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Obesity and Nutritional Sociology: A Model for Coping with the Stigma of Obesity

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ABSTRACT

Nutritional sociology uses sociological theories and methods to study and influence food patterns, eating habits, and nutrition. Obesity and weight loss are important topics in nutritional sociology, and stigmatization of the obese is a long-standing interest. Most past sociological work has only described stigmatization, rather than developing ways to facilitate coping with it. A model for coping with the stigma of obesity is presented here. The model includes four components: Recognition, Readiness, Reaction, and Repair. Recognition involves awareness of the stigma of obesity and understanding about stigmatization. Readiness involves anticipation that stigmatization may occur in specific settings or by some people, and preparation for and prevention of stigmatizing acts. Reaction involves immediate and long-term coping techniques to deal with a stigmatizing act. Repair involves the recovery from stigmatization and attempts at restitution and reform of the stigmatizing actions of others. This model uses a sociological perspective to develop strategies for dealing with stigmatization, which differs from a medical model for dealing with obesity. This sociological model for helping people cope with the stigma of obesity may also be useful with other types of stigmas.

Nutritional sociology is the application of sociological theories and methods to study and influence food patterns, eating habits, and nutrition. Obesity is an important topic within nutritional sociology, with considerable attention

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being paid to overweight and weight loss by sociologists. Examples include examination of patterns of obesity according to socioeconomic status or marital status (Sobal, 1984a; Sobal and Stunkard, 1989), investigation of foods seen as "diet" or fattening (Sobal and Cassidy, 1987, 1990), and the study of weight loss groups and organizations (Allon, 1973a, 1975, 1979a; Laslett and Warren, 1975; Millman, 1980; Sussman, 1956a, 1956b). Using the distinction developed by Straus (1957), little sociological work on obesity involves the applied practice of sociology *in* nutrition, as compared to the academic study of the sociology of nutrition (Murcott, 1983, 1988).

Stigmatization of the obese is a long-standing interest of sociologists. Most past sociological work on the topic has only described stigmatization, rather than developed ways to assist in coping with stigmatization. Sociological work on obesity and stigmatization has much unrealized potential applicability for sociological practice. This paper will review existing knowledge about the stigmatization of obesity, and will then present a four-component model that can be used to assist people in coping with the stigma of obesity.

The concept of stigmatization was developed by Goffman (1963) to describe negative reactions to many conditions, including obesity, mental illness, cancer, AIDS, disabilities, etc. The concept has received extremely wide attention in the social and health sciences. Despite the wide appreciation of the insightfulness of the idea, the concept of stigma has primarily been applied only to the extent of recognizing that a condition is stigmatized. Little further elaboration of specific techniques for coping with stigmatization or ways of assisting others in coping with their stigmatization has been developed. Theoretical work on stigmatization can be clinically applied to stigmatized conditions by sociological practitioners to assist others in overcoming and coping with it.

Sociology is very good at defining, describing and disseminating insightful and powerful concepts such as stigma, but has largely left the development of ways to deal with these issues to other applied disciplines such as clinical psychology, social work, nursing and medicine. Work on stigmatization by anthropologists (Ablon, 1981) and psychologists (Ainlay, Becker, and Coleman, 1986; Herman, Zanna and Higgins, 1986; Jones, Farina, Hastorf, Markus, Miller and Scott, 1984) has not gone much beyond the efforts of sociologists in developing models for applying knowledge about stigmas. The growing areas of clinical sociology and applied sociological practice can fill that gap.

A stigma is usually like the weather: everybody is talking about it but nobody is doing anything about it. Many sociologists have described the concept of stigma and how, when, where and to whom it applies, but have put little effort into helping stigmatized individuals cope with stigmatization and present little guidance for people helping others to deal with it. Description exists for how

victims of various types of stigmatization manage their stigmas (Beuf, 1990; Boute, 1987; Gramling and Forsyth, 1987; Gussow and Tracy, 1968; Hilbert, 1984; Schneider and Conrad, 1983; Wahl and Harman, 1989; Weitz, 1990), including methods of concealing or selectively revealing stigmas, denial, withdrawal, intellectualization, anger, changing social networks, enhancing social support, gathering factual information, educating those who stigmatize, acting with bravado, and developing militancy. However, such activities remain largely descriptive, with some exceptions (Beuf, 1990), and make little effort in applying these coping techniques to actually help people cope with stigmatization.

The Stigmatization of Obesity

Obesity is defined as an "excess" of body fat, although any cutoff distinguishing obese and nonobese individuals is purely arbitrary because body fat is distributed in a continuum similarly to other physical characteristics in populations such as height (Sobal and Muncie, 1990). There is a consensus in the medical community that obesity is associated with a variety of health risks, and most health professionals believe that their patients should not become obese and that those who are obese should lose weight (Sobal and Muncie, 1990).

In addition to the medical problems associated with obesity, there is severe negative evaluation of obesity in modern Western societies, particularly the United States. Social values about obesity in modern societies are generally negative, contrasting with the positive evaluations of fatness in most cultures (Brown and Konner, 1987). Ritenbaugh (1982) suggests that obesity is a culture-bound syndrome that is only seen as a problem in modern, Westernized societies. The social and psychological problems associated with obesity may be as great as physiological maladies (Sobal and Muncie, 1990).

Most work on obesity has used the medical model, which assumes that the problem lies in the obese individual and weight loss is the solution. By contrast, a sociological model may reframe the issue by assuming that the problem of obesity may lie in societal reaction to obese individuals and that solutions other than weight loss may be useful. These two models may function together in some cases and be complementary, while at other times they may conflict.

The stigmatization of obesity in both children and adults has been frequently described during recent decades (Allon, 1973b, 1979b, 1981; Cahnman, 1968; DeJong, 1980; Goodman, Dornbusch, Richardson, and Hastorf, 1963; Hiller, 1981; Jarvie, Lahey, Graziano, and Framer, 1983; Kalisch, 1972; Laslett and Warren, 1975; Richardson, Goodman, Hastorf and Dornbusch, 1961; Siegelman, Miller and Whitworth, 1986; Sobal, 1984b; Tobias and Gordon, 1980; Weiner, Perry and Magnusson, 1988). Beyond stigmatization, discrimination against the

obese has been documented in access to college education (Canning and Mayer, 1966), employment (Harris, Harris and Bochner, 1982; Larkin and Pines, 1979; Matusewitch, 1983; Benson, et al, 1980), earnings (McClellan and Moon, 1980), job promotions (Hinkle, et al, 1968) and housing (Karris, 1977). Weight discrimination is emerging as an issue of sufficient importance to be discussed in the legal literature (Baker, 1984). Physicians (Maddox, Bach and Liederman, 1968; Maddox and Liederman, 1969; Maiman, et al, 1979; Najman and Monro, 1982; Price, et al, 1987), as well as medical students (Blumberg and Mellis, 1985), medical residents (Brotman, Stern and Herzog, 1984), and rehabilitation counselors (Kaplan, 1982; Kaplan and Thomas, 1981) have negative attitudes toward the obese. Stigmatization of obesity appears to be pervasive and frequently denies obese individuals access to social roles and various opportunities.

Stigmatization of obesity can be dealt with on two levels: psychological and sociological. Psychologically, specific individuals are stigmatized and the unit of analysis is the person. Obese individuals can be assisted in coping with stigmatization using one-on-one counseling or small group discussions. Sociologically, institutions and social processes promote and enhance stigmatization of the obese and the unit of intervention becomes a collective one. Here, interventions can deal with organizations or provide broad education and attitude change interventions. Dealing with stigmatization on both levels is important.

Considering the issue of obesity requires a differentiation among stigmas, stigmatization, and stigmatizing acts. Stigmas are qualities, attributes or characteristics that may receive negative evaluations from others. Stigmatization is the negative reaction by others to a specific stigma. Thus, a stigma is the negatively valued condition, while stigmatization is the interaction process of someone responding negatively to that condition. Stigmatizing acts are specific negative behaviors or communications involved in stigmatizing actions or events. The example here will be obesity, although a wide variety of conditions exist as stigmas (Goffman, 1963; Jones, et al, 1984; Weiner, Perry, and Magnusson, 1988). While stigmas vary, the process of stigmatization and stigmatizing acts share many commonalities across specific stigmas. With these commonalities in mind, a model for coping with the stigma of obesity will be described which may be generalizable to other stigmatized traits.

A Model for Coping with Stigmatization

A four component-model for coping with stigmatization will be described here for dealing with obesity. The components include (1) Recognition, (2) Readiness, (3) Reaction, and (4) Repair, combining to form an integrated model (Table 1). This model was developed through observation and work in medical

settings; teaching medical students, physicians and nutritionists about obesity and stigmatization; work with obesity and obese people in practice and research; and examining the literature on stigmas.

Table 1.

A Four-Component Model for Coping with Stigmatization of Obesity

1. Recognition
 - Development of awareness that obesity is stigmatized
 - Gaining insight, information, and understanding about stigma
2. Readiness
 - Anticipating settings and people involved in stigmatization
 - Preparation for stigmatizing acts
 - Prevention of stigmatization by information/exposure control
3. Reaction
 - Immediate coping with stigmatizing acts
 - Longer term coping with stigmatizing acts
4. Repair
 - Repair of problems from stigmatizing acts
 - Recovery from problems resulting from stigmatization
 - Restitution and compensation from stigmatization
 - Reform of stigmatizing actions and values of others

Recognition

The most basic component is recognition of stigmatization, which involves awareness that obesity is a stigmatizable condition and that an obese person may be a target of stigmatizing acts. Recognition involves insight and understanding that obese people are vulnerable to stigmatization, and information and knowledge about the extent and type of stigmatization that may occur. Sociologists have written about stigmatization in the professional literature, but this only led to recognition of the issue among other social scientists. Relatively little sociological attention has been given to describing stigmatization to individuals who are stigmatized, educating the public about stigmatization, or helping professionals who deal with people with stigmas.

Presenting the concepts of stigma and stigmatization of obesity can be done by making parallels with other stigmatized conditions, providing insight and similar examples for clients. Discussing stigmatization of AIDS patients, who carry one of the greatest stigmas of any group in society (Herek and Glunt, 1988), can be used to demonstrate the concept of stigma. Giving examples of

other types of stigmas shows how the U.S. culture focuses on normalcy and is often unaccepting of deviation from the norm. Discussing stigmatization of other conditions also shows how obesity may be similar to and different from other states, which assists in putting the problem into perspective. Obesity is a physical stigma that is fairly easily observed despite the use of clothing or other means to hide or minimize fatness. By contrast, stigmas such as AIDS or schizophrenia may be concealable and only selectively (or inadvertently) revealed. Recognizing that stigmas may or may not be selectively visible is a key insight for obese people who desire to modify or control display of their stigma.

A problem in recognition is avoiding denial about stigmatization. For example, one obese patient in a medical clinic was aware that she was sometimes stigmatized because of her race, but at first was unwilling to consider the possibility that her weight could be treated similarly. After some discussion she saw that thinking about her weight in the same way she thought about her ethnic background could provide insights into dealing with how others treated her weight.

Recognition of the existence of stigmatization of obesity involves awareness that people are vulnerable to labeling because of their weight. Such labeling may vary in extent based on the level of obesity of the person, as well as varying in intensity of stigmatization by actions of others. Helping people recognize that stigmas exist and are not uniform provides them with information and insight into stigmatization. It operates as a first step in dealing with stigmas by raising consciousness about stigmatization.

Readiness

To effectively cope with stigmatization, a person must anticipate situations and incidents where stigmatization may occur and be ready to deal with them. Such preparation is a key step in coping with stigmatization, permitting obese people to be proactive rather than reactive in potentially stigmatizing interactions. Preparation can involve cognitive or actual rehearsal of stigmatizing events. An obese person can practice reactions to deal with various stigmatizing acts, whether they are verbal, nonverbal, intentional, etc. This type of role play can be highly useful preparation for stigmatization.

Anticipatory guidance about facing stigma can be provided. This can help an obese person move beyond simply recognizing they may face problems in the way others deal with their weight into developing strategies to deal with these problems. A review of past stigmatizing acts involving a particular person

can be used as a basis for developing ways of dealing with similar events in the future.

Sources of stigmatization may be differentiated and different preparations made for various types. Beuf (1990) groups potentially stigmatizing sources into four categories: total strangers, acquaintances and peers, close friends and family members, and professionals. Readiness for different types and amounts of stigmatization from each of these sources needs to be anticipated by obese people, along with the preparation important for the range of stigmatizing acts from staring to verbal ridicule.

Readiness can occur both for the obese person, who may be a victim of stigmatizing acts, and also for the obese person's spouse, friends, or others who may be present and capable of providing assistance. Knowing that sympathetic and supportive others are aware of stigmatization and can assist the obese person during a stigmatizing act provides important social support for a person during a time of stress. Organizations and institutions have developed policies prohibiting weight discrimination which provide readiness for dealing with instances of stigmatization as they occur.

An important part of readiness is knowledge about the stigma to which others are reacting. The more a person understands about his or her own obesity, including nutritional and medical information, the more that person is ready to react to any negative responses of others. Relevant factual information and research findings are useful in dealing with other types of stigmas (Wahl and Harmon, 1989), and the same is true of obesity.

Prevention of a stigmatizing act can occur with proper readiness. This can be accomplished through information control, where a person can hide or minimize the awareness other people have of obesity or by making obesity less salient during an interaction. For example, advice about how to dress to look thinner can be useful for some people. A problem in such prevention is that it accepts the deviant labeling of obesity, which can have emotional and social costs for the obese person. Readiness is also accomplished through control of exposure both of a person's own obesity, as in carefully selecting settings where fatness may become an issue, such as recreation events or the beach, to avoid situations where they may be discredited for their obesity. Also, exposure to individuals who may be likely to stigmatize an obese person may need to be monitored, controlled or limited, particularly exposure to people who previously stigmatized obese people.

Readiness for stigmatization requires developing skill in contingency management, which permits planning ahead for potentially stigmatizing events. Obese people who may be stigmatized need to know what to anticipate in order

to cope with or avoid stigmatization and to minimize negative consequences. These skills provide empowerment for obese people who may be stigmatized.

Reaction

Stigmatizing acts may range from short verbal comments to major long-term events that involve severe discrimination or exclusion from important social opportunities or positions. Successful coping with such stigmatization should include a planned reaction that permits an obese person to deal with the stigmatizing event immediately and also to react in a longer-term manner.

Immediate coping with a stigmatizing action needs to be based on the capabilities and personal resources an individual has developed as a part of the readiness component of this model. Beuf (1990) developed a framework for assessing children's ability to cope with stigmatization that considers age, competency, physiological resources, psychological resources, social resources, and levels of interaction. Those who work with obese people who are stigmatized may find it useful to assess these categories in their clients. Reactions use these to diffuse tension, such as the shifting of mean-spirited comments about obesity into another frame of reference by using humor. Immediate coping with stigmatizing acts may shift the focus of the interaction away from obesity as the issue being stigmatized, in order to prevent psychological and social damage to the obese person. For example, many stigmatizing acts directed at obese individuals involve comments about the predicaments they face because of their size. Reactions to such comments can range from demonstrations that the predicament is untrue to retorts that reframe the comment in a positive light. Awareness of the common comments and metaphors used in stigmatization and discrimination against obese people can be used to develop reaction strategies and contingency strategies if immediate reactions fail.

Reactions that redeem the stigmatized person need to be prepared, including various rationale for extricating the obese person from further stigmatization. This could involve the use of medical, rather than moral, perspectives about obesity to shift the frame of reference. The definition of the situation stigmatizing obesity as badness (a moral attack on the victim as being lazy, without will power, etc.), can be shifted to the definition of obesity as an illness (a medical response potentially attributable to genetics, endocrinology, etc.), which uses the exemption of blame implied in the sick role to minimize stigmatization. However, this particular strategy is not without some costs. It continues to accept the social definition of obesity as deviant and only shifts the explanation for the deviance.

Collective reactions to the stigmatization of obesity also can be developed for organizations and institutions. These can include encouragement of group norms and attitudes that promote weight acceptance and do not tolerate stigmatization and discrimination against the obese. Sometimes this can involve written policies of the organization, such as in hiring policies, although it may only require discussion and statement of values that are weight tolerant.

After immediate reaction to a stigmatizing event, longer-term reaction may also be important. This may involve extended reactions to the person or group stigmatizing an obese individual, which may be part of the same social interaction or contacts at later points in time. Longer-term reactions may be more measured, with more opportunity to change attitudes and practices of people who stigmatize the obese. Having a strategy for dealing with longer term reactions and thinking ahead about how reactions might be dealt with make them more important than immediate and transitory reactions. For example, it is more important for an obese person to have strategies to react to persistent stigmatization by coworkers than a random comment by a stranger at the beach.

Plans for longer-term reaction will vary, but certainly will include the development of empathy among individuals who stigmatize the obese, based on having them appreciate the obese person by developing the ability to assume the role of someone who is obese. Open and frank talk about obesity is often a useful reaction, demonstrating to the person doing the stigmatizing that obesity is not a taboo topic and that others can understand and appreciate the life of someone who is obese. Poignant literature may help demonstrate these issues to others (Millman, 1980; Stunkard, 1976).

Repair

After reacting to a stigmatizing event, a complete coping process should include repair of any problems that occurred from that specific stigmatizing act, recovery from these problems, and also reform of the conditions that led to the stigmatization. Social support can be sought by obese individuals who have been stigmatized in the usual forms (families, friends, neighbors, or organizations) plus those specific to obesity as a stigmatized condition (other dieters or associations of obese individuals).

Even if a person was ready for a stigmatizing event and reacted fairly well, they must recover from the fundamentally negative stigmatizing experience. This includes immediate restoration as well as adjustments for the future. The blow to an obese person's self-esteem from verbal comments or discriminatory acts requires entry into a psychological healing process. This can be short and personal or longer and involve others. Social support may be sought from an

empathetic partner or a group of other obese people. Allon (1975) describes how dieting groups provide the opportunity for obese people to share experiences and provide support for one another.

Repair can also involve personal adjustments for future stigmatization. This feeds back into the earlier components of this model for coping with stigmatization. Repair involves new recognition of stigmas by learning from each experience, increasing readiness for similar types of stigmatization in the future, and permitting the current reactions to be assessed and modified.

Repair occurs beyond individual adaptation. This may involve seeking restitution from people committing stigmatizing acts, and reform of people and conditions that were involved in stigmatization. These components of coping with the stigmatization of obesity go beyond specific events to larger social reforms that may prevent future stigmatization.

Restitution may be sought from individuals or collectivities that stigmatize obese people. This can involve seeking compensation through interpersonal or even legal means for damages that occurred as a result of stigmatization. A growing number of legal cases waged for victims of weight discrimination (Baker, 1984) have been decided predominantly in favor of the obese person.

Reform is the part of repair that seeks individual and societal change to lead to less stigmatization and discrimination against the obese. Individuals may be reformed by an obese person or others who recognize the problems inherent in stigmatization. This can occur through the development of empathy and provision of data about obesity using any of a number of approaches that change attitudes and values. Organizations, groups, institutions, and other collective bodies can be formally changed through legal means, policy statements, and other means, and their informal values and attitudes can be changed through discussions and presentations. A fat rights/fat pride movement has developed which has worked toward social reform about weight in society (Grossworth, 1971; Louderback, 1970; Orbach, 1984). Sociologists may assist some individuals in coping with the stigma of obesity by directing them to literature and organizations in this area. Sociologists also may make contributions to reform the stigmatization of obesity at larger levels by doing research, changing opinions and practices of influential people who deal with obese individuals, conducting classroom and public education to change social values, and other activities that reform social values about obesity.

Many stigmatized groups have developed organizations that attempt to overcome the stigmatization of their condition by empowering their members, fostering social change in attitudes about the stigmatized condition, and working for legal reform with respect to their problem. Obesity is no exception. Several support and reform groups exist, including the National Association to Aid Fat

Americans, Ample Opportunity, Diet/Weight Liberation, and others. Sociologists have been involved in these organizations and have contributed to their meetings and activities.

Implications

Nutritional sociologists can assist people in dealing with stigmatized conditions using a model that provides guidance in coping with stigmas. Roles that clinical sociologists have played in dealing with the stigma of obesity include counselors of individuals and families, consultants to health professionals, expert witnesses at hearings and trials, analysts in organizations, advocates of groups, societal analysts, program evaluators, educators, and documenters of the stigma associated with obesity. This diversity of activities shows the potential roles for sociologists in this area, and use of a model to frame these activities should encourage more and improved work with stigmatization in the future.

The model presented here can be applied by sociologists working on many levels. Obese people can be assisted in coping with stigmatization by working with them, and by using individual or group counseling. The stigma of an individual may extend to social units in which the person is a member, such as families (Wahl and Harmon, 1989), and the model presented here also can be used to help people stigmatized from their association with obese people cope with stigmatization. Organizations and institutions can also be guided using this model.

Clinical work on stigmatization can usefully draw on distinctions made by medical and public health practitioners among three types of prevention: primary, secondary, and tertiary. Primary prevention involves avoiding the occurrence of a problem. For the stigmatization of obesity, this could involve avoiding stigmatization by recognizing people, occasions, or settings where stigmatization is likely to occur. Secondary prevention involves identifying a problem at an early stage and intervening to change the typical negative course of the problem. For the stigmatization of obesity, this could involve being ready for stigmatization, reacting quickly, and having repair strategies mapped out. Tertiary prevention involves not letting a problem that has occurred lead to severe and long-term outcomes. For the stigmatization of obesity, this might mean the use of restoration and recovery measures to repair the consequences of stigmatizing actions by others. These examples show how the model proposed here is compatible with and can be translated into perspectives understood and used in the health professions. Sociologists who work with health professionals need to be able to mediate between sociological and medical concepts.

Applying a sociological perspective to the stigma of obesity can restructure the issue by showing that the problem is not only a physical issue based on the stigmatized characteristic, but also is a social problem that can be dealt with using insights and interventions from sociology. The predominant medical perspective for dealing with obesity focuses on changing the stigma by losing weight. Psychologists have largely allied themselves with the medical model by developing psychological methods to modify eating behaviors that assist people in losing weight. The orientation of psychologists dealing with obesity has been more as behavioral scientists than social scientists.

Sociologists can shift the frame of reference from changing stigmas to changing stigmatization. Their real contribution to working with obese people lies in analysis of the interpersonal and social aspects of obesity and assisting obese people in dealing with these issues. This does not negate the potential for sociological contributions to weight loss efforts, but rather points out a more unique social science contribution they can make in their practice with obese people.

Practical tools that may be useful in helping people use this four-component model include memory aids and handouts. The model presented here can be easily remembered using a "four R" mnemonic for the names of each of the components. Another potential tool is using a person's hand as a memory aid, with the thumb representing stigmas that can be opposed by touching it with each finger which represents one of the four components of the model. Finally, a straightforward table or card handout can be developed such as the one presented in Table 2. This uses direct statements that are guides to enacting each of the four components of the model.

Table 2.
A Client Handout for a Model to Cope with Stigma

1. Recognize the problem of stigma
 - Be aware that stigmatization exists
 - Understand how it may affect you
2. Ready yourself for stigmatizing situations
 - Anticipate where you may be stigmatized
 - Prepare yourself for potential stigmatization
3. React appropriately to stigmatization
 - Deal with stigmatization
 - Minimize any problems stigmatization may cause
4. Repair any problems stigmatizing may cause
 - Heal yourself from any problems and injuries
 - Work to prevent future stigmatization

The model presented here could also be used for other stigmatized conditions ranging from AIDS to various disabilities. Application to other conditions would need modification, but the basic framework and many specific strategies may be directly transferable. Information gleaned from other applications may be useful in modifying the model to make it more useful for application to obesity.

Sociological practice includes many opportunities for involvement with obesity and other stigmatized conditions. The extensive weight-loss industry and strong cultural emphasis on nutrition demonstrate interest in the topic. Sociologists can apply their unique theoretical perspectives to make contributions that help people deal with obesity and other stigmas, and should increase their efforts in that area.

REFERENCES

- Ablon, J.
1981 Stigmatized health conditions. *Social Science and Medicine* 15b:5-9.
- Ainlay, S. C., G. Becker, and L. M. Coleman
1986 *The Dilemma of Difference: A Multidisciplinary View of Stigma*. New York: Plenum.
- Allon, N.
1973a Group dieting rituals. *Transaction/Society* 10(2):36-42.
1973b The stigma of overweight in everyday life. Pp. 83-102 in G. A. Bray (ed.), *Obesity in Perspective*. Fogarty International Series in Preventive Medicine, 2, Part 2. Washington, D.C.: U.S. Government Printing Office.
1975 Latent social services in group dieting. *Social Problems* 23(1):56-69.
1979a Group dieting. Pp. 29-81 in N. Allon (ed.), *Urban Lifestyles*. Dubuque, Iowa: William. C. Brown.
1979b Self perceptions of the stigma of overweight in relationship to weight losing patterns. *American Journal of Clinical Nutrition* 32:470-80.
1981 The stigma of overweight in everyday life. Pp. 130-74 in B. J. Wolman (ed.), *Psychological Aspects of Obesity: A Handbook*. New York: Van Nostrand Reinhold Company.
- Baker, J.
1984 The Rehabilitation Act of 1973: Protection for victims of weight discrimination? *UCLA Law Review* 29:947-71.
- Benson, P. L., D. Severs, J. Tatgenhorst, and N. Loddengaard
1980 The social costs of obesity: A non-reactive field study. *Social Behavior and Personality* 8(1):91-96.
- Beuf, A. H.
1990 *Beauty Is the Beast: Appearance-Impaired Children in America*. Philadelphia: University of Pennsylvania Press, 1990.

Blumberg, P., and L. P. Mellis

- 1985 Medical students' attitudes towards the obese and morbidly obese. *International Journal of Eating Disorders* 4(2):169-75.

Boutte, M. I.

- 1987 The stumbling disease: A case study of stigma among Azorean-Portuguese. *Social Science and Medicine* 24:209-17.

Brotman, A. W., T. A. Stern, and D. B. Herzog

- 1984 Emotional reactions of house officers to patients with anorexia nervosa, diabetes, and obesity. *International Journal of Eating Disorders* 3(4):71-77.

Brown, P. J., and M. Konner

- 1987 An anthropological perspective on obesity. *Annals of the New York Academy of Sciences* 499:29-46.

Cahnman, W. J.

- 1968 The stigma of obesity. *Sociological Quarterly* 9:283-99.

Canning, H., and Mayer, J.

- 1966 Obesity—Its possible effect on college acceptance. *New England Journal of Medicine* 275:1172-74.

DeJong, W.

- 1980 The stigma of obesity: Consequences of naive assumptions concerning the causes of physical deviance. *Journal of Health and Social Behavior* 21:75-87.

Goffman, E.

- 1963 *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, N.J.: Prentice Hall.

Goodman, N., S. M. Dornbusch, S. A. Richardson, and A. H. Hastorf

- 1963 Variant reactions to physical disabilities. *American Sociological Review* 28:429-35.

Gramling, R. and J. C. Forsyth

- 1987 Exploiting stigma. *Sociological Forum* 2:401-15.

Grossworth, M.

- 1971 *Fat Pride*. New York: Jarrow Press.

Gussow, Z., and G. S. Tracy

- 1968 Status, ideology, and adaptation to stigmatized illness: A study of leprosy. *Human Organization* 27:316-25.

Harris, M. B., B. J. Harris, and S. Bochner

- 1982 Fat, four-eyed, and female: Stereotypes of obesity, glasses, and gender. *Journal of Applied Social Psychology* 12:503-16.

Herek, G. M., and E. K. Glunt

- 1988 An epidemic of stigma: Public reactions to AIDS. *American Psychologist* 43:886-91.

Herman, C. P., M. P. Zanna, and E. T. Higgins

- 1986 *Physical Appearance, Stigma and Social Behavior*. Hillsdale, N.J.: Lawrence Erlbaum.

Hilbert, R. A.

- 1984 The acural dimensions of chronic pain: Flawed reality construction and the problem of meaning. *Social Problems* 31:365-78.

Hiller, D. V.

- 1981 The salience of overweight in personality characterization. *Journal of Personality* 108:233-40.

- Hinkle, L. E., L. H. Whitney, E. W. Lehman, J. Dunn, B. Benjamin, R. King, A. Plakun, and B. Flehinger
1968 Occupation, education, and coronary heart disease. *Science* 161:238-46.
- Jarvie, G. J., B. Lahey, W. Graziano, and E. Framer
1983 Childhood obesity and social stigma: What we do and what we don't know. *Developmental Review* 3:237-73.
- Jones, E. F., A. Farina, A. H. Hastorf, H. Markus, D. T. Miller, and R. A. Scott
1984 *Social Stigma: The Psychology of Marked Relationships*. New York: W. Freeman.
- Kalisch, B. J.
1972 The stigma of obesity. *American Journal of Nursing* 72:1124-27.
- Kaplan, S. P.
1982 Attitudes of professionals toward the obese. *Obesity and Bariatric Medicine* 11(2):32-33.
- Kaplan, S. P., and K. Thomas
1981 Rehabilitation counseling students perceptions of obese clients. *Rehabilitation Counseling Bulletin* 25:106.
- Karris, L.
1977 Prejudice against obese renters. *Journal of Social Psychology* 101:159-60.
- Larkin, J. C., and H. A. Pines
1979 No fat persons need apply: Experimental studies of the overweight stereotype and hiring preference. *Sociology of Work and Occupations* 13:379-85.
- Laslett, B., and C.A.B. Warren
1975 Losing weight: The organizational promotion of behavior change. *Social Problems* 23:69.
- Louderback, L.
1970 *Fat Power*. New York: Hawthorne Books.
- Maddox, G. L., K. Back, and V. Liderman
1968 Overweight as social deviance and disability. *Journal of Health and Social Behavior* 9:287-98.
- Maddox, G. L., and V. Liederman
1969 Overweight as a social disability with medical complications. *Journal of Medical Education* 44:214-20.
- Maiman, L. A., V. L. Wang, M. H. Becker, J. Finlay, and M. Simonson
1979 Attitudes toward obesity and the obese among professionals. *Journal of the American Dietetic Association* 74:331-36.
- Matusewitch, E.
1983 Employment discrimination against the overweight. *Personnel Journal* 62:446-50.
- McClellan, R. A., and M. Moon
1980 Health, obesity and earnings. *American Journal of Public Health* 70(9):1006-9.
- Millman, M.
1980 *Such a Pretty Face: Being Fat in America*. New York: W. W. Norton.
- Murcott, A. (ed.)
1983 *The Sociology of Food and Eating*. Hants, England: Glower House.
- Murcott, A.
1988 Sociological and social anthropological approaches to food and eating. *World Review of Nutrition and Dietetics* 55:1-40.
- Najman, J.M., and C. Monroe
1982 Patient characteristics negatively stereotyped by doctors. *Social Science and Medicine* 16:1781-89.

- Orbach, S.
1984 *Fat is a Feminist Issue*. London: Hamlyn.
- Price, J. H., S. M. Desmond, R. A. Krol, F. F. Snyder, and J. K. O'Connell
1987 Family practice physicians' beliefs, attitudes and practices regarding obesity. *American Journal of Preventive Medicine* 3(6):339-45.
- Richardson, S. A., N. Goodman, A. H. Hastorf, and S. M. Dornbusch
1961 Cultural uniformity in reaction to physical disabilities. *American Sociological Review* 26:241-47.
- Ritenbaugh, C.
1982 Obesity as a culture-bound syndrome. *Culture, Medicine and Psychiatry* 6:347-61.
- Siegelman, C. K., T. E. Miller, and L. A. Whitworth
1986 The early development of stigmatizing reactions to physical differences. *Journal of Applied Developmental Psychology* 7:17-32.
- Schneider, J. and P. Conrad
1983 *Having Epilepsy*. Philadelphia: Temple University Press.
- Sobal, J.
1984a Group dieting, the stigma of obesity, and overweight adolescents: Contributions of Natalie Allon to the sociology of obesity. *Marriage and Family Review* 7(1/2):9-20.
1984b Marriage, obesity and dieting. *Marriage and Family Review* 7(1/2):115-40.
- Sobal, J., and C. Cassidy
1987 Dieting foods: Conceptualizations and explanations. *Ecology of Food and Nutrition* 20(2):89-96.
1990 University students' perceptions of fattening and dieting foods in relationship to the four food groups. *Nutrition Research* 10:145-54.
- Sobal, J., and H. L. Muncie
1990 Obesity. Pp. 1241-49 in R. E. Rakel (ed.), *Textbook of Family Practice*. Philadelphia: W. B. Saunders Co.
- Sobal, J., and A. J. Stunkard
1990 Socioeconomic status and obesity: A review of the literature. *Psychological Bulletin* 105(2):260-75.
- Straus, Robert
1957 The nature and status of medical sociology. *American Sociological Review* 22:200-4.
- Stunkard, A.J.
1976 *The Pain of Obesity*. Palo Alto, Calif: Bull Publishing Company.
- Sussman, M. B.
1956a Psycho-social correlates of obesity: Failure of the calorie collectors. *Journal of the American Dietetic Association* 32:423-28.
- Sussman, M. B.
1956b The calorie collectors: A study of spontaneous group formation, collapse and reconstruction. *Social Forces* 34:351-56.
- Tobias, A. L., and J. B. Gordon
1980 Social consequences of obesity. *Journal of the American Diabetic Association* 76:338-42.
- Wahl, O. F., and C. R. Harmon
1989 Family views of stigma. *Schizophrenia Bulletin* 15:131-39.

- Weiner, B., Perry, R. P., and Magnusson, J.
1988 An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology* 55:738–48.
- Weitz, R.
1990 Living with the stigma of AIDS. *Qualitative Sociology* 13:23–38.