HEALTHISM AND THE EXPERIENCES OF SOCIAL, HEALTHCARE AND SELF-STIGMA OF WOMEN WITH HIGHER-WEIGHT

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Abstract

This study analyses how the discourse of healthism contributes to the social construction of weight stigma in women with higher-weight. In-depth semi-structured interviews were conducted with nine women who had undergone bariatric surgery and had lived with higher-weight during many years. A thematic analysis from a latent and constructionist perspective showed how the discourse of healthism was behind the experiences of stigma lived by the participants in the social and healthcare field. Even instances of self-stigma were found in our data. This study also illustrates how people influenced by healthism assumed individualism and the importance of body shape, core values of neoliberal consumer societies. In this way, people tended to blame women with higher-weight for their weight and to discriminate against for being far from the socially-established ideal body. The findings can be useful to prevent weight stigmatization and to promote more appropriate and respectful strategies for obesity prevention and treatment.

Keywords: Individualism, ideal body, origin, controllability, concealability

Introduction

Weight-based stereotypes and negative attitudes against higher-weight people have been well documented by the scientific literature (Puhl *et al*, 2008; Puhl and Suh, 2015). Numerous studies have reported clear and consistent weight prejudices toward individuals under this condition, who are accused of being impulsive and lazy, and of having poor willpower, motivation and personal control (Crandall and Schiffhauer, 1998; Puhl and Heuer, 2010). These kinds of social attitudes lead to stigma and discrimination in multiple contexts of the daily life of people with higher-weight. For

instance, when they receive healthcare (Phelan *et al*, 2015), try to find a job (Giel *et al*, 2012; Schulte *et al*, 2007), are at work (Friedman *et al*, 2008; Hayden *et al*, 2010), or even in their social relationships with friends and close relatives (Puhl *et al*, 2008).

These circumstances have a profound impact on the psychological and social well-being of people with higher-weight (Sikorski *et al*, 2015). Research has shown that weight stigmatization is a significant risk factor for psychological stress, body dissatisfaction, depression, and low self-esteem, among other psychological disorders (Annis *et al*, 2004; Friedman *et al*, 2008). In regard to social disorders, weight stigmatization is associated with avoidance, rejection, and marginalization (Puhl and Brownell, 2003). Moreover, there is increasing evidence which associates many of the consequences of weight stigma (e.g. psychological stress, anxiety and/or negative mood) with the excessive activation of hormonal mechanisms (such as glucocorticoids and cortisol) that lead to weight gain (Muennig, 2008).

In a context where stigma is considered a fundamental cause of health disparities and therefore a clear problem for public health (Hatzenbuehler *et al*, 2013), it is necessary to be aware of the existence of certain socially constructed discourses that aggravate weight stigmatization (Gard and Wright, 2001; Turrini, 2015). These discourses are manifested in the daily life and face-to-face interactions of people with higher-weight, and can ultimately be internalized and accepted by individuals themselves (Crocker, 1999). Understanding this problem becomes even more essential when it is referred to women, who usually report higher levels of weight-based stigma when they do not conform to the prevailing body discourses (Puhl *et al*, 2008). The ideal body for women has been associated with youth, beauty, sensuality and thinness, and the social pressure to have an ideal body has historically been higher for women than men (Toro, 2003).

Therefore, the aim of this study was to analyse how the discourse of healthism contributes to the social construction of weight stigma by interpreting the reported experiences and opinions of women with higher-weight. Concretely, informed by the theoretical framework described in the following section, we explored the influence of healthism on social stigma, healthcare stigma and self-stigma, considering different dimensions closely related to weight-stigma (*origin*, *controllability*, *concealability*, *aesthetics* and *pity*). Analysing these issues could be useful to prevent or alleviate stigmatizing situations and their negative consequences in people with higher-weight. It is necessary to remark that this study was underpinned by a relativist ontology, which conceives that social reality is subjectively perceived and humanly constructed, and a constructionist epistemology, which assumes that there is no theory-free or value-free generation of knowledge (Sparkes and Smith, 2014).

The discourse of healthism and weight stigmatization

Western society is characterized by the growing extension and application of principles of the economy and business administration (competition, competitiveness, productivity, efficiency, effectiveness, among others) to spheres of social and individual life that have nothing to do with these fields, such as the everyday language of people (Kenny, 2015; Marsi, 2007). This "economizing" phenomenon has come to affect the social relationships between people, influencing their cognitive processes and way of thinking, and assimilating them to consumer relationships. Precisely, one of the clearest consequences of this economizing effect of society is the primacy of the "economic behavior" of people and institutions over moral values and human ethics, which, in fact, have also been "economized" (Shamir, 2008).

A clear consequence of these ethical changes is the individualization of responsibility, which falls entirely within the person because of the emergence of the neoliberal notion of individualism over collectivism in these societies (Freeberg and Stein, 1996; Rhee *et al*, 1996). The weakening of collectivism has caused that the individual is considered the only one responsible, and therefore the architect of their success or failure. Thus, if the individual does not have success, it is due to her/his moral failing, self-indulgence and lack of self-discipline (Quinn and Crocker, 1999).

What is conceived as "success" or "failure" is often previously established according to a set of social standards and norms that the person must accomplish (Quinn and Crocker, 1999). Social discourses play a fundamental role in the consolidation and maintenance of these social standards and norms (Evans *et al*, 2004; Mansfield and Rich, 2013). Sociologically speaking, discourses are a set of socially constructed ideas that people hold (un)consciously within their social life and which determine particular social practices, forms of subjectivity, and specific relations of power (Denison and Scott-Thomas, 2011). According to Rail *et al* (2010), social discourses demonstrate that social reality 'is made and not found', since the political, social and institutional interests participate in and manipulate its construction. For other authors, social discourses influence the way people understand and interpret their own selves and reality, and the way people behave in life (Beltrán-Carrillo *et al*, 2018).

Among the discourses rooted on neoliberal values are the so-called "discourses of obesity", as healthism (Beltrán-Carrillo *et al*, 2018; Crawford, 1980; Gard and Kirk, 2007; Gard and Wright, 2001; Johnson *et al*, 2013; Turrini, 2015). According to Crawford (1980), healthism can be understood as a form of medicalization that models popular beliefs, which causes a non-political conception of health promotion by situating the problem of health and disease, and its solutions, at the level of the

individual. For that reason, from the perspective of healthism, fatness is seen as a sign of the individual's failure and irresponsibility, who, despite having the necessary tools for its surveillance through various control techniques and disciplinary measures related to diet and physical activity, is not able to self-control her/his lifestyle (Evans *et al*, 2013; Gard and Wright, 2005; Rail *et al*, 2010). Thus, the person with higher-weight is considered a problem for individual and social productivity and competitiveness, and is accused of lack of self-discipline, and of being a lazy and irresponsible citizen (Puhl and Heuer, 2010; Rich *et al*, 2015).

Moreover, a fat body also moves the person away from the socially-established ideals of beauty and sensuality, so the person with higher-weight is considered as unsightly and is pressured to conform with these ideal standards (Shilling, 2012). Undoubtedly, healthism has much to do with a consumer society where the body is an important element in two ways. On the one hand, social agents (e.g. mass media, fashion industry, health and fitness clubs, etc.) use the body as an element of publicity, associating slim and/or muscular bodies with values of success, beauty, well-being or happiness, and therefore creating the particular vision that these are the ideal bodies to follow. On the other hand, the body is also used by these agents as a recipient of consumption of products and services to improve the beauty of the body (e.g. cosmetic surgery, creams and pills to lose weight, exercise, etc.). In this sense, body dissatisfaction and concerns about weight are "desirable" elements to promote consumerism within society (Cafri *et al*, 2005; López-Guimerà *et al*, 2010).

Therefore, healthism is positioning the body as a central indicator of fitness, health, and beauty, promoting simplistic relationships between health and body size/shape (Gard and Wright, 2001; Rail *et al*, 2010). Consequently, fat bodies are considered as unhealthy, while fit, slim and muscular bodies tend to be classified as healthy (Webb

and Quennerstedt, 2010). According to this discourse, avoiding a high weight and achieving health seem simple goals for healthism. People must manage their body through discipline, eating less or carefully and exercising more, and by managing a simple equation between expended and consumed calories to control their weight (Gard and Wright, 2001). Nevertheless, this hegemonic discourse obviates, in its attempt to give full responsibility to the individual, all the socioecological and structural determinants of health that surround the individual, such as the socio-economic status, education, employment, and the physical and social environment (Rail *et al*, 2010).

In short, this biased vision of social reality, magnified for years by public and political institutions, weight-loss companies, mass-media and positivist science has made people with higher-weight as one of the most stigmatized collectives today (Bell and Green, 2016; Meadows and Daníelsdóttir, 2016; Gard and Wright, 2001). For that reason, throughout this article we try to unmask how the discourse of healthism hides behind various stigmatizing life experiences of a group of women with higher-weight. Inspired by the research of Ahmedani (2011) on mental health stigma, we divide these experiences in social, healthcare and self- stigma experiences (see results and discussion). Moreover, in the reported information, we attempt to identify some relevant dimensions of stigma (as *origin*, *controllability*, *concealability*, *aesthetics* and *pity*) which promote that people with higher-weight are "stigmatized or seen as possessors of observable marks of unacceptable difference" (Goffman, 1963). Although these five dimensions were originally devised for mental stigma (Ahmedani, 2011; Corrigan *et al*, 2000; Feldman and Crandall, 2007; Jones *et al*, 1984), based on Goffman's initial conceptualization of stigma (1963), we present a novel approach in which we attempt to identify them in the stigma suffered by people with higher-weight, while also exploring the role that healthism plays in the creation and perpetuation of these dimensions.

Defining the dimensions briefly, *origin* would refer to whether the stigmatizing condition comes, at least in part, genetically inherited, or if the individual has acquired it throughout her/his life by other factors such as those that have to do with her/his lifestyle. This dimension is directly related to *controllability*, since if the stigmatizing condition is given by factors that society perceives as controllable, such as diet or exercise, it will be seen worse than a condition in which the habits of people have nothing to do, as in certain diseases. The visibility of the condition or *concealability* also plays a key role when society stigmatizes a person, since if one condition is difficult to conceal and is therefore easily identified, it will be more likely to be stigmatized. *Aesthetics* involves to what extent a stigma is displeasing to the visual sense and far from what society considers beautiful and desirable. Finally, these dimensions are related to *pity*, because society can show more or less sympathy and pity towards different stigmatizing conditions depending on the previous dimensions.

Methods

Participants

A total of nine women, aged between 31 and 60 years, participated in this qualitative study. They were women who had lived with higher-weight during many years of their lives, and that had made the decision to reduce it by undergoing bariatric surgery. In this regard, the participants were part of a post-operative research project which explored the physical, psycho-social and behavioural effects of a six-month physical activity program on bariatric patients. The inclusion criteria for participating in the research project hindered the access to a bigger sample. First, the inclusion criteria for bariatric surgery included having a body mass index (BMI) greater than 40 kg/m^2, or greater than

35 kg/m^2 with associated co-morbidity, and having no medical, psychological or social contraindication for surgery. Second, participants had to accept their involvement in the six-month PA program.

The program took place in 2012, within the sports facilities of a public university located in a city of the province of Alicante (Valencian Autonomy, Spain). At the time of the study, the economy of this city was mainly based in the footwear industry and tourism, where the most of population pertained to a middle socioeconomic status. The design and procedures of this research project was approved by the Ethical Research Board of the first author's university.

Data collection

Two in-depth semi-structured interviews were conducted and recorded with each participant to collect qualitative data. Both interviews lasted between 40 and 60 minutes. The first interviews were conducted after the six-month physical activity program, seven months after the surgical intervention. Although the main objective of these interviews was to gather information about the physical and psycho-social effects of the physical activity program in the participants, these interviews included questions related to the participants' experiences living with high weight (e.g., What has the high weight meant in your life? Do you think that society do everything possible to help people who have a high weight?). Very rich information was collected about experiences of stigmatization lived by these women, and the idea of the present study emerged. Then, taking advantage of a second round of interviews conducted one year later to analyse the factors hindering or favouring physical activity after the program, new questions about negative experiences related to living with high weight were included (e.g., Have you had any negative experiences related to your weight? How was

your day-to-day life with high weight? Which negative comments about your weight are the most annoying for you?). These questions were also focused on addressing gaps of information identified after the first round of interviews. It should be noted that one of the participants did not take part in the second interview, without giving any reason.

All interviews were audio recorded and transcribed verbatim by the interviewer immediately after conducting them. Transcriptions were analysed with the support of the software NVivo, which was used to organize and classify data efficiently (Bazeley and Jackson, 2013). Before the interviews, participants were informed about the aims and procedure of the study and signed written consent. In addition, the interviewer guaranteed the confidentiality of their testimonies, and the informants' anonymity was preserved by using pseudonyms.

Data analysis

After the transcription of the interviews, a thematic analysis was used to identify and report themes within our data set. First, all the text fragments related to weight stigma were selected in an inductive and descriptive process of initial codification. Second, we checked that the codes could be sorted in three main themes related to social, healthcare and self-stigma experiences, in line with the fields of stigma proposed by Ahmedani (2011). As the purpose of our study was not only to describe the data, but also to interpret them, we adopted a latent position to "go beyond the semantic content of the data" (Braun and Clarke, 2006). Then, we did a search for social theory which could serve us to analyse, interpret and make sense of the data. We finally selected the theory about healthism and weight stigma, previously described in this article, to analyse and interpret the information included in each of the three main themes. This strategy of analysis let us identify hidden ideas or assumptions behind the participants' testimonies,

related to how weight stigma is constructed, manifested and maintained by the social discourse of healthism. Additionally, it is important to remark that the write-up of the article is an important phase of thematic analysis (Braun and Clarke, 2006; Sparkes and Smith, 2014). During this phase, the analysis and the ideas it contains are refined and the authors seek a narrative which can offer a clear description and interpretation of the data.

The data analysis was led by the first author of this article, whereas the other authors played the role of critical friends, reviewing the process of analysis and sharing ideas and reflections with their colleague. The role of critical friends was useful to improve the quality of interpretations, as well as the rigor and trustworthiness of the data analysis (Smith and McGannon, 2018).

Results and discussion

Healthism and social stigma

The participants of this study reported having been stigmatized by people who associated their high weight condition with their alleged inability to maintain a normal diet, despite not really knowing their eating habits:

> Leslie: People laugh and say: "You are fat because you eat… It's because you eat and it's because you eat!" Always the same issue. And I didn't eat so much to be as I was [referring to her previous high weight condition].

> Emily: You go out on the street and some people always remark to you: "Oh, you are so fat! Go on a diet, as you are very fat…" As if it was so simple!

From the perspective of healthism, people with higher-weight are considered irresponsible for not being able to control their weight and lifestyle through disciplinary measures related to diet and exercise (Evans *et al*, 2013; Gard and Wright, 2005; Rail *et al*, 2010). This emphasis on individual responsibility is not casual, and seems to have its roots in the neoliberal value of individualism, so spread among postmodern societies. Thus, making reference to the dimensions of stigma proposed by Jones *et al* (1984) and Corrigan *et al* (2000), a society influenced by healthism tends to perceive that fatness is a highly *controllable* condition whose *origin* is related to a negligent lifestyle (Puhl & Heuer, 2010; Rich *et al*, 2015). This perception intensifies weight stigma. Ronda's quote illustrates the interconnection between both stigma dimensions and the dissonance between her personal reality and societal prejudices:

> Ronda: Society, or most of society, thinks that a fat person is fat because she/he wants to be fat. And you [society] are wrong. There are people who are big because they are sick, in my case, for example. I had a thyroid surgery ten years ago, and I wasn't able to lose as much weight as I wanted. And the thyroid made me gain weight, instead of losing it. But they [society] think that we are fat because we want to be.

It seems that the biased social perception of the *origin* and *controllability* of high weight involves a moral dimension of the body. The fat body becomes a symbol of negligence and lack of responsibility and willpower. In this way, society usually tends to feel little *pity* or sympathy for people with higher-weight. For this reason, some of them would even prefer to possess a less *controllable* stigma with an unfortunate *origin*, such as being blind, rather than having high weight (Brewis *et al*, 2011; Schwartz *et al*, 2006). This moral dimension of the body has practical effects when these people look for a job and enter social environments where body size/shape is valued:

> Ronda: I was looking for a job and I went to a gift shop … "Ok, you would do this job well but … you are chubby …." And I said, "Look, I am fat, but you are stupid, and my problem has a solution, but yours does not" [She remembers the situation with outrage and annoyance] And I turned around and went home …. That has always hurt me a lot. This is unfair not only for me, but for the rest of the people who are like me.
>
> Thelma: I've not been wanted in many jobs because I've been fat. For example, in cafes and places like these I would never ask for work. Never, because I knew I was going to go and they [owners] were going to say no. Many of that people usually say, "No, we don't look at the physique". Bullshit!

With regard to *concealability*, weight stigma is so visible and unconcealable compared to other stigmatizing conditions, such as some mental diseases (Ahmedani, 2011), that prejudices and marginalization toward people with higher-weight bodies seem even more frequent. Weight stigma becomes especially problematic when it reduces the possibilities to labour access, considering that unemployment is one of the main causes of social exclusion (Roehling *et al*, 2007). In some labour contexts such as shops and cafes, a higher-weight-body can clash with the core values of healthism and consumer culture. In this way, an employer influenced by this stigmatizing discourse could think that a person with a fat body could be less productive and hardworking, and could show an *aesthetic* far from the "ideal body" which could increase sales in this kind of stores. In fact, previous studies have highlighted the difficulties this collective find to get a job (Giel *et al*, 2012; Schulte *et al*, 2007).

Healthism and healthcare stigma

One women participating in this study reported to have felt stigmatized by healthcare professionals, who attributed any health problem to their weight, regardless of whether it was related to weight or not:

> Alice: I've done it [bariatric surgery] for me. Because I understand that obesity is not good for anyone. I don't know what happens, but we go to the doctor and everything is a consequence of… [high weight]. For example, I have varicose veins; "[Doctor's comment] Of course, if you work all day and with the weight you have, what do you expect?" Well, sure, but there are people who are not obese and also have varicose veins… Do only fat people have varicose veins? Or, for example, I went to the cardiologist because I felt a pain in my chest. The cardiologist told me "Considering your weight, and your diabetes profile, I give you five years to suffer a heart attack". We go to the doctor and all our problems are due to… [the high weight]. And sometimes they don't ask more or don't look beyond obesity…in order to see if the problem is not that.

In the same way, Alice declared that healthcare professionals did not propose her any additional solution to lose weight than controlling diet and exercise, while she missed a more intense supervision for achieving these behavioural changes:

> Alice: Now, for example, I have been operated on and I have been controlling my diet since May…but I have stagnated and there is no way to lose weight. And the last time I went to the surgeon, he told me: "You have to do more exercise or eat less." Well, I'm going to drink only water, because I'm eating only protein shakes and there's no way, I don't know.

> The only thing they [the doctors] tell you is "get on a diet". They should get involved a little bit more…

Moreover, health professionals doubted about her ability to autonomously control her weight with diet and physical exercise. These findings are in line with several studies indicating that health professionals base their intervention solely on these behavioural, individual and controllable factors (O'Brien *et al*, 2010; Raves *et al*, 2016). Therefore, the dimensions of *origin* and *controllability* were once again present in these experiences, supporting an individualistic discourse of healthism that centres all the attention on the individual. It is not surprising that health professionals adopt discourses of this type when they have been educated under an academic curriculum that has traditionally focused on the individual controllable aspects of high weight, undervaluing the importance of genetic, hormonal, social or environmental factors (O'Brien *et al*, 2010).

Like Turrini (2015) and Zola (1972), we suppose this fact is not fortuitous, since political and economic powers have often used the apparent neutrality, objectivity and scientific status of the medical approach to propagate the discourse of healthism and emphasize individual responsibility on health issues, avoiding their responsibilities at a socio-political level. With regard to the stigma dimensions of *concealability*, *aesthetics* and *pity*, high weight is clearly identifiable at a glance, and can be a symbol of "one's own health irresponsibility and negligence" for some health professionals who can show a lack of respect for their patients at times. In line with our results concerning healthcare stigma, previous research has pointed out that anti-fat attitudes and prejudices of health professionals towards people with higher-weight equate with or even surpass those reported by the general population (Phelan *et al*, 2015; Tomiyama *et al*, 2015; García *et al*, 2016).

Healthism and self-stigma

Healthism also influenced the perceptions and opinions of women with higher-weight. For instance, Ronda felt that her own body was hateful, and she even felt anger when her husband looked at her body:

> Ronda: I've never seen myself as pretty. I've always been a little bit ugly… I didn't like myself, either dressed or naked… When I was with my husband, I even felt anger when he stared at me, because I didn't feel pretty.

It seems that Ronda believed that the *aesthetics* of her body was far from the ideal body (slim, toned, young and beautiful). Perhaps she felt anger because she thought her husband could feel disgust or even *pity* about her body, whereas people usually desire to feel perceived as pretty or sexually attractive in intimate/romantic relationships. However, it is remarkable that Ronda showed this negative reaction without a negative comment or attitude of her husband. As previous authors have highlighted, the self-concept that this woman formed of herself seem to be the product of her own concern about how others might evaluate her, adopting the vision that other people could have of her (Crocker and Major, 1989). Moreover, this negative attitude towards herself could be a logical reaction as a result of previous discrimination experiences (Annis *et al*, 2004), together with the insistent information of a consumer society that encourages the pursuit of an ideal body (Shilling, 2012). Therefore, self-stigmatization seems to appear when women with higher-weight internalize healthism values around body shape and they assume they do not fit in the parameters established by this discourse. This circumstance negatively affects the physical and mental health of these people (Pearl and Puhl, 2016).

The findings of this study also brought to light a different manifestation of self-stigma. For instance, Leslie recognized herself to have stigmatized other people with higher-weight:

> Leslie: The fat person is rejected. I haven't felt like this, I repeat it again, but I see that there is a rejection… because there are very amorphous people who are very unpleasant to see. And I've not lived it, but I tell you, I was lucky that I wasn't amorphous. But I have seen it, you know? I have even rejected this type of people. And those people are... most of them have been people with sadness, sorrow... They usually aren't cheerful or nice people, right?

It is remarkable that Leslie made a distinction between "pleasant" or "unpleasant" people with higher-weight. She included herself in the "pleasant" group, and admitted to have rejected people belonging to the "unpleasant" group. This type of reaction may be related to a self-protective mechanism that stigmatized people use to protect their self-concept and self-esteem (Crocker and Major, 1989). According to these authors, disadvantaged individuals tend to compare themselves with stigmatized others, whose outcomes are also relatively poor, instead of with advantaged outgroup members. Then, the stigmatized people tend to make "ingroup" comparisons and avoid "outgroup" social comparisons which can be painful for them.

The distinction between the "pleasant" and "unpleasant" people with higher-weight was based on the stigma dimensions of *concealability* and *aesthetics*. However, according to healthism discourse, these dimensions related to bodily appearance were perceived as strongly associated with self-identity (a sad or unhappy person, with an unpleasant personality). Previous studies have also indicated that high weight is understood as a

problem for individual happiness and well-being (Beltrán-Carrillo *et al*, 2018; Mansfield and Rich, 2013), whereas consumer society identify the slim, muscular, young and beautiful body as a symbol of happiness and success (Shilling, 2012). This association, so spread in society, seemed to be also assumed by the women with higher-weight of this study:

> Interviewer: What do you think should be done [to help people with higher-weight]?
>
> Leslie: First, be aware of the problem. Some people seem to be happy being fat. I don't think anyone is happy being fat… honestly.

Conclusions and implications

In this study, we explored how weight stigma is constructed, manifested and maintained by the social discourse of healthism through experiences of social, healthcare and self-stigma in women with higher-weight. Moreover, we explored the role that healthism plays in the construction of some dimensions of stigma that are closely linked to weight-stigma (*origin*, *controllability*, *concealability*, *aesthetics* and *pity*).

Overviewing the aforementioned findings, our study brought to light the neoliberal values associated with healthism. It is important to remark that healthism and the so-called "obesity discourses" are not constructed by chance, but are determined by the interests of political and economic powers to propagate social beliefs that maintain the reality desired by them (Rail and Harvey, 1995). The consequences of these interests are manifested in the day-to-day lives of people who do not adjust to these social parameters, as is the case of people with higher-weight, causing situations of

stigmatization and discrimination that ultimately promote inequality and social injustice.

A representative example of this emerges in our study when obesity is understood as a health problem whose *origin* is associated with a negligent role of the individual who is not able to *control* her/his own weight and lifestyle. Comments regarding origin factors that fall under personal control, such as diet or exercise, hide the internalization of the notion of individualism that reigns over postmodern societies (Cockerham, 2005). In this way, a complex and multifactorial health problem is simplified and the responsibility that political institutions should have to promote the welfare of society is avoided or undervalued.

Healthism, through the exaltation of the healthy, fit, slim, muscular, and beautiful body, also plays an important role in the construction of *concealability* and *aesthetics* as stigma dimensions. Whereas the ideal body is a symbol of happiness, success, health and wellbeing, the fat body becomes a symbol of irresponsibility, sadness and embarrassment (Beltrán-Carrillo *et al*, 2018). These associations promote the marginalization of people with higher-weight and negatively affect their self-identities.

Several implications could be proposed from this study. Political and educational institutions, healthcare professionals and scientists should go beyond the problem of high weight and not stay on the surface. Individual responsibility regarding lifestyle is, without a doubt, very important for obesity prevention and treatment. Nevertheless, genetic, health, social and environmental factors should also be taken into account as part of the problem and the solution. In this sense, health professionals should avoid victim-blaming comments towards their patients with higher-weight and treat them with all due respect. These professionals could receive teaching courses about healthism

discourse, including strategies to avoid its negative effects in society and on their patients. Moreover, healthcare systems should offer precise recommendations and counselling services to help people with higher-weight to maintain a healthy diet and do beneficial exercise. Doctors, psychologists, nutritionists and sport sciences professionals should be part of work teams to guide these patients. Solutions beyond lifestyle changes should be also offered if obesity is related to other health problems or genetic factors.

At a macro-level, we should also aspire to construct a social and physical environment which could be appropriate for obesity prevention and treatment. We should accept this commitment in view of previous evidence, which points out that education, employment, the socioeconomic status and the physical and social environment are important determinants of population health (Rail *et al*, 2010). The education system and the mass media also have an important responsibility to prevent weight stigma and promote respect towards this population in all social spheres. In this regard, it would also be interesting that teachers and journalists were educated in social theory about healthism and stigma and in practical strategies to avoid weight stigma. Wider society, family members, and health professionals should encourage people with higher-weight to maintain a healthy lifestyle. Nevertheless, at the same time, they should help them to accept themselves promoting their self-esteem and a positive self-identity. Of course, people with higher-weight should act against weight stigma instead of promoting it with negative conceptions and attitudes towards others in a similar condition.

Finally, future studies should analyse whether people with higher-weight who have not undergone bariatric surgery, and do not want to undergo it, cope with healthism and stigmatization in a different way. Perhaps bariatric patients, and people with higher-weight who would undergo bariatric surgery, tend to experience higher-weight in a very

negative way, and differently to other people with higher-weight who can be more satisfied with their body shape and self-identity.

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