...] The higher levels of activity outside the home and on the playground seem to reflect more faithfully the natural inclination of the obese boys”.

As will be seen from the papers, several parents in the present project expounded the view that their particular child “used to be very lazy”, which was indeed a view shared by several youngsters themselves. Alternatively, a statement of “laziness” on account of a participant often reflected (previous) parental socialization strategies, like limited home interest in physical activity – which theoretically, on the part of the obese child, may represent a form of “learned inhibition” (Waxman & Stunkard, 1980). A child might be forgiven then for thinking her obesity is inevitably or at least partially, a product of her home environment.

**Family Functioning**

As a sort of key informant, I might cite a statement by one of the physical educators (see
Obesity and minority

Method), who recognized childhood obesity as a very complex social and biological issue.

It actually seems to me that children whose parents ‘have more resources’ stand the greatest risk of gaining weight. I mean – those who get ‘full backup’ from home; always being driven by car, here and there, for leisure activities. Children whose parents have fewer resources, perhaps send the children outdoors to play on their own – maybe they have to get by on their own, and that might make them all-around more active…?

(B, gym teacher)

This sentiment can be juxtaposed to conclusions drawn by social research on the question of family dynamics on the development of childhood obesity. “Children who lack parental support have a greater risk of becoming overweight than children who get adequate support at home. On the other hand, it does not mean that overweight children in general lack parental support. Paediatric obesity is also seen in families with good dynamics” (Flodmark, Lissau & Pietrobelli, 2005). And: “…obese mothers were no more likely than normal-weight mothers to offer food to deal with emotional distress, use food as a form of reward, or encourage the child to eat more than was wanted” (Wardle, Sanderson, Guthrie, Rapoport & Plomin, 2002). However, there has obviously been no shortage of research implicating given parental characteristics in terms of childhood obesity; a slew of theories exists. Parents of obese youngsters have for instance been found to show “less positive parenting”, as compared with a representative norm group. The list goes on but, “permissive parenting style” has been associated with less reduction in “obesogenic load at home” (Golan, 2006). This may have bearing on Ulrik’s situation, for instance, as I describe below. Families of obese children have been found to differ markedly from families in a “non-distressed normative sample” – by interacting in a “more negative way” (Tweddle Banis et al, 1988). If we allow for that conclusion to be accurate on a general level, this begs the hen-and-egg question whether family dysfunction is characteristic of “the obese family”, or whether the condition and the treatment process can be experienced as so vexing as to affect how some families interact?

Overall there are “clear connections” between family dysfunction and eating disturbances of all kinds; though, some authors report evidence that family functioning is of even greater importance in the development of obesity in males than in females (Steinberg & Phares, 2001). Whereas, contradicting this, it has also been argued that compared to women, “in men, higher family cohesion was related to healthier eating
attitudes and better control over eating” (Johnson, Brownell & St. Jeor, 2006). What
can be suggested, at any rate, is that family dynamics, call it patterns of interaction and
behaviour – may often be closer to the epicentre of childhood obesity than undiluted
parental ignorance of pertinent life-factors. Even so, parental ignorance is often
ultimately scorned as the driving force behind childhood obesity, the first link in the
figurative chain in need of strengthening: “…treatment programs should address
parental knowledge of nutrition [and reducing children’s TV habits]” (Gable & Lutz,
2000). With reference to the participating families in this project, it will be seen from
examples quoted herein, that such a statement might require more nuance. Many
parents were certainly aware of the mechanisms that might go into the development of
the condition, their own part in this, and the measures that might be necessary to make
changes (though life is complicated). It is certainly difficult for parents of patients to
plead total ignorance on this score, Norwegian society being rather focused on this
issue as I point to above.

**It Takes a Family**

Whatever can be said about family influences on the development of paediatric obesity,
in terms of reversing it, there is decidedly more scientific agreement. I cite but a few
examples. Ornelas, Perreira and Ayala (2007) argue that strategies to promote physical
activity among adolescents should be focused on “increasing levels of family cohesion,
parental engagement, parent-child communication and adolescent self-esteem”.
Epstein, Valoski, Wing and McCurley (1994) argue, long-term changes in patterns of
activity and eating in paediatric patients vary with the type of treatment the child is
subject to, and, significantly – “evidence converges on the importance of the family
and other sources of support.” In the literature, initiatives where parents play integral
roles in the treatment are portrayed as more successful; like: “Effective interventions
for prevention and treatment of weight-related problems should be approached from a
health-centred rather than a weight-centred perspective with the parents as central
agents for change” (Golan & Crow, 2004).

It has moreover been suggested that «Family-based, community interventions» are
«effective methods of modifying unhealthy behaviours of overweight children»
(Moore & Bailey, 2013).

While some research cite a lack of evidence for the effectiveness of interventions with
or without family involvement in non-clinical settings (NICE, 2006), other research
claim that, for obese children, family therapy and lifestyle modification efforts appear to be effective in prevention and treatment, respectively (Glenny, O'Meara, Melville, Sheldon & Wilson, 1997). More specifically, family therapy has also been associated with improved weight loss over two executive years, compared to individual-based therapy (Avenell et al 2004). This is not surprising, since, as noted earlier, to purposefully alter the lifestyles of young patients is an endeavour which is likely to be dependent on parental involvement at some level.

**Family Culture**

To the participants in the present project, this might be taken as something of a vindication, as the rubric “family” was often at the heart of their understanding as to why and how they had become obese. It does not take a leap of imagination, then, to postulate that to entertain hopes of achieving weight loss – often so wrought with friction as it is – adolescents, and clearly even more so younger children, will often depend on family cooperation. Even a young-adult, like Parveen, might find losing weight without the benefit of parental encouragement or “willingness to change”, problematic (*Paper III*). The three papers reflect that most participants themselves are aware, on different levels, how family life has contributed to the problem and, sometimes, obstructs a solution. As intimated, from a child's perspective, in a sense, family can be enrolled to help “explain” one’s obesity. “Family” and “ethnicity” in this way share characteristics in that membership can be seen to dictate both one’s biology and behaviour. For complex reasons, the connection between family and culture comes to particular light in the discussion on the Pakistani participants. Even against the following caveat recently postulated by Nielsen, Krasnik & Holm (2013), applicable to a Norwegian setting:

> Public health authorities in Denmark tend to link diet-related health problems among ethnic minority populations with their ethnic identity, dichotomising ethnic and Danish dietary habits. This may overlook values and concerns other than those related to ethnicity that are sometimes more important in determining food habits.

After some prodding, Tareq explicated on his eating habits and what he had learned through the treatment process:

> I don't eat bread any more. Only 'knekkebrød' (see above) and I often prepare that myself. I used to like sweets and chocolates...I still do...but I'm not allowed to buy it. I'm allowed to go out and I am allowed to buy what I want, only not sweets. Its not good for your body to eat sweets. I think my mother has done a great job following the advice they give about food!
Kim, beyond underlining his own efforts, was concerned with relating how he saw his family, too, as unwitting victims of obesity. He was at pains to describe how the intra-family culture had always been tuned towards halting the weight-problems of the majority of members. Such measures included the standing dietary-regime – in place, he said, since his childhood: “I grew up on light products”. And he stressed the importance his parents had always placed on being active: “…and we always took Sunday walks around the lake”. As he explained, “we think about this all the time at our house”. Whereas Ulrik (Paper I), interestingly, in conversation attributed his diet and pattern of consumption, primarily to such factors as misinformation, and social mechanisms like his mother not wishing to buy “expensive” – more healthy – food. It is clear why Ulrik would want to attempt to defer the responsibility for his circumstances and condition by pointing to his mother. In so doing, he was partially exonerated by Karl – his volunteer “bigbrother” and self-proclaimed lifestyle-guru, himself obese since childhood and a survivor of obesity surgery (a key collaborator really) – who made that connection explicitly:

Yes, he will be kicked out [from the treatment program]. He doesn’t realize that he’s the one who has to face his problems. And in a sense that’s only right – he is only fourteen years old! Parents are after all responsible for their kids!

In this way of thinking, Karl is likely to find some support among healthcare professionals, who, though reported to view obesity as an individual rather than societal problem to solve, allegedly tend to see parents as blameworthy (Edmunds, 2005; also Paper III). Karl felt it was a telling sign of Ulrik’s mother’s general failure to get involved in the solution to her son’s weight problems, that – “she leaves the consultations [at the treatment centre] to me!” He saw her buying video-games etc. for her son as direct sabotage of his agenda, even though, as he said – “she probably does it because she feels guilty…Her parenting really contributes to the problem!”

Parents need to assume responsibility for their own kids! Kids grow fat when parents neglect their responsibility. Children take after their parents – that’s the way it’s always been..! They [i.e. those responsible for the treatment-program] need to ‘grasp for the grass roots’ and create some proper courses and what have you, recruit some experts – it

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60 Quoting Forbes (1964), Parizkova (1982) suggests the existence of, “two groups of obese children”, those being obese since childhood being more, “difficult as regards treatment and normalization”. This mirrors Kim’s view,
wouldn’t be a bad idea if they asked the surgeons [at the hospital where Karl undertook obesity surgery] to come and show the kids here some graphic videos of the operations they do. Shake ‘em up a bit! …Because in ten years time, you’ll see them all on the waiting list for surgery! (Karl)

Witness the other end of the scale in terms of parental involvement with reference to the communication I observed between Berit and her mother, Turid – whose good intentions and perseverance in working to affect “lifestyle change” in both their lives, in the final account is

which can be seen as a sort of self-defence mechanism and one which largely replicates the wider society’s views on the aetiology of obesity: “I think there are two types of obese people. Those who’re used to sit on the couch and drink coke all day long, and those who’re born with a predisposition to obesity and try very hard to do something about it – that’s an important difference, I think!”

beyond question and reproach (Paper II). It was only that, beyond daily life, the very totality of the weight project often seemed to “tie up” their behaviour, vis-à-vis each other. The following is an excerpt from a conversation between Berit and her mother, to hint at how complicated this process of change might seem from a child’s perspective. Other than trying to limit her intake of sugary drinks on weekdays and her general “focus on what is healthy”, Berit told me she has picked up and developed a number of coping devices learnt from TV and other sources, which she puts to use in her everyday life – amidst the many temptations, she confided, that are obviously there. “Often when we go grocery shopping”, Turid pointed out – “I find you standing by the candy isle, tapping your hand or forehead with your finger – that's how much you want chocolate! You use that trick to distract yourself…Come on, let's go, you say”. “Ja…» Berit responds – «but you simply just go right ahead and eat that chocolate, you do!», she says accusingly. “I do love chocolate”, her mother confesses, “I can't resist. But you've grown good at prioritizing and you eat chocolate only on the weekends…” “Yeah, and I drink sodas only on Saturdays”, Berit adds, though this is moderated by her mother, who points out that she is in fact drinking a diet coke as we speak.

This project is about exploring nuances. It would be unfair on a human level to Berit, who is frank about it herself, not to point to how temptations sometimes get the better of her. She is, after all, a teenager with real impulses. There are times that her choices in terms of food and consumption may not be entirely conducive to the spirit of the treatment programme. Following one of our afternoon sessions:
The three of us discuss next week's appointment. Turid suggests perhaps I might take Berit for a meal after school Wednesday, so that the two of us can talk for a while, conveniently, before Berit goes off to some other leisure activity later in the afternoon. Before I have the wherewithal to think the scenario through, Turid asks her daughter whether she prefers Dolly Dimple's (a pizza parlour) or McDonald's. Berit wants the latter, whereupon her mother says, more directed at her daughter than at me – «It's been more than a year since we've been there...» «Yeah,» Berit says, «and I've been plenty of times at Dolly's, so I know its McDonald's I want!» When we actually go there, at the check-out counter, Berit is really shy, blushing and with down-cast eyes. I have to repeat Berit's order to the salesperson because her voice is so low, but my feeling is that this is her regular mode of interacting with people outside home, not so much that she is embarrassed to be a large girl ordering a hamburger with French fries. *Will that be enough for you?*, I ask; she says, “This is my dinner! Tonight, when I get back home, all I'll eat is knekkebrød...”

I have included this excerpt to indicate how family dynamics might play directly into the weight regulation process. Moreover, this type of concern is likely at the heart of Berit's sense of “lived experience” as she understands full well that her everyday choices “add up” on the balancesheet which is their weight loss project. Based on my observations, I respectfully argue that mother and daughter's mode of interaction often seems somewhat complicated by food and eating: Turid offering or even proffering some foodstuff, and Berit accepting, sometimes against her “better judgement”, in as much as she finds herself constantly on the tightrope I describe elsewhere, ever balancing several concerns. Even so, in terms of consumption, Berit conceded her mother's description that she is «fond of food...not as fond of eating as so-and-so is, though!» Notwithstanding, Turid pointed out that for many people, including Berit, eating represents much more than just nourishment. “Her hunger is an hunger for other things. She won't go into it much – says 'it's my dream and you don't talk about your dreams, 'cause then they won't come true...’”

At the heart of the present debate, as will be seen in the paper, Turid also spoke repeatedly about her difficulties in “getting Berit motivated to participate” in physical activity – “she’s just too lazy”. Turid would at other times recognized the influence of her own attitude towards exertive behavior: “*We used to be very lazy...*”, she's say. Meanwhile, in private Berit nuanced this picture even more in terms of family dynamics in their project to “become healthy”: 
We do eat some sweets. Mum eats sweets and chocolate nearly every day. Sometimes she buys a big one for her and a small one for me. I ask her to stop eating those kinds of food, but she won't listen! She says she gonna quit smoking, too, but she doesn't quit!”

On a more general level, central to (paediatric) obesity treatment is a notion that the individual patient must assume responsibility – albeit in a family context – for own health (compare Adolfsson, 2004: 22). Sociologically, the above examples illustrate (as does Parveen, Paper III) the scope to which this is realistic for a youngster to achieve independent of familial encouragement and collaboration. This is in line with the findings of other recent research, which has postulated that “factors influencing children’s body weight are likely to differ from those of adults: for example the influence of adults on children’s dietary and physical activity behaviours are likely to be considerable” (Rees et al., 2009). Also, it may be ventured that in this specific point can be traced a clear difference between how paediatric and adult obesity, respectively, is conceptualized by society – as the former will be read as “a product of his home environment”, perhaps rather than as primarily “personally lacking self-control” and the like. In this sense, childhood obesity becomes a sign of “bad parenting”, rather than first and foremost “bad individual”. The home environment is in many ways likely to be primary amongst the factors which stand to concert existing (or emergent) weight issues and parents are the key to change. Lest we forget, even with what has been called the “medicalization of our daily lives” (Evans, Rich, Davies & Allwood, 2008) – being “too large” is sometimes, after all, only one of life’s many issues.

In sum, family life and family influences are among the factors that to a large extent go beyond the control of young people with weight issues, and this can have major repercussions on the development and resolve of the issue at hand. This is certainly recognized in the scientific debate, but this perspective is often lost in encounters with a large child. It is to the social encounter we now turn attention.

**Subject to Social Scrutiny**

**Gym in School**

I continue the discussion by looking through a prism by which we might understand some of the expectations Norwegian society places on obese young people, how the idea of responsibility for own health through regulative behaviour colours the debate. Gym in school is an experience all students share, including all the participants in the
project. It is a social scenario infused with meaning to children; from a public health perspective it provides an important lever for young people to achieve official physical activity levels. Within obesity discourse, physical education is subject to a burgeoning body of research with a Critical Fat studies slant. Physical educators are often seen to be in the vanguard of society’s effort to curb obesity among children and adolescents (e.g. Kirk, 2007). As Gard & Wright point out, “The physical education profession has long been concerned about the ways in which overweight and obese children avoid, and are stigmatized within activities, that involve physical exertion.” Highly significantly, in this regard school personnel are faced with a not insubstantial dilemma. Practically speaking, gym-teachers are faced with a choice of intensifying efforts specifically towards pupils who are thought of as (or, obviously are) obese, in order that such children might benefit in terms of heightened levels of physical activity. But then again: “Teachers often lack the knowledge and skills to create inclusive and safe learning climates for overweight or obese students in physical education classes or to provide differentiated instruction in terms of their unique characteristics” (Li & Rukavina, 2012). Or teachers may focus on getting everyone involved; which is difficult enough, since, “Increasing regular physical activity among youth is a challenge” (Grim et al, 2012).

At the same time, from the opposite perspective, it can be postulated that physical education classes in school, ironically, is a potential barrier to participation in physical activity, inasmuch as, to many, it provides “a platform for eroding the self-worth of obese young people” (Foster & Page, 2006; see also Faith et al, 2000). It being “essential that young people participate in activities they enjoy and do not perceive as threatening or embarrassing” (Armstrong & Welsman, 1997; see also: Hansen, 2005) – Gard and Wright are not surprised that “many overweight people […] arrive at the conclusion that sport and other forms of physical activity are not for them” (Gard & Wright, 2005, p. 62). Clearly, the issue of body-consciousness (which did come to light here in male and female participants) will be a factor for some obese youngsters when it comes to participation in gym class.

The young boy Espen for instance, has in his mother's words, “started noticing he is not entirely like the other boys – like in the shower after gym. We talk about this a lot at home these days...” There are additional aspects of this weekly experience which can induce negative associations for a large-bodied youngster – and hence, sometimes even results in the decrement of existing enjoyment at being in activity. Bullying and other
kinds of unwanted attention from peers and even teachers, spring to mind. But Physical education is also an activity where ergonomic challenges might be exasperated; highly visible among peers in class, a potentially devastatingly shame-inducing feeling of awkwardness might throw spanners in the works in terms of engagement, though this is by no means a uniform outcome. Some participants here did offer more positive reports on this topic. For instance, though, “Gym is boring. Football is boring, that's what we always do. Basketball is better” — Ulrik professed to prefer gym in school over the exercise component of the treatment programme on account of the former being harder. That fairly large boys often do quite well in gym was attested by several of the physical educators I interviewed as a sub-focus in this project. The teachers also reported that girls from minority backgrounds are more often than not active in class – despite the general feeling that this segment is not very active in leisure, or as the teachers philosophized, perhaps because of that very reason. However, a fair share of participants reported experiencing Phys. Ed. as somewhat problematic. This was made issue of more prevalently in conversations with female participants, which accords with the conclusions reached by other research (e.g. Hansen, 2005). However, gender need not be a very important circumstance for those large kids who “have a problem” with gym. From young people's perspective, gym in school is part of the “problem” and part of the “solution” to their overweight issues.

When asked about negative sides of having a large body Berit would stress P.E. as causing her discomfort, since being “slower then the rest” was an embarrassment to her (CF e.g. Pierce & Wardle, 1997). Beyond finding some of the activities – “difficult because I am so big”, she did not express dismay at participating in the activities per se (though, she was “… a bit scared of the ball”). Participation in exercise training through the treatment programme had probably contributed to making her feel a bit more comfortable in gym. In actual fact, on several occasions Berit expressed regret to me at not having been able to be present in class at some instance of physical activity, such as a class outing or swimming. This is stated, obviously, to pre-empty any ennui that this girl’s problem with gym as an exertive situation is one of attitude alone. There are factors beyond stark laziness which might make gym-class a dreaded experience

61 E.g.: “[…] Teasing and bullying among students were the predominant barriers to students fully participating in [gym] class” (Bauer, Yang & Austin, 2004).
for obese youngsters, a demographic group which in official discourses – it bears repeating – is all-out encouraged to participate in physical activity, period.

Beyond an expressed discomfort with changing attire in front of her classmates, as she said, “that's no fun, the way I look...”, but Berit did not seem uncomfortable with the physical activity in and of itself. Her apprehension, she made clear, stemmed from the efforts directed at her by an extra-teacher, who had, as she put it, in practice taken it upon herself to – “follow me around in class.” Besides making Berit feel under constant scrutiny, the despised teacher had added insult to injury by taking her for walks outside during gym-class, rather than allowing her to participate alongside everyone else. As she explained, Berit experienced very keenly that these initiatives made her stand out among her classmates. Strategies adopted to engage her to become more active, then, had in this way, inadvertently resulted in Berit being rather upset by the weekly experience. It had caused her to be, as she said, “Less active still” – prone, in her mother’s words, to “never take the initiative” there – as her way of demonstrating disapproval. The tragedy for Berit is that she is keenly aware she might have to achieve ever increasing levels of physical activity in order to support her dream of weight loss. She saw the less than optimal condition in this arena as a major obstruction to her aim.

Kim, the late-teen Norwegian young man, on the other hand, reported having been “met [even] in school by a certain attitude”. He was able to trace this attitude, ultimately, to notions of obesity as a condition caused by the individual’s behaviour, and remediable by exertion of willpower (à la, “If you’ve gotten yourself fat, you can get yourself thin!”) Relating this to society’s inability to fundamentally empathize with his bodily condition, Kim would be aghast when nagged in gym and the like, to “try a little harder!” The futility of such advice he felt compounded when issued by a stark friskus – someone who clearly experiences little bodily resistance or issues of motivation to their own exertion. Kim epitomized this feeling, in stating, “My gym-teacher was a former National Champion in gymnastics...!” – implying that someone of that calibre, however good the intentions, may not be overtly sensitive to whatever obstacle an overweight child might face towards, say increasing levels of physical

Chambliss (2004) finds that, “Anti-fat bias and weight discrimination among exercise professionals may further contribute to unhealthy lifestyle behaviours and reduced quality of life for many obese individuals”.

62 Chambliss (2004) finds that, “Anti-fat bias and weight discrimination among exercise professionals may further contribute to unhealthy lifestyle behaviours and reduced quality of life for many obese individuals”.

activity. For Kim, gym did not appear to be an issue of body-consciousness; as he said, his ordeals as a large person had made him “stronger emotionally”. He has, as intimated, articulated a strong conviction that being of a large body – as he saw it, through no fault of his own – is an inescapable part of who he is. Unwavering in exculpating his own behaviour in the aetiology of his body-status, he felt singularly short-changed in terms of gym-grades, sensing that these were issued with a bias against his large body.\textsuperscript{63}

Kim felt the injustice at having in one year made a smashing improvement in his endurance ability, but still falling way short of the requirements for what he considered a more appropriate remuneration. It had been made clear to him, as he said explicitly, that his effort could never hope to achieve an improved grade in that subject. His gym teacher had meanwhile also raised the issue of him not having to participate in the activities at all, should he not be up to it.\textsuperscript{64} He listed his reasons for declining what he saw as a somewhat impertinent offer: A wish to participate as part of the class; a necessity in view of his hectic schedule of tabulating gym-class into his endeavours at meeting treatment recommendations for activity; and a refusal on ideological grounds, to allow scope for fat-prejudice to be confirmed. As an obese teenager, Kim cannot hope to achieve better grades in gym before radically altering his body – as it is, it is simply too heavy and slow. While it is not possible for him, clinically speaking, to achieve sufficient intensity of exercise for such a development to conceivably occur – which can be ascribed primarily to the particular limitations placed on him by his dimensions and girth, and less to him having a life, i.e. outside all but personifying the treatment regiment. To Kim, like it or not, his body’s state of adiposity is an inescapable, all-engrossing presence in his life. As he put it himself: “I am not the sexy man type…I mean everyone can see I weigh a lot more than others!”\textsuperscript{65}

\begin{itemize}
\item \textsuperscript{63} In \emph{Paper I}, I make example of Ulrik having been prevented from using the weight-lifting equipment at his local gym, on account of his age – even though his body is decidedly more robust than most kids his age. Ulrik and Kim both find themselves in situations which illustrate \emph{there are very few good ways to think about obese bodies}.
\item \textsuperscript{64} Obese bodies are “difficult to manoeuvre” – sc. heavy: slow/lumpy: lumbering. In and of itself, the mechanical aspect of this is fairly self-explanatory. But when it comes to large individuals and movement, an overriding concern will often be the perceived need for exercise with a view to lose weight (see \emph{Paper II}).
\item \textsuperscript{65} On a technical, clinical note: Female secondary sex characteristics have been found more prevalent in boys, at ages 13-15 years. “These boys were markedly more obese than all others […] In boys adiposity
The Gaze

Berit would probably corroborate Kim’s sentiment, which an example from our interaction might show. Berit told me explicitly that she in many ways was “really bothered by being overweight” – and more implicitly, that being the only one in her class with overweight issues was among the things that grieved her the most; she would compare herself to the thinnest girl, an active ballet dancer. “She understands she can never be like her!” her mother said while the three of us where playing bowling. As explained above, Berit’s and mine interaction was planned to take place in a variety of social milieux and the methodology of the project was tuned towards gauging the broadest possible impression of how life as obese might play out. On one occasion, on a spur, the two of us stepped into a shop selling dancing shoes and ballet paraphernalia and I inadvertently got a glimpse of the reactions which must be all too familiar to her. Among the sylph-like shoppers and check-out girls with their leotards and toe-shoes, standing there, she momentarily looked distinctly uncomfortable. Regretting having exposed her to the situation, I noted the surprise her presence in the shop triggered. Her counterpart in the instant communication, the check-out girl, gave off a look of surprise as if to say, what might someone like you be doing here? Berit probably came away from the encounter in the shop with a strong feeling that, it’s a thin girl’s world! In Analytical Frameworks, above, I introduce my take on the concept of “lipoliteracy” and sign theory, which I have found useful to explain how the meaning “a sign” generates is transmitted instantaneously and calls for an immediate reaction. To our circumstances, this entails that in the blink of an eye, a spectator gets to “know everything” about an obese person. Such a communication in effect bespeaks a very limited set of human characteristics, in the sense that “our ability to read fat, seems fairly circumscribed and restricted” (Middelthon, Moen & Høstmark, 2010). This feeling of being constantly read by all who see you is likely shared by many obese individuals, children and adults alike.

To elaborate on how the presence of obese people is perceived in social encounters, we might picture Kim as he goes about his daily life, to look at a perhaps more commonplace situation which encapsulates how society’s articulations and stereotypes of obese bodies might influence a youngster. At the end of a given week of avowed and dogged submission to the rigours of his treatment regimen (on which I elaborate enhances [visible] gynecomastia which in turn is likely related to a deceleration in male maturation” (Voors, Harsha, Webber & Berenson, 1981).
below), Kim might find himself, much like any other modern individual, wishing to unwind and perhaps feel entitled to an occasional change of pace. Perhaps in the form of a bar of chocolate, I ventured to suggest, hypothetically, during a conversation. As when, say, he goes shopping for groceries a familiar situation to other participants (though many obviously didn’t shop for groceries themselves):

Maybe I occasionally might feel like something which isn’t healthy, yes, like a bar of chocolate; it being a Saturday and I’d buy it for the weekend. It’s not like the treatment programme people say I can’t ever enjoy myself like people of normal weight do! I’d feel people staring at me, ‘Is anyone watching me now?’ You’re being watched! That’s what fat people feel when they’re out in public.” I am sure many people, when they see a large individual, are quick to think ‘Couldn’t he just skip that chocolate?’ – is that what you mean? “Yes. But not only something as obvious as chocolate! Anything vaguely unhealthy – you could always choose some product which is a little healthier, right? You could always get the light version. I really feel as though strangers are keeping me under surveillance.

The silent evaluation and disapproval of fellow shoppers, regardless of weight, on the basis of the content of their shopping carts, may be more common that Kim imagines. Who has never stolen a sidewise glance, while waiting in the check-out queue, at someone else’s groceries? There are harsher mechanisms at play, I suggest, when junk-food is spotted among the groceries of an obese individual. I relay on several arguments developed above to underscore that obesity works as a total identity marker and cues the free reign of moral reproach. In the shopping cart of a fatso, any article

66 Cf.: “One focus […] has sought to deal with the impending obesity epidemic, requiring regulation of populations by informing them how they are to monitor both their own and others’ ‘bodies’ through constant introspection and surveillance […] in this culture and political climate, unless we are seen to be vigilant in keeping ‘our body’ (and those of others) in constant check, we are likely to be considered irresponsible citizens, letting us all down, at great cost to personal and public health” (Evans, Rich, Davies & Allwood, 2008)

67 Similarly, a person of a certain avoirdupois, a zaftig paunch or a steatopygic posterior, will by the body-conform observer be seen to impinge whenever taking nourishment in public. While an ectomorph individual will be seen to be merely eating, the gluttony of the pyknic counterpart is self-evident (as well as noisome) and manifested to the world by the very substance put to mouth, even if in reality, both individuals consume the same food of same portion size.
of junk-food is proof positive you only have yourself to blame for your body’s condition! Whereat, the glance becomes a gaze.68

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I \text{ am influenced by society, sure. But this has nothing to do with self-control, I can tell you that! Besides, I don’t see what right someone slim has to come up to me and tell me ‘Do you really think you should have that...’}
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It may be conceded that one weekly indulgence is an exemplary display of self-control in a teenager. Beyond that, Kim felt many people ignored his actual efforts:

…Even when I am not doing anything unhealthy, I’m still seen as unhealthy. Of course, they don’t know anything about me. What I have to do to stay at this weight! I only rarely ever eat chocolate. But when I do…it’s as if the chocolate tells people the exact reason I’m large. With the regime I run, to abstain from the smallest reward? They let prisoners out sometimes, don’t they?

I have above expounded on some of the immense social and biological forces at play in childhood obesity, intending to highlight that “to become thin” will for many obese youngsters involve constant and lifelong attention, if not absolute dedication. The point I wish to stress presently is that, as a large individual you are expected – by your doctor, your gym teacher, your mother, by society at large, and ultimately yourself – to work at losing weight, invest an effort.80 In the sense that, If you’re still fat, you simply haven’t done enough...! For a large individual, then, in the eyes of others, the taint of the slightest indulgence belies every effort. “I think they even convince themselves they’re doing you a favour”, Kim despaired.

**Bullying**

From this, the step seems short to an even more crude and dramatic manifestation of how obesity provides for an overriding identity marker – bullying. Clearly, being bullied might deeply influence a youngster, from his confidence in own abilities to his sociability – in short the very quality of life. This is very much at the core of the present line of inquiry. Particularly because it is easy to grasp how bullied patients face additional hurdles against adhering to treatment, be it depressed self-worth or fear of normal social intercourse with one's peers. Obese children report falling victim to

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68 Recall how, “There is no need for arms, physical violence, material constraints”, as Foucault (Foucault 1977, p.

69 ) writes; “just a gaze – an inspecting gaze”. Incidentally, Hill (2006) finds the most frequently encountered
bullying at school but also other arenas; this has long been pointed out, even before obesity became a globalized problem. The classic reference: “Preference tests have shown that 10-to-11-year-old children would prefer friends with a wide range of handicaps rather than stigmatising situations include inappropriate comments from doctors and from peers, people making negative personal assumptions, and being stared at in public.

80 Referring to Basil Bernstein’s idea of a “totally pedagogized society”, Evans et al. (2008, p. 80) hold that “individuals are expected to ‘work on’ or refashion themselves routinely and relentlessly, or be ‘worked on’ or refashioned by others in the interest of pre- or proscribed ideals”.

those who are obese” (Staffieri, 1967; see also Olweus, 1997; Hill, 2006; Hill, 2007). Even fairly young children have been shown to demonstrate antipathy towards obese individuals, and this presumably underscores just how deep cultural roots anti-fatism has in modern Western society. Overweight children are said to suffer more severely from bullying than other victims, though this form of unwanted social attention is known to affect males and females differently (HaydenWade et al, 2005; Griffiths, Wolke, Page & Horwood, 2006). Fat-teased girls in particular are made to feel unattractive, un-athletic, and, in effect, are often endowed with low global selfworth (Hill, 2006).

Among the core participants in this project, only Hafsha and Aisha reported no involvement (i.e. either as recipient or perpetrator) in school or neighbourhood bullying. Italics refer to some participants being better described as bullies than bullied, sc. Ulrik and possibly sometimes Razzaq, both of whose position was one of “No-one touches me!” Maimuna, the Pakistani girl, extrapolated on the steps she herself took for other kids at school not to feel fat-teased. Thereby making understood that this kind of bullying had in fact taken place there – in fact she had witnessed it, she said – and she had no problem pointing to the weight of bias large children face. The essence of the following sentence rings true for a majority of the participants. “I knew I was fat because I was bullied at school”, as Peter formulated it, saying that he has learnt to not care:

It doesn't matter to them and it doesn't matter to me. I used to get very angry when they called me names, but now I hardly ever get pissed off for anything. We have four or five large kids at school, but I don't think they are being bullied. It happens there like once a week or something!
Turid said about Berit’s experience: «She feels they look down at her at school. There isn’t bullied in class as such because she is large – but things happen in school that’s not pleasant for her. It’s no fun for her when a fourth grader comes up and ask her ‘why are you so fat?’, things like that». Or as Kim would have it: “As a fat-kid, you get bullied because of your size, and you know that’s the reason – it’s about you as a person…!” As it were, at least five participants, boys and girls, made clear that fat-bullying had been traumatic to them, inasmuch as having had bearing on their “trust” towards peers. As a direct result, several confided chiefly indoor leisure habits. Peter reported having been bullied in his “special school”, where he lived, and this had been instrumental in chipping away his interest in participating in social activities there, including sports, like skiing, which formed part of the more practise-based approach of the school. In consequence, Peter told me, he preferred the isolation offered through the pursuit of interests like computer games. Tariq, a Pakistani boy of fourteen had also suffered severely in this way. Bullying had contributed to him changing schools, and this had created an additional barrier for him to be active in leisure in isolating him socially. He reported hardly ever leaving his house on his own. A confounding factor in his case, robbing him of a daily opportunity for energy-expenditure, Tariq was now also being taxied daily to and from his new school. At fear of sounding a polemical note, for youngsters in these boys’ situation, twice-weekly-or-so participation in exercise training in compensating for daily limitations to spontaneous expenditure, might well be insufficient towards weight loss even if this activity should involve something as vigorous in terms of exercise as martial arts. Even someone who doesn’t necessarily question the ideal relevance of physical activity per se, if faced with such a fundamental barrier to it, like bullying, might come to probe the validity or applicability of the advice as pertaining to his own life circumstances. The above three social circumstances are examples of instances in the participants’ lives where they must experience very acutely “living an embodiment” of dominant discourses, where they feel the full force of being morally deviant and at the same time, in actual fact – entirely disempowered.

We have seen how there are very strong biological and social mechanisms at play in childhood obesity, beyond the control of the individual – and that society often seems to judge fat children as if they are themselves entirely to blame. In the following I aim to provide some insight into what scope young people have to get around this predicament.
“Fat is Bad!”

Inasmuch as modern Western society can be said to be permeated with the public health message “obesity is bad!” – to a large youth, Norwegian society may seem overly concerned with weight and body-shape and downright obsessive about health issues associated with the fuller body. Patients in treatment in particular will presumably find it hard to entirely ignore dominant obesity discourse. Given the information obese children receive and how they are often met in society, I was not surprised to find that most of the young people I interacted with, on some level had accepted that being “fat is bad for you”. To them this often meant “bad for health!” I proceed with a look at how medical discourses are taken up by the participants.

“I hear it a lot!”

Scientifically, obesity is known to constitute “an embodiment of a multifactorial problem with several intermediates in its casual pathway” (Myslobodsky, 2003). Nevertheless, almost inevitably the condition is postulated as the direct result of ingesting too much energy in the form of food and expending too little energy in the form of physical activity (Cameron, Norgan & Ellison, 2006, p. XX). It has been pointed out that in scientific literature the diagnosis “too much food and not enough physical activity is generally not questioned” (Gard & Wright, 2005, p. 37). At the same time, the question has been raised as to whether “mental health issues may lead to obesity rather than the other way around, and that obese people seeking mental health support from professionals may be generally more distressed than the average obese person” (Paradis, 2010). Moreover, it may not be entirely coincidental that psychological co-morbidities have been found to be more common in obese individuals enrolled in specialist weightmanagement clinics (Tuthill, Slawik, O’Rahilly & Finer,

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70 Had one asked for instance the pharmaceutical industry for a definition, a notoriously slim percentage of the possible range of human bodies would qualify as “healthy” – as vividly and visually exemplified by any standard BMI measurement device. “Healthy” on the scale of a measurement band represents the BMI range 20-25; other than that, below or above, is categorically defined as unhealthy. Quoting Campos et al, Evans et al (2008, p. 41) write that, “A weight-range norm is being pathologised and classified as a potentially life-threatening condition, despite convincing evidence that the ‘ideal’ weight for longevity is, indeed, ‘overweight’” (See also Cooper 2010).

71 Evans & Davies, 2004: “…knowledge(s) largely produced by the disciplines of the biological, behavioural and health sciences […] which now constitute largely taken for granted ‘regimes of truth’…”
This arguably points to a certain discrepancy between, on the one hand, “scientific truths” on aetiology and treatment, and on the other, the lived experiences of (some) patients. To them, ultimately, the consequence may be detrimental to efforts to optimize their health, in the sense that Paradis (2010) argues. “An emphasis on weight loss in public health is potentially hazardous to patients’ health, and may only increase their frustration and weight cycling patterns”. Further qualitative insight may therefore be of interest from a Public Health perspective. Meaningful assessments of health must take into account how this social quantity is perceived by the individual (Adolfsson, 2004). The following discussion, therefore, in a sense, elaborates on the claim made by Kim that, “overweight is a disease”.

“Bad for Your Health!”

Despite the frequent use of euphemistic self-descriptions, with appellations like “big-boned”, “hefty” (but also terms like “fat” and even “fatso”) – in general participants were well aware of their own bodily status and could identify processes which had lead to that development. Involvement in the programme had been a catalyst of thought for many of them. For instance, as a common theme, a number of participants made a point of now associating obesity more clearly with illness than previously. Some applied in conversation terms and phrases one might expect from treatment staff, thereby tellingly adopting the language and rhetoric of the program. For instance Tareq is in his words a “big-boned” boy (“I don't like the word 'fat'”, as he said, “I use 'large'”), whom I thought had understood very clearly what is expected of him as a patient in the programme, in the sense that he was always very quick to foresee how any topic might relate specifically to the subject of obesity (his own ability to lose weight notwithstanding). The following is excerpts from field-notes:

During our interaction I often feel Tareq to be answering my questions in a way he might have done during a consultation with a doctor, with an air of compliance, sort of anticipating my inquiry. Playing billiards: I ask, *What do you like to do in your spare time?* “Homework, training and more homework”, he says, “...sometimes I go out.” I ask, *Do like playing computer games?* He gives off a smile, as if to say he has heard the question before. *What do like to eat?* “Do you mean candy and stuff?” *I mean, what is your

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favourite dish? “Pizza; I prefer the ones my Mum make to the take-out ones, actually. But we seldom have pizza these days...” The hospital, what advice do they give you there? “I don't wanna talk about it!” he says, after a second, smiling (coyly) knowing how I had stressed he was free to talk or not talk about any subject I might raise.

Tareq did finally relent and insisted he follows the advice the nutritionist and doctors give him: “I am to eat only salad now and bring knkkebrod (a Scandinavian type flat bread) to school for lunch”. Obviously more complicated in real life, in practise, as far as I could observe and discuss, it seemed to me that almost all the youngsters I interacted with were trying to make an effort to live more according to the advice given through the programme. Though, as we've seen above, in this they were variously encouraged from home. This commitment to trying (which might be expressed as fastidiousness interceded by everyday life) which many participants insisted on, is not surprising. Immense pressure is put on the patients in terms of their being met across the board in society (and the researcher's questions might be part of this, as exemplified in Tareq), that they make use of their new-found knowledge and “become thin”. All obese people are in a sense expected to utilize this knowledge – this is where the apparatus of Governmentality as it were, “kicks in” – but as patients, these kids are subject to additional pressure, since they cannot deny now knowing and are also in vested personal relations with people (parents, treatment-staff, etc.) who share these expectations. The pressure mounts on any individual who despite the actual expended effort does not obtain the pivotal goal of body-regulation – since “eat less and do more” is the panacea for obesity and so any failure must be due to personal shortcomings. For many, this might have the potential to derail long-term commitment. I will take up later how this potential seems very real in Berit's case.

In Paper III, I expound on representatives of a segment of participants who (somewhat surprisingly) have both “accepted the premises” of the programme and, after a fashion, learnt to adapt to dominant obesity discourse; who acknowledge that “obesity is bad for you”, and have been able to take steps to counteract implicit hazards to health, such as they are. Perhaps on their way to a happier life: On them, good and well. The present discussion is more concerned with those individuals whose life and circumstances in some way stand in the way of losing weight – viz. that glitch between public health and patient reality.
With reference to the three papers, I argue that the fairly stark common denominator of what the bodily condition in question represents to our young patients is a hazard to health. Though I should hasten to add, to the participants in the present project, “health” often carried somewhat vague connotations. Berit, Razzaq, and Tareq, for instance, seemed to have a fairly generalized understanding – “You can get sick”; “I don't wanna be fat, 'coz I don't wanna have an operation!”; “Bad things about being large? Well, you can get diseases and stuff. It wasn't the doctor who told me, I hear it a lot!” This would seem to be in keeping with the findings of Neumark-Sztainer et al. (1997), who argue “overweight youth [are] more likely to perceive their health as only fair or poor and [are] more likely to express weight-specific concerns”. Rail et al (2010) report that the participants in a Canadian all-weights research project on health and weight, “did not seem as concerned about health as they were about their bodily weight and shape”. While Wright (2004) finds that the kinds of meaning patients can draw on to “construct a response […] correspond very closely to the kinds of meanings which seem to be promoted in most health-related classes and the media […] Health is about eating healthy and engaging in exercise.” I might mention Karl’s retort to Ulrik, regarding the latter’s body-shape, as an instance where public health and public opinion intertwine:

In many ways you’re luckier than I am, Ulrik. The dangerous fat is what is called abdominal fat, beer-belly! This! Your fat is more all over; that’s healthier. Its belly-fat that’s dangerous!

This message is, as it were, straight from the book: “Indeed, excess abdominal fat is as great a risk factor for disease as is excess body fat per se. It is useful, therefore, to be able to distinguish between those at risk as a result of ‘abdominal fat distribution’, or ‘android fat distribution’ in which fat is more evenly and peripherally distributed around the body” (Gard & Wright, 2005). Beyond aetiology, the exchange indicates how the young people in the project are continually exposed to dominant obesity discourse. Even so, with basis in input from treatment-staff and the patients, it is fair to say that not all patients in the treatment program had come to accept wholesale all aetiological premises in practice. Others demonstrated more aloofness in terms both of obesity being problematic and the urgency for change. For instance, at one point Razzaq, by now familiar, had the following to say about the onslaught of his weight issues – though said in an off-hand way:
“When I was in grade four or five, I was shit thin. I weighed about 40 kgs. And then I just got like this – I don’t know how...I don’t really know why some people are thin and some are fat”. To be fair, if pressed further on etiology Razzaq would certainly be able to refer to what he’d been told through the programme.

Peter, on the other hand, seemed to have come to accept his bodily status and his participation in the treatment program without much further ado. Like other participants, he expressed a wish to –

Lose some kilos – not become all slim!” though he doesn't seem to have reflected much about the situation other than that. When I ask him what they tell him at the treatment centre, he answers by saying he doesn't “train in the exercise-component, if that's what you mean!” Well, what do they say about food? “Less butter, only one slice of cheese. I don’t remember the rest right now!” What do you think you're body will be like in five years time? “It is a bit freaky to think about the future like that, not only because of obesity...But I haven't thought much about it. It's not like I walk around thinking about being fat all the time. I have other things to do!

A third participant, Natasja, a Norwegian early-teens, expressed a primary concern with the intention of losing weight as having to do with not feeling pretty “as a girl with a weight problem”. For her, the condition seemed to have caused her embarrassment, saying, “I mean, I recognized in the mirror that I had weight issues and I wanted to be thin like other girls...But I can't do all the things they do either – like I can't climb up a tree!” Her main concern may be taken to exemplify a not unexpected gender perspective since in the literature on paediatric obesity aesthetical concerns are often seen as an important incentive for young girls to attempt weight regulation.

On a more general level the rhetoric of paediatric obesity treatment surely ultimately works to instil in patients (and parents) a world view which reflects and re-enforces a pathologically focused understanding of obesity, presently found across much of Western society. Which is to say, treatment rhetoric, the media and public opinion etc. relentlessly drive home a fairly unison message: “…Bad for your health!” With reference to the present research project, I'd argue that a health oriented rhetoric has explicitly been replicated and taken up by many of the participants and their families. I could observe that many participants had internalized much of the current socio-medical framework of understanding very large bodies. Beyond the idea of “a disease”, Kim also argued that:
I think there are two kinds of fat people; there is the type that sits on the sofa and drinks coke and can really only blame himself, and there are those in my situation who were born with obesity and do their best to change their lives. There really are two kinds!

Clearly, navigation of this moral terrain and dominant obesity discourse is a highly complicated exercise, and it must be very hard to shake off the premise that pervades society's view of the obese as fundamentally flawed and diseased. These examples I take to bespeak the “elucidating power and authority of the medical voice in making ‘fat’ bodies intelligible as pathological and immoral, not simply to the doctors, but to the ‘fat’ individual” (Murray, 2008, p. 79) A similar process can be evinced from Rail et al.’s discussion: “The young people used many moral terms to qualify the ‘lazy’ individuals but qualifiers used to describe others were not applied to themselves. In line with this, most participants considered themselves ‘healthy’ despite the fact that few reported being involved in regular sport, exercise or fitness activities...” (Rail, 2009, p.150) Rail concludes that, “discourses that emphasis the importance of ‘not being fat’ and having a ‘normal body’ [...] is particularly oppressive to corpulent [...] youth whose bodies are often constructed in opposition to ‘normality’ and ‘healthiness’” (Ibid, p. 146).

**Making Sense of “Being Fat”**

The analogy to a number of youngsters in the present project: “I used to be very lazy” [i.e. “…before I joined the programme”]. In other words, an admittance that, yes, *I am fat because of my own behaviour* – but admitting this with regards only to a previous lifestyle – might sort of take the sting off what others might think and say about your body. We have seen other examples from the sample; Tareq, on observing an obese lady on the tram, was able to articulate that –

> Many people are obese – I didn't think anything special about her; maybe the reason she is fat is because she eats too much. Many people eat too much sometimes...Myself? Perhaps I am large because I *previously* trained too little and ate too much...

And Berit added to her explanation of being big-boned (“I am not fat! Fat can be dangerous for health!”), that -

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73 More curiously, I find, Rail is left “perplexed” that a set of students who were “well versed in the school and public health messages about nutrition and physical activity [...] reported *behaviours* [which] *did not necessarily reflect that knowledge*” (Ibid, p. 150; italics added).
I used to eat a lot. In the kindergarten I used to eat three portion while the others only got two. Mum had to tell them not to give me so much. But then I got into the habit of eating a lot...

Beyond this common “strategy”, a (very) limited number of what I call alternative explanatory models are available to obese youngsters. That is, to lend credence to notions capable of putting young minds a bit at ease in terms of being obese. I found participants were able to offer up limited “narrative resistance” of sorts – though, without being entirely able to reject a feeling of unease at living life in a hefty body. As an aside, other than the exercise-training one such “freezone” in terms of allowing the youngsters some figurative breathing room, was a popular TV show entitled An Easier Life, focusing on the weight loss process of a group of teenagers. Running while the project was operative, though the message of the show seemed to underline the public-health message participants are exposed to everywhere else, several youngsters looked to the contestants there as role models or at least as cool kids, being able to express some of the same experiences.

Berit for instance enjoyed watching the show since a girl she knew was featured, and Razzaq joked that he wanted to become “a weight-celebrity by getting on the programme”. In terms of narrative resistance though, boys likely have more strategic options in this regard than girls, but it should not be surprising if young people with weight issues tend to “construct narratives around their own bodies which reflect morally responsible, food- and diet-conscious, exercise-prone, ‘neo-liberal’ self-images” (Evans et al, 2008, p. 75). Again, the “big bone”-epithet springs to mind, allowing a youngster to claim “correct” behaviour though “cursed” genes. Kim was able to articulate an advanced notion of obesity-as-disease, which might be another common explanatory option. We have seen how Kim makes for an excellent example of how fat has the power to engulf all aspects of an individual’s identity. Seeing how his body’s size encroached on nearly everything in his life, as he says himself, his obesity is such as to be impossible to conceal in any social encounter. Kim has however been able to articulate some ideas which allow his to defer some of this personal burden, as a matter of speaking, morally, from his own shoulders.
Full of praise for the treatment programme, Kim expressed gratitude for their taking his condition seriously, which he called *pretty much a first-time experience.* Yet, he also made clear that for an individual to entertain hopes of achieving the treatment-program’s definition of success – call it *weightgain normalization* – then, “Certainly, everything in your life must be perfectly aligned to that purpose. *Everything* [including biology] must be just right!” Relating this to his own situation, Kim repeatedly and adamantly insisted on his complete adherence to the treatment-regime, making a point of satisfying the recommendations made for him there in terms of both exercise *and* consumption. Regarding his diet, he said:

I don’t eat more than I should on a daily basis. In fact, I probably eat less and healthier than other boys my age. They eat whatever they like and don’t seem to gain weight. Like classmates who say they eat half a loaf of bread for breakfast – thinking about my diet all the times, I make do with a couple of slices. I eat the same for lunch and evening, plus a regular dinner. That’s all! Something special for Saturdays…I never drink Coke. And yet it’s me who gains! I feel that’s somewhat unfair. I’m fully convinced this isn’t my fault – I’m sure many people think that, and many fat people use that as an excuse, I know. Even with all the effort - at some point you must live your life, too!

He said of the programme and his commitment: “They pull at their hair [at the treatment centre] – they simply don’t know what else to recommend me cutting down on or doing more of!” In fact, as it were, by his “constant efforts” – a tightly run ship of caloric measurements and a host of weekly activities, Kim had in the last years been able to arrest his hitherto thirty-kilo annual weight gain. Even so, he had been told in the treatment program, and professed to have acknowledged, that he could probably never hope to *negate* the trend. Hence, “as encouraged in the program”, he had made it his project to *maintain his current weight*, rather than aiming for an actual reduction (Cf. Wilson, 1994.)

For Kim, *alternative notions* make sense in light of a need to *explain* obesity explicitly as “a disease”. I interpret this as an attempt to debunk the myth of self-control and thus escape the stigma of being perceived as weak-willed – “disease” being easier to conceptualize as beyond the control of the individual. Kim’s corner-stone argument is that his behaviour it is not the primary cause of his obesity. When *his* body accumulates fat and gains weight under circumstances where other individuals would

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74 Kim complained – “there is no point in going to the [regular] doctor, when he only gives you the advice of eating less and exercising more!”
actually diminish, as he sees it, this must be the result of some congenital condition, “a disease”. As a disease, Kim understands the role of genes and biology in this picture and he is also well aware that his family fits the tag “obesogenic”.

Ulrik on the other hand took a more flippant approach, summarizing his stance in saying things like, “Fat people don't fall over easily!” For him, something like a dissenting view of what obesity represents (more on that shortly), had likely contributed to his rather cavalier attitude in terms of compliance to change. It will be noticed that neither of these “alternative models” question the link between obesity and health. As Pakistanis, Razzaq and the two sisters, as well as Maimuna, have to some extent been able to “make sense of being fat”, as I see it – by placing the problem of obesity in an ethno-cultural context. “Culture” and “family” may be said to be analogous as means of “explaining why” one is obese. These “strategies” – this is my analytical term and is not meant to convey “articulated policy” on part of the child – are ways of managing a stigmatized identity.

Future research might focus on how children construct different health parameters other than established nosological categories, and the psycho-social aspects variously at play. As pointed out in the papers, none of the young participants reported suffering from any of the long list of co-morbidities associated with obesity. The exception being Razzaq, who volunteered that he “lacks vitamin D” – a deficiency he could explain in relation to his indoor leisure habits. His sister Parveen, diagnosed with Diabetes Mellitus, is not technically a patient in the treatment program. It may be suggested that a feeling of not being sick is not the most forceful motivation for change. Rather, for many participants, including some whose obesity may be said to impede in very concrete terms on other aspects of their lives, as a disease, though this may be true to other patient groups as well, being fat for a large part represents an abstract notion of a risk to future health. In this light, to a young patient, the exact nature of both the

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75 When perusing the papers, I ask the reader to forgive my rather pompous literary proclivity. Beyond the reference to Job – in describing Karl “…a very stout man”, I have pilfered a phrase from Judges 3:17; and another from Corinthians in an analogy on seeing through “a glass darkened”. The phrase “the resplendent title of this section…” intimates Book of Splendour, whence the headline quote of that subsection was lifted. The same applies to the phrase “…inexpungible but for extreme exertion”. “Double burden does her sore disease”, paraphrases Spencer’s Faeri Queen.

76 Reilly et al (2003) point to, “a strong link between childhood obesity and morbidity/mortality in adulthood, which should reflect increased cardiovascular morbidity in future” (emphasis added).
disease and its treatment may come across as somewhat hazy. Added to that, bio-anatomically speaking, counteractive change, to be effective, must be permanent and intensive.\textsuperscript{77} The intimation is that some individuals will be tempted to as it were, embrace the condition (by somehow contravening extant stigma) – rather than the cure (Schwartz & Puhl, 2003).

**Need for Change**

Treatment of obesity involves making fundamental changes to one’s body but also, in effect to one’s person and even personality, which, once this need is truly accepted can only in a sense drive home that everything up to this point has been all terrible. In other words, a fundamental problem with this highly contentious bodily state or disease is precisely that in many ways, obesity constitutes a lived condition. To rid oneself of it, too, is intimately connected with lived life. It should therefore be taken into account that the personal life of patients in a variety of ways may be averse to the thorough inculcation of the aims of treatment. To exemplify, two articles (Papers I & III) explore how some male participants read largeness as a byword for physical strength; Ulrik’s bowling prowess is intended to illustrate what being large might mean to him (“…He does not totter”)\textsuperscript{89} For these boys, this is a valued personal characteristic which would arguably seem to mount a hindrance of sorts to their wholehearted embrace of lifestyle change. For other participants, other mechanisms made an impact. Like other male participants, several of whom attended “special schools” as they called it, Peter found that the live-in school he attended complicated adherence to dietary prescriptions. For him, eating in the cafeteria at school subjected him to ready choices he did not have at home, he missed out on parental guidance in everyday life, and eating the cafeteria food made planning difficult and intake unpredictable. Besides, he explained that living in this type of environment had limited the scope he allowed himself to give the problem of obesity – since to be overly concerned about his bodystatus might invite further unwanted attention from the other boys. Whereas, to Maimuna, who attends Qur'an school in the afternoon and is therefore not able to participate the exercise component of the treatment programme, and might thus be in a position where she feels she must balance several foci.

\textsuperscript{77} The level of intensity can be quantified by “obsessive” (Shama A, personal communication, ECO 2007). “You have to live a more-than-perfect lifestyle” (Flodmark, Lissau & Pietrobelli, 2005). No wonder, then, that in the
Discussions throughout this thesis point to that being an obese adolescent in treatment is tantamount to being stuck – if a colloquialism can be tolerated – between a rock and a hard place. We do well to remember that, from one angle, for a segment of patients, the very cure itself is likely to be experienced as an additional stressor in life. Finally, it should be remembered in this present project, it had crossed some parents’ minds that overt focus on weight loss might induce anorexia or other eating disorders in their children.

Akin to: “Strength resides in his neck; Power leaps before him. The layers of his flesh stick together; He is as though cast hard...” (Job 41:13)

that the weight loss process must be fitted into the lived lives of individuals – implying that, reasonably, there is a limit to how consumed a young person can possibly be with this one aspect of life. (Having said that, a number of participants, like Hamza & Aisha, seemed to find the rigours of the treatment regimen invigorating.) The point of this line of reasoning is as follows. Young obesity patients, who in their everyday lives do not necessarily experience being sick as such, are obliged to commit themselves, notwithstanding family cooperation and encouragement, to a health-regime, which – if hope of success meaningful to the patient is to be reckoned with – must involve extensive investment on all counts of life. It’s not difficult to imagine how for very large youngsters the true nature of this task may generate issues of motivation in the long run, particularly since prescribed remedies often prove excruciatingly slow in taking effect. To venture a speculation, compared to childhood diseases like cancer and diabetes, obesity may be experienced less immediately as a disease. Which is to say, to be counteracted by specific, delineated medical measures, towards, as it were, the (re)establishment of some corporeal equilibrium. Nevertheless, as ‘disease’, obesity in a sense affects the whole body (as well as, semantically, the total personality) of the fat individual; more literally, the task of slimming must involve

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78 This can be compared to a recent lesson learned: “It is notable that the more robust or intense form of exercise appeared to enhance perceptions of enjoyment, whereas the low intensity placebo exercise condition did not. This is contrary to some suggestions in the literature that low intensity exercise would be preferable in overweight/obese cohorts, due to their discomfort or fear of robust/intensive exercise.”

79 “Patient-meaningful” implies that youngsters will expect to lose tangible weight, say, see changes in physical appearance, etc.; whereas the medical aim of treatment might be the more opaque “health benefits” often associated with weight loss or “build-up of lean body-mass”, perhaps more than actual reduction in body size.
the entire life of the obese individual. For a lot of patients this really makes the experience of living life as a large individual, a double bind.

Based on what I've argued so far, the obese bodily experience in youth will be seen as faceted and differing among individuals according to her circumstances and experiences; often, “being fat” makes the individual grasp for some “explanation” – since the condition is often ascribed by others to an individual's behaviour; moreover, dominant discourse weighs very heavily on how a large youth is able to articulate his or her bodily experience; all though, being large, in and of itself, is not always bound to be only as negative as the image suggested by dominant discourse; finally, dominant discourse has the power to instil in the individual a mindset where not feeling bad for being fat is, in the long run, all but impossible. Having uncovered something about what being fat entails to Norwegian youngsters, we now turn to a closer look at how they might relate to the discourse of treatment and specifically the means they have at their disposal to comply with recommendations pertaining to physical activity.

**Getting Thin by Doing More?**

It has been argued that to sustain “healthier habits” children often need to develop a brand new habitus (Lindelof, Vinther Nielsen & Pedersen, 2010). In the relevant literature, beyond consumption this healthier lifestyle largely predicates on an individual achieving higher levels of energy expenditure in daily life. The reminder of the discussion is taken up with physical activity as a means to achieving weigh loss. The debate is meant to crescendo into the fullest possible discussion on Berit's ergonomic potential and ability to perform the actions involved in physical activity, which is likely to be a seminal part of any weight loss endeavour. I have chosen this path because her particular experience on this subject is illustrative of how eschewed our cultural understanding of obese bodies is.

**“Must Be More Active!”**

I have pointed to a “void” in our knowledge on physical activity and obesity – between scientific uncertainty and the textbook projections of gospel truth which permeates the domain of public health, schools and media etc. This void has been sized upon, as I have mentioned, by critical fat scholars (Gard & Wright, 2005; Kirk, 2006; Evans et al, 2008; Hals et al., 2009; Rail et al, 2010; Harjumen, 2009). Gard and Wright (2005, p. 121) argue, for instance that, “considerable uncertainty exists concerning whether inactivity causes overweight and obesity or whether, conversely, (for whatever reason)
overweight and obesity lead to lower levels of activity”. To which Rowland (2007) adds the following: “Suppose a study indicates that three-day physical activity levels in a group of obese 10-year-old boys are significantly less than in a control group of lean children. Does this mean that lower levels of physical activity tip the energy balance and cause accumulation of body fat? Or do the findings imply instead that obese children, because of physical bulk, are less prone to exercise? The answer is not clear”. But even if critical voices are beginning to break through the din, it remains to be seen what effect this will have on the administration of physical activity as a remedy for obesity among children. With reference to the above summary on the extant knowledge on obesity and physical activity in childhood, it is my contention that the picture still needs nuance. More awareness might for instance be needed regarding optimal level of intensity in terms of the highly personal nexus “energy effectiveness vs. ergonomic functionality” – i.e. how to burn the maximum amount of kilojoules over time at a serviceable level of intensity, which is: the “appropriate physical activity” (Hills, Okely & Baur, 2010) – in each case. Perhaps even a realization that contrary to a common perception in ongoing discourses, physical activity is not always a sure-fire remedy for obesity. A crucial element in this scenario is that modern Western society prescribes increased activity to shape-up hefty bodies without, as I suggest, fully grasping how individuals are adapted corporally to and may be affected by the task.

Indication of this variation can be had with anecdotal reference to the wider group of patients in the treatment programme. Amongst the group of youngsters taking part in the exercise component of the treatment programme, informally I encountered two youngsters (nonparticipant patients) who had shed substantial body mass, in fact having ostensibly been able to normalize their weight. A larger segment of patients is reported to have experienced moderate weight loss or increased levels of lean tissue as a consequence of participation in the exercise. Then there is perhaps the majority, those who have laboured admirably (more or less, as the case may be), but to little avail in terms of weight loss. In the reminder of the discussion, the overall argument I wish to make is that while no-one doubts that exercise carries benefits to health beyond induction of weight-loss itself, if increased physical activity is promoted specifically as

80 I plan to explore this topic further in a forthcoming article tentatively titled Physical Educators, Fat kids, and obesity discourse – a need for a critical pedagogy in physical education.
Not only will-power

It is clear that competence and confidence at some level intertwine, with bearing on a person's desire and stamina vis-à-vis performance of physical activities (e.g. Sallis, 2007). In the initial overview discussion, I identify a number of such factors beyond the conscious control of individuals playing on different levels on a person’s desire and ability to exert. These combine to put many obese people at a very skewed position vis-à-vis participation in exercise as a means towards weight maintenance. External factors may work to dually offset a day’s potential for energy expenditure as well as an obese youngster’s overall attitude to participation in physical activities. Beyond this, it has been upheld as essential that young people are given opportunity to engage in activities they enjoy and do not perceive as embarrassing (Armstrong & Welsman, 1997; also Hansen, 2005; Bauer, Yang & Austin, 2004). This seems important inasmuch as “long-term compliance might be higher if they engage in activities they like instead of clubbased exercise they dislike” (Lindelof, Vinther Nielsen & Pedersen, 2010). These factors hint at the importance as to the presence of user-friendly amenities within walking distance of communities, in calling on young people of all weight groups to become more physically active. These structural and societal influences include density of sport facilities and the availability of organized activities – access to which should not be taken lightly when discussing young obesity patients’ complying with the concept of “lifestyle change”.

By way of an example, Tareq, the bullied Pakistani boy, spoke to me about the fun time he had had visiting family in the US, where he had had occasion to play outside and ride bikes with other kids. The very mention of this as a peculiar experience in his life, made me keep in mind that it may not always seem feasible to «be more active» in everyday life. Other than that, several participants and family-members in the project

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were able to articulate sharp lines of argumentation regarding less than perfect access to physical activity opportunities and the effect this had on their exercise regiments. Which is to say, they were able to pin-point societal mechanisms – rather than personal ones (but those too!) – that could be seen to contribute to the prevalence of childhood obesity. No mere fib, participants made repeated issue of having limited opportunity to participate in organised exercise, such as sports teams. One might include in this category attitudes towards large individuals prevalent among leisure-time physical instructors – who may be prone to seeing performance, after all, as more important than participation. Kim, “attended three practices [with a regular sports-team], but [I] sat on the bench the entire time. You might say the trainers had some ideas about fat people! But we’re trying to be sporty and meet the recommended levels of activity” (CF: Bauer, Yang & Austin, 2004). Whereas, Espen's mother despaired – “What team will let these kids play in a match?” I introduce Espen above; though ever energetic, he is not strong on motor skills. That is why, his mother told me she wanted him to do karate, to learn body-control. “Espen was on a football team for a while”, she explained. “He didn't really get which way to kick the ball. They put him on the bench when the other boys started getting a bit better...That's the way it often is with these kids who train here,” she said referring to the exercise component.

This is probably why many participants lamented the termination of the exercise organized through the treatment programme – which for many had had the added advantage of taking place in a supportive social environment, with other young people in similar circumstances.\(^{82}\) It should be remembered that when obese kids engage in physical activity it is often done in public, exposing them to a less than fat-friendly environment. In other words, physical activity must often be performed in “contexts long governed by performance and perfection rather than competency codes” (Evans & Davies, 2004, p. 7). Coupled with a perception of poor physical ability among fat children, this can be expected to take its toll on many, even though, like the participants in the present project “most overweight children remain positive about physical activity [...] aware of the associated health benefits” (Fox & Edmunds, 2000). Like Tariq, the bullied Pakistani boy, who reported enjoying exercise training in the form of martial arts. He confided:

\(^{82}\) The implication is that it might just be easier to not-do-all-that-well when the experiences of others can be seen and learned from – all in the same boat.
I used to do Tae-kwan-do earlier, but I didn't feel motivated to continue. Those people didn't know how to motivate the children. I have been doing kick-boxing for a while now and that is much more inspiring. I have a yellow belt and I would have excelled another belt up, if I hadn't been sick a lot back then...

This, I took to mean he doesn't mind doing sports as such. As he said: “Before, I used to be reluctant to try new activities, but now I wanna try a bit before I make up my mind...!”

In terms of preference, I found it interesting to note that Razzaq and Ulrik could unite in stating harder exercise as more enjoyable. To digress slightly, as I elaborate in the papers, these two are among as many as four boys in the sample who attend what they all described as “special schools”, with curricula tuned more to practical learning and with an element of some physical labour mixed in. Peter, for instance, told me he is presently in the “wood and carpentry group”, which is a bit “heavy” – “You carry forty kilo sacks of firewood in the forest”, and this is remarkably similar to how Ulrik described his school day: “My school is gym all the time” (Paper I). Among these boys, there is certainly an element of involvement in daily high intensity energy expenditure. Moreover, both Razzaq and Ulrik commented to the effect of liking gym in school more than the exercise training, because “it is harder” – which in Ulrik's case I took to bespeak a hope that a suitable, challenging, physical activity might go some way towards getting him active in his free time. For someone like Ulrik, the “special circumstances” of the exercise training through the treatment programme would seem to represent all that he hates about the whole weight loss process – anything that smacks of “weakness”. A recent recommendation has been made, seemingly just for Ulrik’s type: “Being surrounded by more advanced pupils might also motivate subjects to train harder in such an environment, and it may inspire the subjects in other psychosocial aspects, which may not have been possible to achieve in a hospital clinic, surrounded by other novice study participants (Tsang et al, 2013). On a more general level, I would certainly not conclude that the participants as a group articulated a dislike for physical activity in its own right; beyond that, I’d say that in fact, all of them had understood the role physical activity is ascribed in terms of treatment. It may be quite another thing, obviously, to find the motivation in everyday life to meet the recommendations for activity.
Nevertheless, if access to socially inclusive organized sports activities rings true as a factor in the activity levels of normal-bodied youngsters, it may be reasonable to question whether this applies all the more to children with extensive weight issues. It may be useful to keep that rhetorical question with us, as we investigate an influence on obese individuals’ levels of physical activity which can only be surmised among those listed above – somehow alluded to in the fault line between skills and constraints. Namely, how bodies-as-organisms influence the propensity to execute movement, and thereby, more or less, radically alter an individual’s balance of energy. First a brief recap of the introductory discussion on the propensity of human organisms to achieve weight loss mechanically.

Weight-loss. Sounds Easy – Exceedingly Difficult

The above summary on physical activity as treatment for paediatric obesity was not intended to launch a major revision of the biological facts related to paediatric obesity and physical activity. Merely to lay the groundwork and open for questioning, from a patient perspective, one of the more fundamental “truths” in obesity discourse, that “physical activity” will induce “weight loss” in equal measure in all comers. On the issue of physical activity as a means to weight loss, what can be accepted as incontrovertible beyond scientific controversy, is that better comprehension of the mechanisms that lead to intentional weight reduction is needed (Avenell et al, 2004). This statement is in a sense obvious, in as much as modern medicine has failed to stem and reverse the oft-reported globally increasing incidence of childhood obesity. At any rate, the crux of the summary, what we should bear in mind in the following, is the essential realization that not all large individuals stand to become thin, mechanically, by eating less and doing more (see e.g. Karavirta et al, 2011); certainly, for many, the weight loss process is bound to be painfully and incomprehensibly slow. This biomechanical conclusion is all but absent from Public Health messages propagating exercise.

At the same time, weight loss is the obvious aim – the holy grail of sorts – “body normalisation” is the ultimate focus of near all commentary on “the global obesity epidemic”. Though physical activity is often understood to be a cornerstone of obesity treatment, little is known about “how excess body mass affects adolescents’ capacity to perform sustained exercise” (Norman et al, 2005). As I note above, just as there are individual variations in terms of ability to perform physical activity, substantial individual variation exists in terms of biological responsiveness to exercise as
treatment for obesity. However, there is growing academic awareness that what we know about physical activity as treatment for obesity is “inconclusive” in general (Bouchard, Dépré, Tremblay, 1993; Jebb & Moore, 1999); and undetermined in terms of paediatric obesity in particular (Summerbell et al, 2006; Jain, 2005). As I make clear, the state of knowledge on this point is “extremely limited” (Bouchard & Blair, 1999; Reilly & McDowell, 2003). The findings of two recent meta-analyses are revealing: “Synthetic reviews on the effectiveness of interventions promoting PA among obese populations remain sparse [...] The global positive effect of interventions on PA must be interpreted cautiously” (Gourlan, Trouilloud & Sarrazin, 2011). And: “The evidence from controlled trials for successful behaviour change interventions is rather pessimistic” (Biddle, Brehm, Verheijden & Hopman-Rock, 2012). To recap the overall conclusion in the above discussion, in terms of “practical recommendations”, little has been written (Nowica & Flodmark, 2007) and research evaluating the effect of child and adolescent obesity treatment trials on physical activity is “limited in both quantity and quality” (Cliff, Okely, Morgan, Jones & Steele, 2010). There is not much that can be said in sum as to what works in terms of asking children to “be more active” in order to lose weight. There is in other words no way to give sound advice in each case, and that might leave room for disappointment and, ultimately, disillusionment.

Movement impaired

In the following, banal as it might seem, it is essential to bear in mind that individual bodies – and more so obese bodies – are unique in terms of size, shape, and fat distribution, as well as in the compactness and texture of body tissue, as pertains to the “ergonomic ability” to execute movements. I discuss the “ergonomic” angle in depth in Paper II, where I focus on Berit’s bodily comportment. To preview the line of argument developed there, embodying a large corpus may radically influence an individual’s ability to carry out physical movements (e.g. Parizkova 1982), and thus contribute to make activity cumbersome (Bouchard, Dépré & Tremblay, 1993) – particularly such as require support of body mass (Armstrong & Welsman, 1997). This may be why previous studies have observed “lower physical activity enjoyment” in overweight/obese children/adolescents (Tsang et al., 2013). Essentially,

83 Also, obese adolescents must apply, “increased cardiorespiratory effort required to move their larger body mass through space. The higher percentage of oxygen consumed during submaximal exercise indicates that overweight adolescents are burdened by the metabolic cost of their excess mass” (Norman et al, 2005).
to Berit, even seemingly trivial body tasks are sometimes made complicated. The actual complications involved would seem to stem from her weight but in combination with other body structural features, and it is particular kinds of weight-bearing activities where she is the most disadvantaged. She pointed out the running-mill as particularly trying and professed to prefer the spinning done on a stationary bike. As she explained it, physical activity is not loathsome to her *per se*; not at all. Her commitment should be proof of that. As I've stated, she harbours a strong incentive to “*be in activity*” (to render a translated Norwegian term) and upheld swimming and walking as favoured forms, despite the ergonomic challenges to the latter as elaborated in the paper. Some of the activities we did together allowed her to employ her body with more ease and indeed use her dimension to some advantage. Playing the “air-hockey” game for instance seemed to me to be one such activity, which I might briefly describe for maximal nuance. After bowling we made a habit of playing a few rounds of this game, as it was evident that she both enjoyed the activity in itself and that she felt her body did not represent much of a hindrance. This was somewhat true to billiards, too, which she seemed to enjoy as, “You don't have to be strong to do this! The bowling ball is pretty heavy...” Supporting herself with her arm, she could lean in over the billiard table to manipulate her body to the most functional angle – the same technique she'd employ playing air-hockey. Defending her side of the air-hockey “field” she would glide the little puck across the table with manoeuvrability and controlled movements. I noted in my fieldnotes one afternoon that her body-movements in this scenario seemed “*decisive and assertive*”, quite in contrast to the more weight-bearing mode of moving her body. Berit would show her appreciation of this activity by smiling broadly and even teasing her opponent whenever winning a game. Playing both billiards and air-hockey – doing this she stands firm on two feet and has good support – she was able to use her body with a degree of confidence.

Having said that, the disadvantages to being fat in terms of movement must be explored more fully, and a brief look at how another participant is hampered by corporeal dimensions and structure will enlighten on how a massive body might force some obese individuals to accommodate movements of the limbs. Thus we might get a clearer picture of what movement might entail for someone very large. Now of Razzaq, it was said that, “…he has become so fat, he has a hard time participating in some of the exercises [in the training organized through the treatment programme]”. Movement seems even more complicated for his young-adult sister, Parveen, whose bodily
The proportions are not dissimilar to Berit’s. The following, short empirical exposé may therefore be of interest, even though by virtue of her larger muscle mass and more advanced physical maturity, Parveen is, if anything, probably better ergo-anatomically equipped than Berit to handle her body in exertive situations. Parveen came along with her brother for an afternoon of bowling. When engaging in this activity, for Parveen, physio-anatomically for her to bring her arm from behind her back to extend it forward in making a throw, is difficult. Her upper arm, shoulders, and torso appeared to be of size and tissue-composure as to leave her unable to swing her arm pendulum-like, unhindered. Rather, to avoid the trajectory being mired by her torso, she was observably forced to move her arm forward in a semi-circle rotation. For her to execute the particular series of movements involved seemed to necessitate her mobilising a fair share of her force – which, by muscular strength and her body’s momentum, is visibly considerable. By painstakingly manoeuvring her upper body to a specific angle, she is then able to compensate for reduced upper-limb functionality and lack of competence at physical activity, with raw strength. Observing her having to substantially accommodate her movements, however, made me cognisant that for her, the level of force she must necessarily bring to bear on the bowling ball entails that the operation takes on an entirely different dimension then it does to say, me, who inhabit a body which is clearly much closer to the “normative body” (Smiet, 2012) of classical phenomenology, a point I raise in Analytical Frameworks. There, I introduce the idea that in that scholarly tradition, “the body” constitutes a very particular type of body and this has contributed to (and is symptomatic of) the narrow definition circulating in the wider Western cultural canon of what human bodies are and do. It can be straightforward observed that Parveen’s mobility is reduces due to her girth, that her movement is impaired as it were – but an observer might not is automatically reflect on how her body likely makes for an ergonomic entity which produces qualitatively different and unique experiential input, which is so central to our understanding of the world. I wish to prepare the reader to the notion that such input from daily lived experience surely play into the differences in terms of what it means “to be a fat body compared to a thin body” (Smiet, 2012). This minute insight is intended as a prelude to the following debate on obesity and physical activity – which is based on a notion that existing within the confines of a very large body can make bodily movement a radically disparate undertaking than for slim individuals. Wiser to the vantage-point a

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84 Parveen and her brother Razzaq are discussed more extensively in Paper III.
very large body might generate, we are now slightly better positioned to appreciate how many obese people get a raw deal when admonished to “exercise more!” The discussion so far has been intended to build up to this very point, in that we have now examined the various streams that run in confluence at the culturally construed imperative for weight loss for young people and their means to comply. For the reminder of the discussion we turn focus squarely to Berit. (She is certainly owned that honour here).

A Dream of Weight Loss

Berit, it seemed clear to me, harbours a strong personal desire to shed substantial weight. However, for all her prolonged efforts, given her size and dimensions, it has proved mechanically impossible to achieve a sufficient “deficit between caloric intake and energy expenditure” (Lombard & Lombard, 2003) – to actually slim. Essentially, the line of argumentation developed so far has built up to the following question. Surely there is reasonable doubt that the amount of weight Berit yearns to loose will, in clinical terms, prove unrealistic if not quite simply an impossible goal – for someone in her shoes? That is, within the framework of what can be said with certainty about the effects of exercise on adipose tissue in children and adolescents. The discussion so far has pointed to variation between individuals in obesity in all factors ranging from aetiology and risk to the ability to expend energy. This suggests that the total life circumstances of some individuals will congeal in ways that make obesity almost impossible to counteract or regulate to “normality”. At the confluence of these arguments we might finally appreciate the enormity, constancy and intensity of the actual effort involved for a young girl, Berit, to achieve the weight and shape of her dreams. (Sufficient time has since passed to make the following argument hypothetical). In strictly physical terms, at core this is a question of physiological ability to elevate sufficiently the rate of energy expenditure by available bodily means. For Berit, what is at stake, though, are expectations.

As will be clear from the paper, the tragedy of Berit’s situation is directly related to the fact that very few cultural articulations are able to do her bodily reality justice in terms of ergonomic functionality. “Laziness” is the only message conveyed. Which is to say – the society in which she shares part sees reason to believe that if only she exerts herself, she will be thin. The following part of the discussion is intended to bring light to the process whereby medicoscientific mediated and culturally grounded expectations
of weight loss may come across as exaggerated vis-à-vis an individual’s de facto prospects of such an achievement. There is little point here to attempt to give measure of the precise energy count of the physical activities Berit engages in during the course of a week. Suffice to say, both daughter and mother were adamant Berit fulfils the official recommendations regarding physical activity. Berit confirmed her exercise regime: Walking twenty-thirty minutes to and from school every day; regular gym classes; twice-weekly exercise through the programme; additional leisure activities, such as excursions and “exercising at home”. To indicate the pair’s focus, Berit's participation in the present research project was agreed partly on account that this would be beneficial towards Berit’s total energy expenditure, seeing that we would primarily be doing activities together.

A common theme in our talks and interaction was that Turid did not seem to think Berit was active enough throughout the course of the day. Berit, for the most part shares this opinion, at least on a theoretical level; but finding the will to actually exert more in everyday life, sometimes seems hard. Her actual levels of energy expenditure over the past two years in treatment notwithstanding, by her efforts (a combined strategy centred on energy-in/energy-out), Berit has lost agonizingly little weight. This brought me to believe there are two irreconcilable strands of thought running through her life. There is the strong urge to slim down – for reasons of aesthetics, health, social concerns, pressure from family, medical staff and teachers, and also because large bodies are cumbersome to live. On the other hand, there is the very real issue of motivation: to persevere at training several days a week in organized exercise; to always face having to think about everything in terms of one’s weight; and in terms of maintaining everyday limits to temptations – but also: physical fatigue, occasional disillusionment, and not to mention a feeling of personal shortcomings when weight-loss has failed to materialize after a particularly vigorous period or stint.

**Movement-as-Treatment**

Certainly not lost on her mother, Berit is unmistakably not a stationary child, inert and entirely docile. She “easily” accumulates, I’d say, on most days, “one hour of every-day activities” (Nowica & Flodmark, 2007). Even so, both spoke throughout about increasing their levels of physical activity as highly important to their common project of “lifestyle change”. Berit described her participation in the organized exercise of the program, as –
Fun! It’s nice to train there, they have ‘spinning’. That’s kinda fun. I go twice a week…Exercise is fun!

This is stated here, obviously, to pre-empt any thought that her problem with exertion is one of stark laziness alone, to bring to the fore that there are other factors that sometimes cause her consternation when being in activity. However, indicative of the complexity of the issue, Turid repeatedly lamented her “difficulties in getting Berit motivated to participate” in physical activity – “she is just too lazy”. Turid nevertheless recognized the influence of her own attitude. Not one to sanitise impressions or shy from broaching any topic; “We used to be very lazy”, she said forthright; “I walked quite a bit myself though…Berit didn’t wolf down large quantities of food or anything! It wasn’t like that. She just didn’t move very much”.

Turid also pointed out that following her participation in exercise as part of the treatment, as a side-effect, Berit had become a little more confident at movement. In addition to “being less scared of the basketball”, and consequently now somewhat happier to participate in gym-class, her improved level of body-confidence had allowed Berit to adopt “a noticeably easier gait”. At this point of our conversation (one of two without Berit present), it suddenly dawned on Turid – midsentence – that this had had the unintentional effect of Berit preserving energy by lately walking more efficiently. A pragmatic parent, this realization made it instantly important for Turid to find means of compensating for Berit’s reduced energy-expenditure; saying – “come to think of it, that means we should intensify our efforts even more, then! I never thought of that.”

Turid deemed the tuned regime she had fostered in terms of exercise no longer sufficient – hitherto, “ten thousand steps per day. That’s the recommendation” – “verified”, as she pointed out, “by pedometer”. Turid referred to their participation in the Every-Step-

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85 CF: “Patients were capable of walking progressively faster due to the combined effects of body weight loss and improved physical fitness” (Foss, Lampman & Schteingart, 1980). And, “Many patients progressed to continuously walking one or two miles even though they had achieved only modest losses toward their body weight goals” (Foss, Lampman & Schteingart, 1976).

86 This should be recognized as something of an insight into a significant mechanism whereby culturally-engrained perceptions of the human body, body-fat, and the precept of exercising the second from the first, has up to this point prevented her from more fully grasping her daughter’s bodily reality. This thread is spun further in the article.
Counts Campaign as an example of their habit of embracing “all official recommendations” on exertion.\(^{87}\)

**Physical Activity, Prospects of Weight-loss**

The literature notes that obese patients often experience less-than-optimal treatment when consulting primary medical care-givers.\(^{88}\) Reported critique often hinges on the inevitability of the advice given – irrespective of ailment or complaint, to the effect of “eat less and do more!” The aetiological basis of that instantaneous admonishment seems often to remain unquestioned (Gard & Wright, 2005, p. 37). For Berit, for one, such cure-all is not always easily catered to. In a nutshell, beyond her rather poor motor skills, ergonomically speaking, her body is simply incapable of achieving sufficient energy-expenditure to normalize her body weight. Indeed, it is something of an understatement to say that Berit experienced the weight loss process as fraught with friction.

I might note *obiter dictum* that in terms of intake, Berit has adopted an impressive array of devices to help her withstand everyday temptations, and in her mother’s words – “does much better at it than me”. In my opinion, there is little doubt Berit wishes very keenly to loose weight, even “to become thin” – perhaps more so than other participants. She ties this desire explicitly to energy-intake and exercise. It may therefore be ventured that her aetiological understanding of obesity is largely commensurate with that of the treatment programme.

During our interaction it surfaced that, two long years as an obesity patient has produced what to her amounts to depressingly meagre results. She has – to her great credit – successfully increased her proportion of lean mass; though, to her this achievement seems a fairly moot point. Her body’s resilience to weight reduction and the exceedingly slow process of visible change, at times make difficult, it seems

\(^{87}\) The slogan of this highly profiled, though short-lived public health campaign – at once very concrete and dubiously metaphorical – underscores current notions both on exercise and the promise this pursuit holds towards ‘making things right’. Responsible for mass-distributing the gadget by which Turid substantiated her claim, the campaign prevailed upon individuals to walk daily the number of steps she referred to. As an aside, this might be seen to illustrate Valverde’s notion (1998: 17) that, “Our desire for freedom and the requirements of the authorities have become increasingly aligned” (See also Harjunen, 2009).

\(^{88}\) Cameron, Norgan & Ellison, 2006; Edmunds, 2005; Foster et al., 2003; Schwartz et al, 2003; Teachman & Brownell, 2001.
reasonable to say, her daily efforts at meeting recommendations for activity. Herein lays the problem. A female adolescent set to all-consuming duty, *ad perpetuum*, at ever-so-slight returns – it strikes me as perfectly reasonable that Berit at times should find weight loss a veritable Sisyphean task. For her, movement in general being (relatively more) tiresome, much activity is downright cumbersome and gravitates almost by definition towards embarrassment. Worse still, according to the damning verdict of the scale, it is not even very effective in terms of what motivates her to engage in strenuous activity in the first place (viz. becoming thin). Closer scrutiny, then, should make convincingly plain that Berit’s stamina, *by any standard*, is nothing short of laudable. One does well to pay heed to the enormous discrepancy between the sustained efforts, the sheer persistence, constancy and intensity required clinically speaking, and what to a twelve-year-old must seem like an incomprehensibly prolonged delay of results. This is in fact represents a *third* burden in obesity, inasmuch as that condition is – 1) a form of corporeality made heavier to bear by, 2) a lack of cultural signs and signals capable of adequately articulating one’s bodily reality and 3), a *gap* between medico-oriented expectations of weight loss and the intensity and durability of the actual task.

The first component of the equation is obvious and needs no further elaboration; the second, I explore in depth in *Paper II*; while the third component is not a new argument (though seldom heard!) Hilda Bruch, for instance – who opined that even those medically responsible, “will promise success and resolution of life’s difficulties as a reward for becoming slim” – in a classic of the discipline, warned against encouraging, “romantic notions about the likely by-products of a triumphant effort at weight reduction” (quoted in Mayer, 1968, p. 99). On this note, in closing, I therefore argue with Zametkin, Zoon, Klein & Munson (2004) that, “health care providers should focus on modest weight loss goals that correlate with significant health benefits” (also, Golan & Crow, 2004). This may be one way to avoid young patients being disillusioned by the aforementioned gap between expectations and efforts.

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99 There, due to limited space in the paper, I refer to the *double* burden of obesity.
Conclusions

We inhabit what is often called an obesogenic world. It is clear that quite beyond the fundamental aetiology of the condition, obesity in children is the result of extremely complex cellular and social mechanisms; it is at once part disease, part behaviour. As we have seen both from the literature and in practice, the process of reversal is certainly no less intricate. This stands to reason in as far as the “global obesity epidemic” may not have reached its peak. I have argued that though many factors go into the development of obesity, effectively, only one is valorised against its regulation – self-control. I have taken as a fundamental trait of the obesity epidemic discourse that the resolve of this systemic development, a syndrome caused by many contributing factors (macroeconomic mechanisms in food supply, price and nourishment composition; access to sports facilities; global and local culture; human biology, thrifty genes as well as taste), is levied on the most minute and incidental parts of that system – namely, the individual. I have attempted to give insight into the daily lives of the young participants, broadly, how being fat as a child might influence your outlook in life. The material is mostly descriptive and contingent on my own presence in each scenario, which means that another research might draw entirely different conclusions. It also means that such as they are, conclusions are by and large foregone. It is still fruitful to summarize some of the major findings of the research.

In terms of how the obligation to assume responsibility for «being fat» and the process of body regulation, in short how the diagnosis of obesity plays out in the lives of the young patients, perhaps the most important observation I have made is the broad variation. An important conclusion, then, is that there is no such thing as a fat personality. As it were, obese children in Norway come in all shapes and weights, in all genders and ages, and from all ethnic groups (though marked distribution differences have been posited by quantitative research). On a general level, each individual’s handling of an obesity diagnosis is likely to be equally idiosyncratic and, though this may be construed as banal, that is in and of itself an important conclusion.

I find that for many of the participants having a weight issue often takes centre stage, in various guises and in many situations in life: namely, in public, among friends and in leisure, in school and gym-class, and importantly, for different reasons, when doing physical activity – and the list might be extended. At the same time, perhaps it is the
nature of the game that many of the children and adolescents would seem to experience
the idea of “responsibility for own health” as amongst the more tangible aspects of
precisely, “Health”. Like the school yard bully who does it for your own good so you'll
change! –in a sense, to use one final colloquialism, it's all very “passive/aggressive”.
We might conclude guilt is likely to be up there with the social stigma associated with
obesity even among fairly young individuals as a driving force for participation in
obesity treatment, body regulation and “lifestyle-change”, dieting or other extremely
unhealthy-but hopefully-slimming behaviour for that matter. The public attention
directed very much at the obese child's person (if also family) will often be among
motivating factors for weight loss, difficult as I have shown that to be.

However, I have also explicated on a segment of patients for whom being of a large
body is not necessarily all that traumatic and constitutes less of a social and
psychological burden. I have related how individuals from this patient sub-group may
display behaviour which is rather far removed from the spirit of treatment and these
might therefore represent a peculiar public health challenge. As I’ve intimated, this
might depend on factors like gender, age, personality type, and the shape and degree of
obesity on the body. Representing the dissenting voice, Ulrik made clear that the «soft
edges» of the exercise component of the treatment programme would be highly
alienating to him. I would conclude that perhaps his particular ilk is better off not being
treated, as a matter of speaking (in terms of physical activity), with kid gloves. If only
in terms of optimal treatment response, as I’ve said, it seems important to appreciate
how these differences in experience play out in the lives of the patients (à la «Skipping
ropes is not for him...»)

I call the variation I have reported in the above discussions and the three papers, the
«lived experience» of obesity (even as my own access to this symbolic material has
perhaps ultimately been moderate). This thesis has aimed to convey how the
responsibility for own health metered out to the youngsters in many cases amounts to
an extra burden in their lives. In the sense that this governmental dimension has the
power to corner many social encounters, always (or often) looms large to inform food
and activity choices, and generally, strains many obese individuals' sense of self-
identification. In extension to this, I think one of the most important conclusions I can
draw from the research process, is that current obesity discourses tend to place an
unfair if not unrealistic burden on the individual child. To be a very large youngster
and (a good) obesity patient, is to be subject to a constant pressure to conform and
comply. We have seen examples of children who seem to experience this pressure as corroding their motivation to pursue more optimal health related behaviour beyond actual weight status. This would seem to be the worst possible outcome in a public health perspective. (The discussion on obesity and physical activity above rests on a notion that there is such as thing as fat and fit.) Judging by statements from treatment staff it is fair to say that many patients in the programme, who might well see the whole weight loss process as simply too arduous and long-winded, will come to resign to the notion of being fat. This is then obviously viewed as a fairly serious concern. More knowledge is needed as to the mechanisms involved in this attrition and behavioural change among children and adolescents is a topic worthy of future qualitative research: Factors that go into children's decision- and identity-making processes in everyday life.

A related, very important realisation I have made from the research and literature is that no matter the effort invested, the time spent, the blood, sweat and tears, for some young people – perhaps like Berit and Kim – the dream of radical weight loss is likely to remain elusive. Statistically speaking, many obese children and more so adolescents will go on to face life as an obese adult (which is not to put it beyond an obese teenager to optimize her health, notwithstanding.) Indeed, “Not everyone has the physiological, social and cultural resources to achieve these things (thinness or ideal weight) and in some cases it may be impossible” (Evans et al, 2008, p. 53). Given that obesity in children is not likely to disappear in the near future, social research might fruitfully focus on an aesthetic dimension; how large children and adolescents order their lives around large-ness, dress large, engage the world as large individuals.

The present empirical material consists of first-hand information and the verbal input each participant contributed, meaning there are many aspect of life in each case I can say little about. For instance, for operational reasons, I have not primarily uncovered the intricacies of food choices in everyday life and my insight into how obese children make regular decisions pertaining to consumption is at best based on theirs and their families referring to such patterns. Future qualitative research may profit from paying even closer attention to the daily lives of obese youngsters, to learn more about choices and interactions, and researchers might benefit from partaking in more of life’s scenarios, say among friends, outdoors, in school if ethically feasible, doing sports, etc.
I have made a case that minority populations may have particular experiences and motivations in terms of obesity and treatment. To generalise, for Pakistani youth, life in Norway offers impulses that influence towards a health-conscious attitude, while some “cultural practices” pull in a direction that will be seen as contributing to obesity and other lifestyle diseases. Young Pakistani-Norwegians are under pressure to adopt Norwegian values, particularly those epitomised in “an active lifestyle” – and this will by definition be even more true to obesity patients; at the same time they likely face expectations from their surroundings to uphold some semblance of Pakistani cultural identity and practises in everyday life. This might include the religious duties that befall adolescents, the idea of gender-related modesty and the value traditionally placed on women doing sports and bodily exercise in general in the Pakistani community, and there is obviously the important cultural trait of eating, a habit which is known to often be slow in the changing.

Certainly, far from every young Pakistani-Norwegian is obese or suffers from diabetes. In the community, many youth obviously engage in regular physical activity and otherwise show themselves perfectly capable of steering a path through these socio-cultural messages. Many young Pakistanis will be aware of the specific health concerns associated with their ethnicity and various “lifestyle disease” – and feel strong incentive to comply, no matter their weight status. However, it should not be overlooked that likely this is also a question of social mobility and internal differentiation of modernity within the Pakistani community.

Meanwhile, in this project more specifically, particularly the Pakistani girls and their family members made issue of having difficulties with access to culturally sensitive physical activity venues where to engage in sports and at the same time meet expectations from parents etc. in terms of dressing modestly, avoiding brazen interaction and contact with males etc. I might therefore, optimistically, conclude that some of the hindrances “minority” girls, here represented by Pakistani-Norwegians, face to their participation in physical activity might be remedied by structural measures. Perhaps such as initiatives on municipal- and communal levels, including all-girl sports teams and localised training facilities with professional trainers. This is not to forget that I did observe participants lay bare personal and motivational factors for selfprofessed, though often “previous”, laziness. Obesity in youth is obviously very much a complicated issue and as everyone involved in treatment knows, there are no quick fixes.
On the other hand, the present research has uncovered that many participants including Norwegians and boys expressed a desire to and in fact did participate in physical activity of many kinds. However, not only Pakistani participants spoke of issues complicating their participation in such activities. Some may point to a «bias» in such statements – *fat kids finding excuses not to be active* – but what we should take away with us is: Structural measures can be taken to facilitate obese children's, including minorities, participation in physical activity (the effect of weight loss notwithstanding). We have for instance seen that many of the participants in this research, alongside other patients in the programme, regularly participated in the treatment programme's exercise component. Many possible reasons for this relative eagerness: A friendly or accepting environment for one; no competition to win (but that could go either way); while, it could actually be fun and it might just feel good. This very thesis rests on a notion that these children are under emotional pressure to do everything in their power to lose weight. In light of some of the discussions above, it may not be surprising that large children should appreciate the seclusion offered through this type of arrangement. Interestingly, most of the participants reported actually enjoying training when doing it there. As in relation to sub-groups among overweight children, this advocates making accessible sports facilities that provide obesity patients with a more fat-friendly environment and thus perhaps open for their more enthusiastic participation in physical activity generally. That is by no means an easy target. But a more flexible approach and a baseline of individual differences, motivations and restrains, might go some way to help create cultural symbols more in tune with the obese reality. Beyond that, the proposed lacuna of cultural representations that I argue potentially misrepresent some obese children’s lived experiences, can only be stopped up by paying closer attention to the whole picture in each case.

In closing, the above discussions show there is something to be said for taking seriously the label “chronic disease” and at the same time to seek out means to deflate some of the personal responsibility heaved on individual children to shed substantial weight. Because in some cases that is a biologically infeasible, and as suggested, even unsound, admonishment. I go as far as to suggest that childhood obesity in a sense is a price to pay for globalism – albeit a price which should be shouldered on a societal rather than an individual level. We must learn to accept the presence of obesity and more importantly, obese people, in our midst. Unrealistic expectations carry serious consequences and can deteriorate a young person’s resolve. For a share of the patient
group in question here, the only viable alternative will in fact be radical surgery, as attested by recent Norwegian research (Andersen et al., 2013).

Rather than think this a statement of defeat in terms of public health policy (Danielsen & Sundgot-Borgen, Aftenposten 05.03.13), this conclusion is, on a sociological level, inevitable, if slow in the coming and obscured from view by the powerful perception of morality which triumphs other explanations for obesity in childhood. “Inevitable”, not because fat children are so lazy and gluttonous, but because biology and sociology in reality is all tuned towards this development. All things considered, to finish on a polemical note, it is arguably denial of the macroeconomic and microbiological mechanisms at play in childhood obesity, which truly constitutes negligence.


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Obesity and minority


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Appendix: Preprepared Questions/Themes

Razzaq:

• What do you want to do when you grow up?
• What will your body look like in ten years time?
• What is your aim with being in the treatment program?
• How do you feel about the current shap of your body?
• How would you describe yourself?
• What are the advantages and diadalvantages about being large?

Parveen:

• How do you (as the family cook) relate to the advice they give to Razzaq in the program?
• How do you help Razzaq eat right?
• What do think makes Razzaq continue to gain weight?
• Are you concerned about your own weight?

Razzaq:

• What is your aim with being in the programme?
• What do you do yourself to lose weight?
• Is there any difference between gym in school and the exercise in the treatment programme?
• How do you relate to the advice they give you in the programme when you are in Pakistan? Food? Exercise?
• Do you have any overweight friends?
• Do large people have particular personality traits?
• What do you think when you see someone overweight on the street?

Razzaq:

• If you were thin – what would be different?
• What do you do to lose weight?
• Is there parts of your body you feel need or don't need change?
• What will it mean for your body to gain or to lose weight?
Berit:

• Which word do you use to describe yourself? One boy I spoke with uses the word 'Large', he thinks that is a good word. We decided to use that word when we talk. What do you think?
• How is buying clothes for you?
• What will you achieve from participating in the programme?
• Regarding being 'big' – how did you get to know that you are 'big'? How did you think about joining the programme?
• When you see large people on the street, how does that make you think?
• Are there any bad things about being overweight? We spoke about being bullied...

Hamza and Aisha:

• Last time you said you «had been lazy» – what did you mean?
• How is the swimming practice coming along?
• Does your family do things together outside?
• What do you mean when you say «Pakistanis watch more TV»?
• Why do you think Pakistanis are «less active»?
• Why do you want to «become thinner»? Will you be thin, do you think?
• You said Pakistanis think differently about body-size. Why?
• What do you do in your spare time?
• What do you think about Hijab in terms of «being active»? Teachers call it «a hindrance», what do you think?

Ulrik:

• One boy told me he wasn't embarrassed in the swimming pool and that kind of thing. Are you?
• Are there any situations where being «fat» makes you feel bad?
• How do you like gym in school?
• What do you think about the future? What will your body look like in ten years time?
• What do you do, as you see it, to lose weight?
• Do you talk to girls?
• What do you think are some of the reasons you're «fat»?
• How did Karl's words to you last time we met effect you afterwards? It looked like you had an epiphany...[Karl had confronted Ulrik rather directly]
• Has that conversation made a difference in terms of how you do things, say eat?
• When you told the nurse that you eat two litres of ice-cream – was that because you didn't think about it or to sort of tell them to mind their own business?
• You used words like «I am dead!» and «Very big» in describing how you might look in terms of your future body? Elaborate.

• [Karl has been through surgery and uses this as an effective scare tactic to make Ulrik pay attention.] Thoughts on surgery?

Peter:

• How is it like to be involved in the treatment program, do you think?
• What can you achieve by being involved there?
• What is your future plans?
• What do you think your body will look like in five or ten years?
• Which words do you use to describe yourself?
• What are the good and bad things about being large?
• How did you get to know that you are large? How did you get to be involved in the programme?