

Abstract

This study explores men's experiences of weight stigma with a sample of men attending a weight management programme. Men's understanding of stigma, including its sources, their responses to it, and its impact, were discussed using focus groups. Findings from a thematic analysis indicate that weight stigma undermines men's masculine sense of self. Weight stigma becomes a social threat – real or imagined - that entails negative psychosocial outcomes, impeding men's participation in social activities, including weight loss. With adequate social support, a men-only weight management programme is perceived as a safe environment where the men recovered their impaired self-concept. We suggest that weight stigma should be considered in the design of men's weight management interventions, to generate a more compassionate approach to weight loss.

Keywords: men, health, weight, stigma, intervention.

‘Sorry mate, you’re probably a bit too fat to be able to do any of these’:

Men’s Experiences of Weight Stigma and its Implications

The negative attitudes some people hold toward those who, from a medicalised perspective, might be labelled overweight or obese often translate into the social disapproval of *big*¹ bodies in the form of anti-fat bias and weight stigma. With regard to the former, Stunkard et al. (1986) and O'Brien, Latner, Ebner, & Hunter (2012) point out that anti-fat bias remains the last socially acceptable form of prejudice since the 1980s and that its prevalence has increased by 66% in the last decade. This often entails a negative dynamic between the individual and society that results in a deleterious cognitive set (Ogden & Clementi, 2010) that leads stigmatised individuals to be more vulnerable to depression, low self-esteem, poor body image, lower mood and increased self-criticism (e.g. Bombak, 2014; Puhl & Heuer, 2009, 2010). An insufficient understanding of how people experience weight stigma may explain the inadequacy of interventions to reduce it.

Just how these undesirable outcomes are produced is not well understood and inconclusive evidence is available from previous studies on weight stigma (Carels et al., 2009; Monaghan & Hardey, 2009; Puhl & Heurer, 2009, 2010). These studies are often based on cross-sectional designs, quantitative approaches, and female dominated samples (Monaghan & Hardey, 2009; Puhl & Heuer, 2009). Although stigma may trigger dieting among men (Monaghan, 2008), fear of discrimination might also explain men’s anxieties to attend structured weight loss programmes. This is important because ‘big’ men have

¹ Since Greenleaf et al. (2004) suggested that terms like ‘overweight’, ‘obese’ and ‘fat’ may increase stigma, we will identify the participants in this study as big. Yet, this connotes excess weight, instead of muscularity.

traditionally been ‘hard-to-engage’ (HTE) or ‘reluctant’ to attend health interventions, especially weight loss (Pringle et al., 2014). Given the prevalence of excess weight in males, and the role weight stigma may play as an inhibitor or facilitator to men’s engagement in weight loss, it is surprising that so many studies have left men’s experiences of weight-related issues underexplored (Roehling, 2012).

According to Lewis et al. (2011), more qualitative studies are needed to explore how men interpret and make sense of weight stigma. Understanding this can inform practice in a variety of ways. For example, Sparkes and Smith (2014) note that qualitative findings can influence policy development, refining the implementation of stigma-reduction interventions. By revealing ‘how things work in particular contexts’ (Mason, 2002, p.1), these studies offer a chance to make a difference to how practitioners work with HTE men. Qualitative research can also contribute to social justice by empowering stigmatised individuals (Sparkes & Smith, 2014, p.241). In view of these issues, this study adopts a qualitative methodology to explore men’s experiences of weight discrimination and considers how the findings can inform practice.

Methods

Setting

Following ethical clearance, participants were recruited from a 12-week, free of charge, men-only WMP in North West, UK. The programme aims to help men lose 5% of their body weight through exercise sessions and education on healthy lifestyles. Similar to Gray et al. (2013), the context, content and style of delivery of the sessions were gender sensitive.

Participants

This study is part of a larger research exploring men's experiences of body weight before, during and after attending a weight management programme (WMP). Based on self-report data, most participants were middle age, White British, who lived in urban areas, employed and were in a relationship. Participants' mean Body Mass Index (BMI) was 32.8 kg/m² and their mean waist circumference was 101.1 cm. Half of the participants reported health problems, with most indicating either 'poor' or 'average' health status. Almost half 'never' visited their doctor and the majority 'never' sought health advice. Therefore many participants in this study could be classified as HTE (Pringle et al., 2014).

Data Collection

For the larger study, participants completed self-reported questionnaires on socio-demographics, health behaviours, and social support – including answering yes/no to the question 'Have you ever experienced weight stigma?'. Interviews, ethnographic observations, and focus groups were also conducted. In the initial research plan, six semi-structured focus groups were planned addressing two areas; (i) 'men's weight problems' and (ii) 'masculinities and health'. In three of the six focus groups, we unexpectedly found instances that could be related to, or directly about, weight discrimination. As a research team, guided by previous literature, we believed that this issue needed to be addressed formally. Thus, a third focus group on 'weight stigma' was designed, piloted and implemented. Twenty five men who self-reported experiences of weight stigma in the questionnaire were invited to participate. Of these, 14 provided informed consent and volunteered to participate.

The focus group schedule included the following themes: men's experiences and understandings of anti-fat bias and weight stigma, including its sources, men's responses to it

and the psychosocial impact of these negative experiences. The semi-structured nature of the schedule allowed for other themes to emerge. These will be discussed in the next section.

Focus groups took place immediately after an intervention session, and lasted from 60 to 90 minutes. Due to the impracticality of reconvening a focus group at a subsequent point in time (Kidd & Parshall, 2000, p.299), member checking (often known as respondent validation) was performed at the end of each focus group.

Four groups were formed and met in a quiet room at the research venue and were facilitated by the first author. Since Grogan and Richards (2002) suggested that men may be reticent about talking about their bodies in large groups, the groups were limited to 2-5 participants. Discussions were audio recorded and transcribed verbatim.

Data Reduction, Rebuilding and Representation

Data analysis was conducted using Braun and Clarke's (2006) approach to thematic analysis (TA). First, the lead researcher transcribed verbatim all the verbal comments made during the focus group meeting and noted relevant nonverbal data. Second, emergent themes were identified and discussed within the research team, based on the theoretical area of interest, i.e., weight stigma. The methodical flexibility of TA also allowed for important additional themes to arise from the transcripts. For example, while it was not anticipated that the effectiveness of the WMP would help to reduce stigma (since this is not an explicit aim of the WMP), this was a strong theme in the first focus group discussion. Consistent with the relevant literature (e.g. Puhl & Heurer, 2009), this issue was included in each subsequent focus group and through the analysis.

Similar to Robertson et al. (2013), in that follows the findings and discussion are presented together. All the participants have been given pseudonyms to maintain their anonymity. Descriptors are also used to identify the number of men who articulated a theme. These include the following terms: *few* (0-4 respondents), *some* (5-9), and *many* (10-14). Yet, the *keyness* (Braun & Clarke, 2006, p. 82) of a theme not only depended on its prevalence but also on whether it captured something important in relation to weight stigmatisation.

Findings and Discussion

Participants' histories of weight control were heterogeneous across the sample. While some referred to a youth onset of undesirable weight, others invoked 'middle-age spread' (Monaghan, 2008, p. 41). Participants' 'manner' during the focus groups was supportive and empathetic: they were willing to contribute to discussions and showed their solidarity and when other participants shared their – sometimes upsetting - experiences.

What Do Men Think Stigma Is?

Men's understandings of stigma were similar to the definitions of anti-fat bias and weight stigma presented in the literature (e.g. Carr, Murphy, Batson & Springer, 2013). Most men described stigma as people's negative attitudes towards big bodies, detailing experiences of disrespectful comments, assumptions about a big person's physical inabilities, and anticipation of the negative health outcomes that big people may display. For instance, Jason described what stigma meant to him:

Stigma of being overweight, you are always the fat one... I have suffered from lack of respect from people who don't even know me, people pass comments on the street, they

don't know me from a hole in the floor, but they still think that, because I'm big and overweight, they're entitled to say something about me.

Jason's experience shows that regardless of how he presented himself, other people often attached stigmatising preconceptions to his bigness, rather than seeing him as a person. For Goffman (1963), the visibility of bigness as a stigmatising sign is a crucial factor, because it is an unintentional means of communicating to others that the individual possesses that stigma. They are 'discredited' because their larger bodies – a stigma symbol in Western societies – constitute a 'failure' that is immediately apparent. Hence those who embody that differentness are subjected to 'potentially offensive' prejudices (Monaghan and Hardey, 2009, p. 347), such as being evaluated as less intelligent, attractive, sexually desirable, competent and moral than their thinner peers (Carr et al., 2013). Under these circumstances, bigness 'draws attention to a debasing identity discrepancy, breaking up what would otherwise be a coherent picture, with a consequent reduction in our valuation of the individual' (Goffman, 1963, p. 59). Consistent with this, Matt said:

Very often, for the opposite sex the fat lad is the one who will have the fun stories; he's a good laugh and a joke, but as a partner, you are not a serious prospect. You're just perceived as less attractive to the opposite sex; the one who never gets a chance with the girls. It's always the good looking and skinny ones would get the girl, and the fat lad always ends up going home on his own.

Big persons' inability to present a 'non-discredited' self, together with the impossibility of quickly losing substantial amounts of weight, places big people in a position where they become the 'butt of everybody else's jokes, and everybody jumps in the bandwagon' (Phil).

The men, by ‘sucking it up’ (Ronald, talking about being the object of a joke) and letting those jokes ‘getting inside of my head’ (Mark), became ‘too self-conscious’ (Josh) of their own bodies to show them in public spaces. For example, Josh said: ‘I’ve always jogged along the canal, now I don’t jog anymore because I am too self-conscious’. These examples illustrate the ‘hidden distress model’ detailed by Scambler (1989, p. 445), which refers to a distinction made between enacted and felt stigma. Phil’s comment epitomises enacted stigma, the type of overt discrimination big people are often subjected to, on the sole grounds of their social unacceptability. As a result of enacted stigma, men developed a sense of shame and fear of encountering it, which is denoted by Scambler (1989) as felt stigma. For example, felt stigma predisposed Mark to secrecy and concealment: ‘I’ve got what they call “man boobs”, and that makes me conscious. If I’ve got my T-shirt off, I’ll get someone from the other side of the pool who would go: “look at him!”’. The single act of being seen implies a host of further, aversive experiences that entail spirals of negative judgement of personal shortfall and inadequacies.

Does stigma impair men’s identities?

In the UK, ‘big’ male bodies are viewed ambiguously (Monaghan & Hardey, 2009); on the one hand, ‘men are supposed to have hearty, even voracious, appetites’ (Bordo, 1993, p. 108). On the other, broadcast media reinforce the aesthetic of the ‘fit’, lean and muscular male body, making that ideal appear achievable to all (Crawshaw, 2007). Since masculinity and maleness are social relational constructs (Connell, 1995), men adopt different attitudes toward their fatness, depending on context and relationships. For example, while having a beer belly was a sign of belonging and masculine pride in the pub environment, as illustrated by Steve: ‘It’s cost me a lot of money this beer belly you know, I was sort of proud of it, you

know?'; paradoxically the same body, in other contexts, generated a sense of being an outcast:

When somebody says 'fat bastard' and all that, I go quiet. I think normally I feel quite gutted with people when they mention the size. I've got no answer for that, because I am ashamed of my size. So I can't really reply with a sarcastic answer back, so that's when the depression sits in.

Monaghan and Hardey (2009) note that 'gendered' labels such as 'fat bastard' are indicative of deviation and 'depending upon social context, may outcast men who threaten established bodily images' (p. 349). Consistent with the examples we have presented, Monaghan and Hardey (2009) note: 'men may be deeply ambivalent when "proudly" identifying as "fat bastards" and feel stigmatised when others, "the prejudiced", impose this or other discrediting labels on them' (p. 350). Weight stigma was particularly discrediting in sport context, where oppressors implied that fatness equated with physical incompetence. Jamie exemplifies this point:

We were playing touch rugby to finish off the session, and I got the ball passed to me and I ran about 50 metres, and I remember the whoever, the player who was trying to catch me, and a teammate said: 'Did you not catch the fat bastard?' He said 'bastard', you know, and I thought: 'Why did he say that?' You know what I mean, I was so quick, and even so, he said that.

Phillips and de Man (2010) drew a gendered distinction between two aspects of self-concept. The first, self-as-object, emphasises appearance and has traditionally been associated with females. In the second, the self-as-doer emphasises physical ability (e.g.

Jamie's example above) and has been identified as the 'male' element of self-concept.

However, men in this study were also preoccupied about aesthetic evaluations of his appearance: 'You 're always thinking about what other people may think, you know, is this showing off my tits, [...] is my belly sticking out?'. Hence, the current findings suggest that both aspects of self-concept play an important role in men's identities.

Onlookers often criticised aesthetic appearance to justify their own prejudices about the participants' physical incompetence. When this happened, the 'discredited' were denied the ability to embody Connell's (1987) a form of desirable masculinity, which is manifested in physical power, and expressed in social contexts. As a consequence, their status, pride and identity were undermined, which further limited their opportunities to display social competence. This process can be illustrated using Matt's account of going to an adventure playground with his colleagues. Due to his body size, he was not allowed to ride a zip line, causing him to feel socially excluded:

The guy who was running the activity just looked at me and said: 'Sorry mate, you're probably a bit too fat to be able to do any of these, you won't be fit enough'. And to be honest with you, I was probably the fittest one there, but because I was so much bigger than anybody else, I was left out before I even opened my mouth.

Likewise, as a consequence of his experience on the rugby field, Jamie explained that the social exclusion he was exposed to made him feel 'down and upset, and I thought: no one actually wants me'. Thus, it is not surprising that big men, who are often publicly reminded that they do not 'fit in' (Rogge et al., 2004), commonly experience interpersonal constraints on their social and community engagement.

Who Stigmatises ‘Big’ Men?

Most men in this study felt that ‘everybody’ stigmatises big men. The men experienced stigma at the hands of people of all ages and across genders. A few men noted that strangers, family and friends contributed to these experiences.

Stigma from different age groups. The men talked about being stigmatised by children, teenagers, adults and the elderly. Matt narrated how his own daughter innocently disapproved his body in certain clothes: ‘my daughter, quite cheerfully said; “Oh daddy, don’t come and pick me up in that, it looks way too small for you, put something else on, get changed, you are not coming out with that, you are so embarrassing, dad”’. While offspring frequently hold biased preconceptions of their parents’ fatness (Puhl & Heuer, 2009), the men in this study did not perceive these experiences as stigmatising. The difference was explained by the children being regarded as ‘innocent’, ‘naïve’, and ‘honest’. For example Ed, laughingly, explained how Chinese children associated his belly with the laughing Buddha²:

I think children say it as it is, they just speak honestly. I can’t remember where it was, but you know, Buddha, there is the slim Buddha and there is the laughing Buddha. I can’t remember where it was, but the Chinese children wanted to rub my belly, they were saying: ‘you’ve got a big fat Buddha belly’.

Many men blamed the parents for their children’s adverse judgement of fatness. Phil, speculated about reproaching parents for what their children said:

² The laughing Buddha is a Chinese monk traditionally portrayed as an obese, bald man, who is often depicted being followed by adoring children. His figure appears throughout Chinese culture as a representation of contentment (Hyers, 2004).

If you had said something to the parents, the parents would have said: ‘What do you mean?’ Because they wouldn’t have a clue, you know. They wouldn’t know, but they would have been rude, hurtful or anything. They are just the parents of the kids these days: they are that stupid they wouldn’t understand. You know what I mean, if you bring your kids up right, they will not go and do that to people on the street. Once the parents are educated in the fact that they don’t stigmatise weight, or anything, then the kids won’t pick up on it.

In light of these examples, some children’s perceptions of overweight men often resulted in discriminatory acts, which according to Carr et al. (2013) can be classified as stigmatising. However, perhaps to safeguarded notions of children’s naïveté, the men placed the blame on the parents, who lack social consciousness or sensitivity.

Based on the men’s accounts, stigma from teenagers was also common, especially when teenagers were in a group:

The teenagers would just try to show off with the friends usually, a group of kids would make comments if there is three or four kids together, 15 or 16 years old... I’ve had the odd comment for being bald, short or whatever, fat (Josh).

Dave vividly recalled his powerlessness when a group of teenagers upset him by calling him ‘fat bastard’:

I was walking around the fields with the dog and I caught a gang of fellas well, lads, school age, I would imagine 16 or whatever, with their girlfriends. And they were rocking the fences, so I gave them some abuse. I said something and they said: ‘So what are you gonna do about it fat bastard?’ And I thought, ‘hang on a bit, am I as fat

as it shows?' You don't realise – well, I didn't realise - I was that fat. So that annoyed me because I thought: 'I cannot do anything anyway, there is too many of them'. So... tail between the legs and walked home with my dog.

These accounts show that stigma occurs within a social context that often involves groups which, either explicitly or implicitly, support the aggressor, especially teenagers. Teenagers often engage in a process of self-evaluation within the context of their peer group (O'Connell, Pepler & Craig, 1999). They may be highly self-conscious, paying close attention to the opinions, real or imagined, that others hold of them; preoccupied by a need for peer acceptance. In this instance, the essential role of power in the social production of stigma is clear. The oppressor degrades the 'big' target, and invites others to support the degradation process. If they do, a power difference may be created that the oppressor may evaluate as an effective way of peer acceptance.

A few men talked about older people stigmatising them. They agreed that older, slim men and women often stigmatised younger, bigger men. Matt explained:

Because everybody's body shape is changing now, a lot of younger women don't see the difference between overweight men and themselves. Whereas somebody who's later in life, older in years, very often would say; 'Oh, he's a fat lump of a lad'. And that's more to do with when they grew up and the times they grew up; times were harder and you didn't see many fat people around, because there just wasn't that much food around to eat, long ago in the war.

Ed believed that older men who were still thin and fit were more likely to stigmatise young men who carry extra weight. He said:

Someone who is older but slim themselves, they are probably more likely to say something... I have a cracking example. I was in a party and there was an older lad, we used to play rugby in the same circles, and in talking he kind of said: 'Oh, you've let yourself go mate, haven't you?'

Although Lieberman et al. (2012) suggested that negative attitudes toward obesity decrease with age, these findings indicate otherwise; slim and older people also hold negative views toward fat men.

Stigma created by men and women. Our findings suggest that while both men and women hold negative attitudes towards male bigness, big men attached different meanings to stigma, depending on the gender and body shape of the individual who initiated it. Mark and Phil said that men, especially slim men, 'stigmatise more, definitely more than women'. Phil said that slim men are 'the first ones to start the criticism, they are the ones that make the sarcastic comment, they make you feel this big', showing a small gap between his thumb and index fingers. Once again this illustrates the centrality of power to the social construction of stigma. This was evident in sport settings, which were environments where slim men reinforced the assumption that 'fat can't be fit' which – intentionally or otherwise - excluded big men from these activities. This assumption often originated in school:

When I was at school, I was always being picked last, because they didn't expect me to be as fit as everyone else, because everyone else was skinny. I remember one day, I wanted to play in field and someone said to me 'Get out of the way, go in goal', and someone else said 'Give him a minute, because he's fat'. (Jack)

Some men also talked about women making stigmatising comments. However, women were ‘nicely stigmatising’. Josh explained how his female colleagues gave him extra food, because he was big:

I’ve worked with women for years, and I’ve found that [stigma] all the time, but they [female colleagues] did it too nice to me. They looked after me, they mothered me.

They gave me extra food. I was big, they knew I liked me food and chocolate, so there was always chocolate and biscuits there. There was always free food as well. So I was looked after, too much really. I was getting really spoilt.

Women’s ‘mothering’ through food reflects Western women’s greater acceptance and promotion of men’s ‘bodily bigness’ and ‘love for food’ (Monaghan & Hardey, 2009). Being fed by women signalled to some men that, in the eyes of these women, the men did not conform to society’s standards of attractiveness (Roehling, 2012). For example, Matt described himself as ‘not being a serious prospect as a partner’. This is problematic because being able to attract a partner is an important element of the repertoire of sexual behaviours that Western men are expected to fulfil (Carr et al., 2013). Being unable to meet this ideal impeded their wellbeing, and may explain why some men described stigma from women as more ‘hurtful and cutting’ (Simon) than that of men.

Stigma from other groups. A few men provided examples of stigma from family members, health professionals and strangers. For example, Matt explained that he had always experienced ‘general lack of respect from everybody, including people who don’t know me’. He said he was ‘always the comedy and the butt of the jokes, always being the chubby one’. Ed recalled one time when a relative said ‘You have a stomach like a beach ball’, and although ‘they don’t mean any harm by it, afterwards you think, crickey, it’s my family and close friends. And because it is the loved ones it hurts a bit more’. Others felt that their bigness was medically sanctioned as a ‘badge of stigma’ (Herndon, 2005, p. 128), even though it represents an (in)appropriate proxy for weight-for-height measurements: ‘BMI is a major stigma that dispels things, because my cholesterol was higher when I was thinner than what it is now’ (Harris). Monaghan (2008) also writes about the incredulity men in his study expressed about biomedical labels based on the BMI.

The recent recognition that some obese individuals can be metabolically healthy reinforces the heterogeneous nature of obesity (Puhl & Heuer, 2010). Although there is enough compelling evidence revealing the -still- eye-catching idea that ‘fat can be fit and healthy’ (Bombak, 2014), this understanding is not yet widely established. For example, Hebl and Xu (2001) found a strong, linear trend in the way that physicians responded to the size of patients: as the patient became heavier, physicians judged them to be less healthy. Perhaps, this sophistry stems from the vested interests of some obesity entrepreneurs in constructing thinness as a health and social ideal; they profit from defining obesity as a universal problem that can be corrected (e.g. the media, the weight loss industry, to name but a few) (Monaghan, Hollands & Prtichard, 2010).

Diverse Responses to Stigma

Perhaps to protect their own sense of physical and social competence, men reported paradoxical reactions to anti-fat bias. Overall, these reactions varied from implicit or explicit retaliation, to making jokes, contributing to banter or ignoring the situation. As opposed to many women, who ‘passively agree with the major construction of obesity as their own fault’ and who ‘rarely publicly challenge the social construction that weight is the result of personal weakness’ (Rogge et al., 2004), some men challenged the social acceptability of stigma. Phil illustrated:

I used to work with a lad who always patted me on the stomach, implying that I was fat, so I used to retaliate. I said to him, ‘What are you touching me for, what are you making a comment for, why are you even supposing that I wanna know [that I am overweight]?’ The problem is that they don’t see it. They think it’s a joke, but it isn’t. So, eventually I ended up losing my temper. Once I lost it, every time he opened his mouth I’d just rip his head off, I used to shoot him down in flames, I wouldn’t put up with it anymore, because I’d had enough. You can only take so much before you get really fed up with it, innit? You give as good as you get, don’t you?

Others, like Jamie, made reference to implicit forms of retaliation. Jamie set about improving his physical performance after someone assumed that because he was a ‘fat bastard’, he would not be able to run fast:

I am not that bad at sports, just because I am big. You know, I can play a bit, you know what I mean? So I try to do that on the field, I just try that extra bit harder and try to show them that I am actually good.

These examples illustrate participants' attempts to challenge what Scambler and Hopkins (1986) identified as the 'orthodox viewpoint'; Phil and Jamie confronted the way oppressors referred to them and took action to 'negotiate' their identities. Nevertheless, other men were not as strong about facing people's prejudices, nor were they as confident in their physical abilities as Jamie was. Instead, these men used jokes to divert attention from their own vulnerabilities and maintain social connectedness. For example, Josh, who participated in the same focus group as Phil, confirmed that 'not everybody could be as strong as Phil was. I would make a joke about it all the time; make a joke to these people who were taking the piss out of me'. Paralleling this, Williams (2009) concluded that men use humour to reduce tension, hide embarrassment and demonstrate that they are 'normal' or 'proper' hegemonic men. Men were particularly likely to use humour to respond to women's biases. Dave explained:

With women, you put it into a joke. I shouldn't say this, but there was one time when a female friend patted my stomach saying: 'You've put weight on, haven't you?' And I said to her: 'Mind you, that's my willy, I wrapped it round!' [laughs] However, when a bloke says something I just give the insult back, you know what gives them an edge, something like 'You've got a big nose' or something like that. You know what the sensitive spot is, and you have a go about it.

What are the psychosocial consequences of stigma?

Despite the men's attempts to challenge stigma by retaliation, these efforts did not prevent the men from 'internalising' the negative reactions of others into their own bodily self-concept. Since we live in a 'somatic society' (Turner, 1996) where 'fat bodies' may be equated with breaking biomedical and social 'rules' (Monaghan & Hardey, 2009), it is not

surprising that men felt overwhelmed by their ‘failure’. In some cases, inadequate bodily appearance had become a ‘master status’ or identity, effectively subsuming all others. For example, Jack said:

I don't like the look of myself. When I look in the mirror now after losing weight, I don't sort of see what weight I'm losing. Even my wife caught me looking in the mirror and she said: ‘You need to stop doing that, because you are paranoid’. But it's always in here (pointing his head). I want to look normal [...] Because I used to go for meals when I was younger, with my friends. I used to sit there; I was sweating, not moving about [...]. And sitting there after having a meal, sweating, I thought to myself: ‘This is not good’. Because I just want to be normal, basically. Compared to other people, just in my mind, I am not the same as them. Personality wise yeah, personality is fine, but I just wanna look better.

To identify somebody as fat is to label them undesirably different and deviant, in need of reform. Scheff (1966) claimed that ‘labelling’ is the single most important cause of mental illness. Phil, who initially said that his weight was not a problem for him, later admitted that he became ‘a bit of an obsessive and you keep thinking to yourself: I am overweight’. Phil shows how even though he did not necessarily regard himself as ‘fat’ – nor did he see it as problematic - being subjected to ‘shocking’ social processes and ‘fat’ labelling was a disruptive experience that changed the way he perceived himself. Similar to Lewis and Van Puymbroeck (2008), this ‘owning’ of stigma led to negative psychological consequences, including depression, low self-esteem and low sense of worth. These outcomes were salient among men who ‘bottled things up’:

I felt very very hurt, and you keep it inside, because I found it difficult to talk to anyone really. Even my wife, I wouldn't really wanna talk to her about my weight, or how I felt. I bottled things up, and then all of a sudden you end up going back to the doctors and saying: 'I don't feel right', because I didn't. (Mark)

'Bottling things up' may be a consequence of the pressure Western societies place on men to be stoical (Möller-Leimkühler, 2003). Although this may be a socially acceptable code of male expressiveness, such emotional restriction can bring a number of adverse psychosomatic effects. In the current study, these effects were long lasting and increased with time:

Interviewer: Did those feelings [low self-esteem] change after the event?

Matt: Probably they intensified if anything, because I couldn't get it out of my head. They lasted a long time, maybe months. I was still pondering it after the event.

Matt's example illustrates how enacted stigma (overt discriminatory behaviours) became felt stigma (the person's feelings of being looked at and judged) over time. The latter progressively intensified over time and translated into fear of discrimination or public humiliation. Echoing Scambler and Hopkins (1986), this type of stigma often causes more unhappiness, anxiety and self-doubt than enacted stigma. The following example illustrates how for some men, felt stigma is an important social driver assessed as a threat:

Someone said to me: 'Oh, you've put weight on' and I thought: 'Oh, I have, ain't I?' So I decided to do something about it. But then you go to the gym and you see all these meat-heads pumping iron and you think: 'They are still looking at me'. But when you look at them they are not, but you still got that paranoia in your mind. You are out of

your comfort zone, you just want a nice exercise to feel right in yourself and you just feel out of place. And it puts you down, it really makes you depressed. (Jack)

The above excerpt suggests that ‘felt’ stigma undermined Jack’s long-term mental health and sense of worth. Interestingly, by saying ‘you see all these meat-heads pumping iron’, Jack is also judging others on the basis of his own insecurities. As a consequence, Jack employed strategies to mitigate or avoid situations where he was open to - sometimes imagined - negative labels. This example confirms that prolonged and/or intensive stigma has severe consequences for men, and these may be more severe than what has been suggested (Carr et al., 2013).

Strategies to Prevent Further Stigma

The damage generated by regular and frequent negatively valenced emotional experiences was described by some men as an ‘educational experience’ (Dave). This encouraged them to attempt weight loss to improve their body image, often by joining a gym. Despite being drawn to them, gyms were often perceived as environments of recurrent, and almost exclusively negative, social and physical comparisons. In these spaces, men were overtly vigilant about checking out ‘who’s looking’ and about assuming negative assessments were being made. This reinforced felt stigma which, in the way of any downward spiral, further reduced the men’s self-concept, and eventually resulted in withdrawal from those activities. The following interaction illustrates this:

Interviewer: Before coming to [name of WMP], had you ever tried to find a male-only fitness programme?

Jack: No, I just went to my local gym. I did a few sessions and I just didn't feel comfortable there so I obviously left it.

Interviewer: What made you feel uncomfortable?

Jack: I was just being a bit paranoid of people looking at me, because obviously I was trying to exercise and they had been there a lot longer than me, I had just been there a few times and I just felt paranoid, a bit out of place really. I know in my own place I was doing my best, but I don't know... I didn't feel right so I put it to one side.

Facing these difficulties, the men gave up their attempts to lose weight and developed some self-protective strategies to 'hide' their bodies. This type of 'hiding' is what Goffman (1963) identifies as 'pass' or 'cover', and it is common among discredited people, because it enables them to conceal their stigma symbols. The men adopted different types of 'adjusted' adaptations to (in)effectively neutralise the negative impact of their 'bigness' on their lives. These adaptations share similarities with Schneier and Conrad's (1983) typology of modes of adaptation to epilepsy. They identified three categories of individuals with epilepsy; 'pragmatic', 'secret' and the 'quasi-liberated'. Data from the current study is used now to illustrate the types.

The 'secret type' used elaborate tactics to conceal their 'bigness'; especially using baggy clothes and dark colours. Ben explained: 'I am not happy with the way that I look. It's all to do with clothes really; you're always thinking about what other people may think. So you have to wear something baggy and things like that'. By covering their bellies and other stigma symbols, the men reduced tension. In Goffman's (1963) terms, they made it easier for

themselves and others to withdraw covert attention from the stigma, and to sustain spontaneous involvement in the official content of the interaction.

The ‘pragmatic type’ downplayed their ‘bigness’ by attempting to pass or cover (Goffman, 1963). Since ‘big’ men are automatically ‘discredited’, due to the visibility of their bigness, their attempts to pass or cover are more complex than those of ‘the discreditable’, who can choose when to disclose their stigma (Scambler, 2009). These men covered their stigma, or passed as normal, by using it as an advantage to perform in a different setting. For example, Matt, who had been bullied in his first school, recounted how his body privileged him to join the rugby team when he changed schools:

I was a big fat child, a big lump of a lad, as we say in Lancashire. But one of my [new] school masters said: ‘Why don’t you try out for the rugby team?’ He said: ‘We’re looking for some big lads, you’ll fit the part. I don’t know how fit you are, but go and give it a go!’ And I did, and as luck had it, I landed with a games master, a PE teacher, who was interested and bothered about the kids that he taught, and sort of worked with me and helped me. And once I got into training with the rugby team, then things began to develop from that.

Using Goffman’s terms (1963), stigma symbols can become prestige symbols depending on context. ‘An attribute that stigmatizes one type of possessor’, he writes, ‘can confirm the usualness of another, and therefore is neither creditable nor discreditable as a thing in itself’ (p. 13). This ‘relational anchorage’ (Scambler, 2009) was obvious in the example above, where Matt used his bigness – which had been a sign of his stigmatized failing in his previous school – as a privileged attribute that secured access to those

previously inaccessible sports because, as he said, he was ‘the chubby child, always the last one to be picked for everything, always the butt of the playground jokes, the big soft fat lad who can’t really do anything’.

The ‘quasi-liberated type’ goes beyond pragmatism by publicly proclaiming their ‘bigness’ in an attempt to sidestep any antagonism (Scambler, 2009). These men managed their identities by acting as if they did not care about their ‘personal failure’, by revealing information about it before anyone else:

It’s easy to put like a smiley face on it, you know, you kind of laugh at it sometimes. I come up with comments quicker than the other people do because I find it easier to handle if I say it than if they say it, so you know, in front of other people you come across as ‘Oh, I am all right’ you know, that sort of thing. But really you are trying to save yourself by making the comment before anybody else does. (Simon)

This quote corroborates Goffman’s (1959) view of the lifeworld as a theatrical production where actors play scripted parts. Individuals adopt a number of ‘ground rules’ to afford normative regulation. One of these ground rules has to do with ‘maintenance of face’ requiring individuals to present and sustain consistent and positive images of the self (Scambler, 2009). Perhaps, by ‘putting a smiley face’, Simon was not only maintaining face through lines in ‘front regions’, in front of others, but also - in absence of an audience - he stopped performing, behaving in ways that contradicted his performance identity. It is in this ‘back region’, at home, where Simon decided to strategically change one aspect of his appearance to misdirect people’s attention towards a different aspect of his ‘face’:

Last year, I started to grow my beard and it was simply because I was fed up with the comments at work about my weight so I grew a beard so I knew that they wouldn't like the beard and the comments were against the beard, and not my weight. You know, it's a kind of misdirection, you know, by growing the beard. And it worked, everybody started making comments about the beard and they forgot I was overweight.

Facing the impossibility of being seen by others as a person, Simon decided to change an aspect of his physical appearance in order to misdirect the critical gaze of others towards a different part of his body (i.e. his face). Interestingly, he did not mention any previous attempts to lose weight. As Monaghan and Hardey (2009) discussed, men who accept they are fat may not necessarily strive to be slim, or try to embody any aesthetic ideal. Rather, they may develop special techniques to construct a situationally fitting identity that distances them from the discrediting (emasculating) qualities commonly associated with fatness, so they continue to 'conform to hegemonic values' (Robertson, 2007, p. 122; Goffman, 1963) to pass as 'normal' (Scambler and Hopkins, 1986). This may be what Simon aimed to do: by growing the beard, he constructed a new masculine identity that enabled him to distance other people's attention from the emasculating qualities of his fatness.

Is A Weight Management Programme A Safe Haven From Stigma?

In previous studies (e.g. Puhl & Heuer, 2010; Rogge et al., 2004) experiences of stigma have been positively correlated with motivation to avoid exercise, health and healthcare. Likewise the current study identified that felt stigma was also an initial barrier for some men that delayed joining this WMP. Although the programme eventually provided an opportunity for the men to regain their social and physical competence in the company of similar others, initially the men did not trust the programme because they believed that they would be the

only 'fat lads' who would not be able to 'keep up with the rest'. Echoing Robertson et al. (2013), trust was an important factor to initiate involvement in the programme. This is reflected in Jack's 'reserved initiation' approach:

I was a bit nervous really, I even said to my partner: 'I am really, really scared about going tomorrow', and she said: 'Why?' and I said: 'Because there will be fit, fanatic people and I won't be able to keep up with them'. But my misses said: 'Go. It'll do you good; mentally-wise it will break that shell where you are in: Just get out and go'. And it's totally different from what I expected really, I do enjoy it.

Many men were highly vigilant about 'personal fit' and potential weight-related discrimination. This delayed them from joining the WMP, just as for other so-called 'help' activities. As Cahnman suggested, weight-bias often causes withdrawal from normal activity and significantly impedes social interaction (Cahnman, 1968). Despite these anxieties, social support from others was often central to getting the men to join the WMP. After an initial period of 'weighing up' the programme, the men described the WMP as a 'safe haven from stigma' (Glenn); it provided them with a supportive opportunity to 'fix themselves', which contrasted with previous gym attempts:

Interviewer: What do you remember about the first session in this programme?

Matt: I think looking around realising that I wasn't on my own any more, there was other guys in the same boat as myself, and by the look of them and by the red faces at the end, I realised that some of them were a lot worse than I was, so I kind of came out and thought, well, I am not a complete basket case after all, there is hope for me, and I

felt positive, I felt I had done something creative and I had something positive about fixing myself.

Interestingly, Matt does not mention losing weight in his account. Instead, he refers to ‘fixing himself’. Similarly, independent of (or despite) the organisers’ prioritising weight, weight loss was not invariably the reason for attending the programme. For Tom, restoring physical competence was more important than losing weight:

I have not come here to lose weight. I have come here to get fitter, to understand more really what I need to do. I didn’t know what to do. But I need to be told and told and told. Men I think need to be constantly nagged to do things, because if you’ve got a heart problem and you are told to exercise and you do it for so many weeks, you do it for three weeks, and then you say: ‘I have done it for three weeks, now I am all right’.

Among those mainly motivated by weight loss, they soon explored and prioritised other opportunities offered within the programme. Once the men became immersed in this new environment, they encountered a new subculture that could be understood as a form of ‘hiding’ as much as social integration. Being ‘hidden’ in a WMP that provided safe opportunities to exercise and play sports, enabled the men to recover their concept of self-as-doer. This is how Matt described his second session:

When we did the fitness test, I was with one of the guys who has been coming for probably nearly 10 weeks now. He says he isn’t, but he is he is a fit, muscular lad. And it was really good because he went first, and we were doing squats. And I was pushing him, ‘Come on, have a minute, come on, push it!’ So I started, and he started doing the same thing for me, and I’m thinking: ‘What? That’s just happened! That’s

just happened! That's just the dynamic! That's happened within the group, so everybody is pushing and everybody is looking for each other'.

Involvement in the physical exercises and sports helped the men to improve their physical competence. This facilitated social interactions and the men improved their social competence as well: at this point, their 'hiding' can be understood as a positive social experience of 'big-boys-together'. Comradeship was mentioned by all the men as a positive aspect of the sessions. Jamie explained:

Once I got here I found there was a great camaraderie between the lads, everybody seems to really encourage each other, which I didn't think would happen. I thought it would still be a case of 'it's you versus the next versus the next'. But is not, is very much 'well done, you've played well, you really pushed yourself there'.

These findings show that, even though social support was not a key priority for the organisers, comradeship was the mediating mechanism that made this WMP a 'safe haven from stigma', where men did not have to worry about being vigilant about even the idea of social threat. This provided them with an opportunity to move from a threatened state (e.g. 'I was scared') toward a state of self-discovery where they diverted their attention to assess new opportunities (e.g. 'I had something creative and I had something positive about fixing myself') and learn new behaviours. The role of others, their encouragement, and the 'great camaraderie' found in the group were the cornerstones for this change.

Conclusion

The uniqueness of this study lies in its capacity to disentangle the complex meanings men construct around weight stigma. Understanding how this affects men's health can significantly contribute to the current evidence on how to optimize men's health interventions (Gray et al., 2013; Pringle et al., 2014). Through a qualitative methodology, the men became active participants in explaining the impact of the 'war on obesity' (Monaghan, 2008) on experiences of weight stigma.

Our findings confirm the high prevalence of weight discrimination among a group of men who were recruited from a WMP. We have shown that, regardless of how the men presented themselves, the gaze of others often drawn toward their expanded corporeality. This translated into negative attitudes and prejudices about the men's attractiveness and doubts about their physical functionality. These 'gazers' came from different age groups and genders, and were variously strangers, family and friends. The men's responses to weight discrimination depended on the gender, age and body shape of the person who stigmatised them.

Although participants' attitudes towards their weight were ambivalent, the impact weight stigma had on their self-concept often resulted in a loss of masculine hegemonic values, and negative, long lasting psychosocial implications. These were particularly evident among men who remained emotionally restricted, in an attempt to pass as normal. When this normality veil was uncovered, it brought about men's recognition of their 'failure' and subsequent spoiled identities: the reason why they attempted to lose weight after stigma.

These attempts often resulted in a threatened status, especially when they found that by exposing their bodies in public spaces (e.g. gyms) their 'failure' was subjected to social judgement. This then resulted in withdrawal from those activities.

Arguably, men's fear of enacted stigma was a barrier but also a plausible stimulus for them to attend the WMP. In the face of this ambiguity, social support was fundamental to help the men take that step forward and attend the WMP, overcoming their uncertainties. The realisation that 'everybody was in the same boat', together with the social and physical interaction with others through physical activity and sport, was perceived as offering a promising venue for the men to recover their impaired self-concept.

Implications for Practice

Since weight stigma delayed some men from attending a WMP, this proposes some practical implications for the design and implementation of WMPs. While current health improvement interventions emphasise sport as a means to attract men (e.g. Pringle et al., 2014), this may be problematic for men who, like many participants in this study, have experienced social exclusion on the basis that 'fat can't be fit'. This suggests that interventions should clarify from the outset that all levels of ability are welcome, to facilitate access.

This study has shown how the solidarity of the men only weight-management group provides a degree of protection for men's gendered selves. This solidarity – recurrently mentioned as 'camaraderie' - was often more meaningful for the participants than weight loss itself. This finding has policy implications, as it suggests the possibility of revisiting interventions intended to promote men's health through a focus on weight. Indeed,

Aphramor (2005) challenged traditional WMP that focus on weight and endorse dietary approaches to weight loss. She challenges clinical recommendations to lose weight, maintaining that 'a continued focus on weight loss even on the basis of staggering failure rates alone is simply unethical' (p. 317). Instead, Aphramor subscribes to an alternative clinical paradigm: Health At Every Size (HAES). This paradigm is explicitly formulated as a more compassionate and evidence-based approach to health and 'weight problems', and prioritises health – physical and mental - over weight (Monaghan & Hardey, 2009). HAES is an approach that better aligns with recent attempts to re-theorise stigma, moving beyond a 'personal tragedy approach' (Scambler, 2009), towards an understanding of the nexus of social structures that embed stigma. If powerful structures such as health policy and practice – including WMPs - reject personal attributions of shame and blame, then a more successful, bottom-up approach, that is aligned with individuals' needs and interests, could prove beneficial.

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