OBesity as a Liminal and Marginalized Experience

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Introduction

This paper is based on my forthcoming doctoral dissertation exploring obesity from the viewpoint of social sciences and women’s studies. The working title of the dissertation is: The Fat Subject - Social scientific perspectives to women and obesity.

The focus of the research and this paper is on the study of social construction of obesity and women’s personal experiences of being fat. Theoretical starting point of the project can be found in the Foucauldian thought, and the social constructionist thought concerning the body (e.g. Foucault 1979). Furthermore, I understand obesity as a socially and politically meaningful difference that is analogous to other significant differences based on the body such as disability, gender, and ethnicity, for example (cf. Cooper 1997&1998; Young 1990). In my research, I approach obesity, on one hand, as a discursive category that is created, produced and reproduced through various social practices such as medicine and health care system, school, religion, and media (e.g. Foucault 1979) and on the other hand, as a personal experience. Central hypothesis of the research and this paper is that discursive construction of obesity is an ongoing, gendered and embodied, and often a marginalising and violent cultural process that has real consequences for the obese individual (e.g. Harjunen 2002&2003).

I claim that in our culture, a thin body is held as the ‘original’, normal body, whereas obesity is viewed as a ‘temporary disruption’ to the balance of the body. According to our cultural understanding, obese body is constantly seen as being in the process of transformation. The idea of a permanently fat person is unacceptable and obese body must be standardized and normalized. The goal is to transform and return the ‘original body’ through dieting, surgery etc. This is in stark contrast with reality, since obesity is becoming more widespread, and increasing number of people is permanently fat. In effect, obese women in particular, are culturally and socially driven into a marginalized position. This view is supported by both previous research (e.g. Brownell&Teachman 2000; Cooper 1997& 1998; Puhl&Brownell 2001) and empirical data I have collected for my doctoral dissertation. From my data I have been able to draw a conclusion that for women obesity seems to be a marginalizing or a liminal experience on a multiple of levels e.g. medical, discursive, social, political, liminal (in the sense of the concept used by Van Gennep 1960) and on the level of personal experience of one’s subjectivity and agency.

In this paper, I approach obese women’s experiences through the concepts of marginalization and liminality. I am developing the idea of obesity as a marginalized and liminal space and experience e.g. between normal and abnormal, health and disease, acceptable and unacceptable femininity etc. My idea is that construction of obesity as a marginalized and liminal space contributes to the experience of marginalization for obese women and often leaves them in a symbolic and concrete state of limbo. In this paper my aim is to begin discussion on these marginalities and women’s experience of liminality from the point of view of an embodied and gendered fat subject. The data used in this paper consists of 35 autobiographical writings and 12 thematic interviews with Finnish women aged between 21 and 65 years. Altogether, the data consists of 47 personal accounts of life as a fat woman.
I will begin my exploration by briefly introducing the concepts of liminality and marginality as used in this paper. I will continue by examining some of the key factors that contribute to the construction of obesity as a marginalized position. Finally, I will explore personal experiences of liminality and marginalization as represented in my data.

The Concepts of Liminality and Marginality

The concept of liminality was originally used by Arthur van Gennep (1960) in his study concerning rite of passage. It was later developed further by the anthropologist Victor Turner (Turner 1977&1979). The rite of passage is a transitional ritual designed to help the individual to move from one status, place or state to another. According to Turner (1997&1979), there are three phases in a rite of passage: separation, the margin or the limen and reaggregation. When the subjects are situated in the limen, they are positioned outside established social structures and they have no active status within society. The purpose of the rite of passage is to completely transform the individual, the whole person including the body.

My use of the concept of the liminal broadens the meaning it was originally used by van Gennep and Turner. Liminality can be positive liminality that is necessary in preparation in a transition to a new phase of life. On the other hand, I am of view that the concept of liminality can be used to describe the position and experience of people who are defined as others or left outside the accepted or established way of being due to having been determined somehow unacceptable by society’s standards. My interpretation is that experience of liminality relates to denial of full subjectivity and agency from subjects that do not fulfil society’s norms of being. Being placed in a liminal position promotes marginalization and marginality of such groups of people.

In my thought liminality as a concept is to some extent overlapping with marginality. They illuminate different aspects and levels of the experiences of obese women. Based on my data, it would seem that obese women feel that they are simultaneously in a liminal position, in-between accepted positions, and pushed into the margins. In my opinion therefore, the concept of liminality can be used to explore and describe the discursive position of an obese person in the Western obesity discourse and culture, as well as personal experience of obesity.

Social Construction of Obesity as a Liminal and Marginalized position

Social constructionist thought sees the construction of body as a social and cultural process. This concerns all bodies, and especially those bodies that are considered somehow deviant to the norm (e.g. Foucault 1979; Goffmann 1968). In our culture, obesity is seen as a bodily abnormality and deviance that should be corrected. Obesity has indeed become one of the most stigmatizing bodily characteristics in our culture (Brink 1994).

The social construction of obesity as an abnormality is a long and multi-faceted process, in which several discourses concerning the body meet. In the dominant mainstream discourse regarding obesity, for example medicine’s definition of the normal body and medical attempts to create an optimally healthy body become intertwined together with Christian-philosophical conceptions concerning morality, virtue, and moderation (Stone 1995, 413-424). In the case of women, the general ideals of bodily normality and virtuosity of character are further linked with gender-bound expectations concerning the female body and women’s role in society. Women’s appearance, behaviour and sexuality continue to be under stricter normative control and regulation than men’s (Stone 1995; Wolf 1991). My hypothesis is that construction of obesity as an abnormality and deviance leads into production and reproduction of obesity as a marginal and liminal space situated between normal and abnormal, health and disease, acceptable and unacceptable femininity etc, and this has got a number of effects for cultural understanding of obesity, treatment of obesity and obese people, and consequently, the experience of obese individuals.
Production of Obesity as a Temporary ‘Illness’

For decades, obesity has been approached mainly from a point of view medicine. This means that obesity has been seen predominantly as a curable medical condition and obese person as someone who is in need of rehabilitative treatment. Obesity research has been strongly focused on the origins, health effects, and treatment of obesity. Emphasis on medicine has meant that the manifoldness and complexity of obesity has been rarely acknowledged in research until recently. This narrow approach has meant that for example social or personal aspects of obesity have not been systematically or scientifically explored. Persistent construction of obesity as a temporary condition within medical discourse might explain the lack of research on such vital fields; there has been a strong belief that obesity can be treated successfully through medicine. Perhaps it was felt that there is no need to examine social construction of obesity, obesity as a personal experience or the experience’s social and political relevance, since within medical discourse no-one is permanently fat.

Social scientific research interest and study of obesity has truly emerged only during the past two decades both in Finland and internationally (e.g. Cooper 1997; Polso 1996; Sarlio-Lähteenkorva 1999; Zdrodowski 1995& 1996).

As a result of the dominance of medicine in obesity research and production of obesity discourse, obesity has become strongly medicalized. Within biomedical discourse obesity has been constructed as a physical and medical abnormality or disorder that requires medical attention. As a result of this an obese person has often been perceived merely as an object of medical treatment. Treatment of obesity within medical discourse can be justifiably compared with treatment of disabled people in the context of medicine (Cooper 1997; Harjunen 2003). Just as disability has been viewed as a personal problem within biomedical model of thought, being obese is seen as a personal failure and the individual him/herself is viewed as the source of any problems that may be connected to obesity. This kind of approach and blaming the individual has been contested within disability research over the past two decades. Alongside the individual or biomedical model of disability there has emerged a so-called social model of disability. According to social model of disability, it is not the disability that disables an individual, but society that put cannot provide for disabled persons needs (e.g. Barnes, Mercer&Shakespeare 1999; Oliver 1990)

Obesity between healthy and unhealthy

In the medical context, the possibility or the calculated risk of developing a chronic weight-related disease, labels the obese person as always already ill or ‘pre-ill’. Obese persons find themselves often in some kind of medical limbo, not ill, but treated as they had a medical problem. It has been noted that even if the obese person did not have any health problems relating to the body weight, obesity in itself is habitually seen as a disease-like condition by medical professionals (e.g. Cooper 1997& 1998; Harjunen 2003). The possibility of an obese but healthy individual has been for a long time denied completely within medical context. Since also healthy or fit obese people are treated as unhealthy, it seems that we are not always dealing with medical facts, but with social and cultural prejudices against obesity.

Social constructionist view to health and illness gives an interesting insight to the discussion on medicalization of obesity. According social constructionist view, no disease, or what is labelled as one, exists separate from society and health and illness are always defined through various social processes. This means that all illnesses, diseases, and disabilities are essentially human constructs (Litva 2000).They are defined culturally and socially and our cultural conception of the ‘acceptability’ of an illness or what is perceived as such is always influenced by our understanding of normality and acceptable behaviour among other factors. Although medical professionals often like to claim otherwise, the dominance of medical approach and consequent medicalization of obesity have had a great influence to the cultural construction and understanding of obesity not only as a health related risk, but as a sign of moral and social deviance that must be eliminated and normalized. Medicine has unfortunately many times helped to enhance the social stigma relating to obesity.

In fact, often obesity treatment seems to be as much about making the individual socially more acceptable as promoting health. This is evident both on the conceptual and pragmatic levels. Recently also some members of the medical profession have expressed doubt about the motivation behind obesity treatment. Fitzgerald for
example has suggested that medicine’s battle against obesity could be partly explained by a tendency to medicalize behaviour that we do not approve of (Fitzgerald 1994). Kassirer and Angell for their part have observed that obesity treatment is sometimes clearly more driven by the will to normalize the obese person’s body than improving the patient’s health (Kassirer & Angell 1998).

**Social Stigma and Obesity**

It is obvious that cultural construction of obesity as an abnormality and as a personal failure has a number of consequences both for our understanding of acceptable and unacceptable bodies, how we treat those who are labelled unacceptable and the lives of obese people themselves (Harjunen 2003). For example Pamela J. Brink has argued that a fat body has become one of the most stigmatizing physical characteristics in our contemporary culture. (Brink 1994). In the Western culture, thinness does not just mean the size of the body, but it is associated with such qualities as being healthy, attractive and in control. In contrast, a fat body is viewed as a sign of poor health, inefficiency and lack of personal will. (e.g. Kissling 1991, 136; Ogden 1992, 7-9; Cooper 1998). Brink (1994) has observed that obese people are stigmatized for both their physical appearance and for their assumed moral weakness.

Recent research has shown that the social stigma associated with obesity can have serious consequences for an obese individual. According to for example studies by Puhl and Brownell (2001) and Brownell and Teachman (2000), obesity can often lead into serious discrimination in such central fields of life as education, health care and employment. The extent of discrimination experienced by obese people is such that obesity researchers in the United States have begun to talk about weight-based discrimination, which means that a person’s weight is seen directly as the cause of discrimination. In other studies it has been shown besides health, obesity may have for example social, emotional, psychological and economic consequences for an individual. (e.g. Zdrodowski 1995 & 1996; Cooper 1997 & 1998; Sarlio-Lähteenkorva 1999). It is evident that in society obesity is treated as a broader issue than just a medical one.

**Obesity, Gender and Appearance**

Stigma and stigmatizing effect of obesity is not similar for men and women. Research has clearly shown that obesity is more stigmatizing for women and obese women are discriminated against more than men because of their weight (Puhl & Brownell 2001). Some of the stigma attached to obesity relates to the cultural emphasis placed on appearance and especially women’s’ bodies. The norms concerning appearance and body have been stricter for women than for men and also the norm of thinness has affected women more strongly (Bordo 1991). Medical, and social discourses combined with popular media have actively promoted the view that for women thinness is a requirement for happiness, success in personal relationships and career (Wolf 1991). The dominance of the discourse that implies that body size determines one’s status as partner, student, worker, or friend overwhelms many women. For example Silberstein, Striegel-Moore, and Rodin (1987) have observed that for women even imagined overweight is a significant source of feelings of shame, guilt and inadequacy. The significance of social consequences of obesity for women is underlined also in other studies such as Sirpa Sarlio-Lähteenkorva’s research in which social, behavioural and health-related factors in obesity and weight-loss maintenance were studied. Sarlio-Lähteenkorva found that the motivation for dieting for women in particular is often driven more by social than health reasons (Sarlio-Lähteenkorva 1999). Therefore, it can be argued that for obese women there is also a third ground for stigmatization: failing to comply with the normative ideal of appearance set for the female body.

**Liminality and Marginality in Women’s Own Narratives**

**Dieting as a Liminal Experience**

Obesity represents several types of liminality at the same time. In my data the idea and experience of being in margins and feelings of liminality are represented at least in five different forms. There is experience of liminality in the van Gennepian sense, but liminality comes up also in the forms of medical, discursive, social and political liminality. These liminalities are overlapping and intertwined with each other in different combinations.
First of the liminalities in the data is liminality in van Geneppian and Turnerian sense. The van Gennepian and Turnerian definitions of liminality and rite of passage can be directly applied into the study of some aspects of obesity, especially those relating to its understanding and treatment within medical discourse and the experience of being in transition when dieting for example. Women in the data have clearly internalized the cultural understanding of obesity as a temporary phase. It is expected that obese individuals, especially women constantly work towards thinness. The goal is to transform the body of the individual and return the ‘original body’ through dieting, surgery etc. Even if they are not dieting, they feel that have to talk about going on diet. Diet talk serves two purposes. It validates the obese body firstly by indicating that the individual is aware of the acceptable weight and secondly, that she intends transform back to ‘normal’. Some women in the data say that they are annoyed by thin people’s diet talk. It is seen as invalidating one’s own experiences of living as a obese person.

The idea of a permanently fat person is unacceptable and obese body must be standardized and normalized. According to our cultural understanding, obese body is constantly seen as being in the process of transformation, whether individual is trying to lose weight or mould the body otherwise or not. Indeed it is assumed that all the obese people actually want to lose weight or are capable of doing so. Losing weight is seen as merely a matter of will power.

The expectations to lose weight and reality of the informants’ lives are often contradictory. The result is that many informants appear to live in permanent state of limbo. Most of the informants have been more or less overweight from the medical point of view all their lives. However, they tell about constantly thinking of losing weight, repeated diets and relapses. Only a few of the women do not want to lose weight and tell that they are comfortable in their bodies. In our cultural understanding there is no room for happy or content obese subject. Since thin body is considered the only valid foundation for a person’s subjectivity and identity in our society, it is inevitable that the obese individual is placed both symbolically and concretely in a liminal position. This is of course in stark contrast to reality. We have plenty of scientific evidence that being obese is more often a permanent than temporary phase. Increasing number of people both in Finland and around the world is permanently fat (Lahti-Koski 2001). Furthermore, according to recent research, only approximately 6% of the dieters manage to maintain their goal weight. Relapses and weight-cycling are common (Sarlio-Lähteenkorva 1999). Many times dieting phase becomes a permanent lifestyle (Polso 1996) thus leaving the person in a permanent state of liminality, in-between positions. In some cases the identity of in-between is established.

In those women’s narratives who have dieted or lost a significant amount of weight in the past or recently, the dieting process clearly represents a liminal phase. Dieting means both physical and psychological liminality for them. Mental re-orientation and anchoring of identity to a transformed body takes place in the liminal phase and the return to the ‘original’ thin body is reaffirmed in the reaggregation phase. Women in my data have expected that after they have lost the weight, their life would change drastically for the better. Some feel that after weight loss they have become more accepted and their choices and possibilities have increased. However, many have been disappointed too. Even those women who say that they quality of life has improved note that the process has been psychologically challenging. For example realization that people’s attitudes to them have actually changed after their body size has changed, many feel sorrow and even anger for not being accepted the way they were before. For many understanding of discrimination and prejudices against obesity are only revealed after they have themselves lost weight.

Losing weight is often approached lightly as a simple bodily transformation, although what is actually taking place is intentional alteration and tampering with the bodily foundation of the individual’s subjectivity and identity. So far not enough attention has been paid to the painfulness and personal emotional and psychological strain involved both in the transformation of the body and living in a permanent expectancy of transformation.

**Obesity as a Liminal Experience and Position**

The second ‘liminality’ relates to experience, one’s personal experience of living in a fat body. This relates to the idea postponing life into future when one has lost weight. Obesity is clearly not seen as a valid bodily
basis for subjectivity. It is seen as a personal failure and all aspects of life are entangled with the experience of ones’ body being different or rather not acceptable. Feelings of inferiority become often entwined with the experience of obesity. All difficulties one experiences can be traced back to obesity. Making people feel that they are inferior and undeserving is a serious outcome of systematic marginalisation.

It is apparent in the data that obesity is not seen as an accepted mode of being. It is seen as a stigmatizing and marginalizing characteristic that can is often used to discriminate and exclude socially. An often expressed idea in my data is that of not fitting in and being different. Women feel that their physical appearance sets them apart from other people both symbolically and concretely. They tell about feelings of isolation and moments of social exclusion and discrimination.

It is apparent in my data that to reach full subjectivity, many informants feel that they have to transform their bodies first. The idea seems to be that ‘proper’ subjectivity and agency can only be achieved in a thin body. As long as the body does not fit the standard of normality, life is not proper life and person does not see herself as a competent agent. Feeling of competence and agency is clearly bound to the experience of obesity. If and when weight has been lost, person becomes accepted and agency becomes possible. As Cooper states, obese people have learnt not to expect to fit in and they are constantly receiving the message that they should change and adjust to the norms in order to be accepted as a fully-fledged human being (Millman 1980; 208-209; Cooper 1997, 31).

Many women in the data in fact tell that they feel that many things are not allowed for them because of their weight. One does not have right to agency and life. They avoid doing things and do not work towards their personal goals or dreams because of their weight including hobbies, relationships, education, travel, job, buying nice clothes etc. A recurring thought in my data begins with “when I lose some weight I am going to ….” The idea is that life can only begin when one has left the state of liminality where one feels she is not a valid member of the established social world. Many times it seems that their lives are put on hold to wait for the day one has lost weight, the day that may never come.

Discourses and Counter Discourses

The other liminalities I have identified in my data are better described as marginalities or marginal experience since specific concept of liminal does not capture the political or more societal meanings of obesity. In my data being in-between refers not only to the liminal experience, but also marginality, feelings of otherness and experience of social exclusion. The similarity of women’s experiences suggests that it might be possible to find a shared cultural experience relating to obesity.

The third liminality of obesity found refers to discursive construction of obesity. By this I mean any means and practices that produce obesity as a liminal and temporary space. Science, media and everyday disciplinary and normalising practices among others recreate the liminality of obesity. Discursive construction of obesity has been discussed in this paper elsewhere.

The fourth liminality visible in my data sees body as matter of political struggle. Some informants clearly see obesity as a political and politicizing position. As a political liminality obesity is understood as analogous to other political differences such as ethnicity and disability. Obesity is seen as a form of otherness and as an othering position. When obesity is seen as a political question attention is focused on social discrimination. The experience of discrimination is made visible and the right to be defined not only through obesity is demanded. Comparisons to struggle for rights of other groups of people defined as others are relatively easy to make (e.g. Young 1990).

The central aim of political fat activism movement is to promote fat or size acceptance; increase awareness of the cultural bias against obesity and to condemn weight-based discrimination (Millman 1980, 4-9). However, presently, there are signs of a more widespread counter discourse that is critical of medicine, diet industry and current obesity research. To the extent, fat acceptance movement’s ideas have been integrating into the mainstream, for instance, through popular media. One important factor of fat activism is the support it can offer. For this purpose, a thriving fat politics scene can be found through the Internet.
As Charlotte Cooper has noted, fat people’s political position is somewhat problematic. Fat people are not seen as a ‘natural’ group whose civil rights as fat people should be protected by special legislation. (Cooper 1997, 33). However, it is predicted that the situation will change in the future. We have to start thinking about obesity in different terms and from multiple perspectives. We need to acknowledge that obesity may have significant social, political, and legal consequences for both the fat individual and the society we live in.

**Conclusion**

I have attempted to show how obesity is being discursively and on the level of social practices produced as a marginal position. Labelling obesity as a bodily abnormality, the social stigma associated with obesity and other discriminating social practices systematically marginalise and mark the obese person as different. It could be claimed that obese person’s bodily base of subjectivity is constantly under suspicion and threat. The validity of obese body as a basis of subjectivity and the obese individual’s embodied experiences as a fat person are being effectively denied or ignored. On the basis of my empirical data, the experience of marginalization and liminality is constantly present for obese women.

Embodiment and embodied subjectivity have become some of the most important concepts within women’s studies over the past two decades. If the body is understood as the foundation of subjectivity and identity, my question is how is the embodied subjectivity and identity negotiated and what is the nature of embodied experience for an individual whose body is by the dominant cultural understanding seen as unstable and temporary, that constantly faces demands to change and is generally understood as physically, socially, morally and aesthetically unacceptable by the society’s standards. What choices are there available? These questions clearly require further exploration.

**References:**


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