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Theorizing Failure: Explanations Regarding Weight Regain among People with Fat Bodies

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Abstract:

Drawing on interviews with Swedish men and women who live in fat bodies, this article articulates people's own explanations of weight regain and failure to lose weight permanently. The aim is to give a glimpse into a system of explanations where eating is perceived as a way of handling other problems, fatness is considered as a symptom of something else, and where weight reduction practices are seen as contributing to fatness. The participant's theorizations of weight regain, here called *theorizing failure*, are characterized by two types of shift in focus: *cause-shifting* and *problem-shifting*. The first seeks to attribute fatness to causes outside the received view, focusing on behaviors and energy consumption. Cause-shifting means that over-eating is seen as being caused by underlying problems. The second, problem-shifting, means that fatness is viewed as an effect of an underlying, 'real' problem, and defines fatness as a symptom, and weight-centered methods as part of the person's weight problem. This article pinpoints shortcomings with the weight-centered approach and addresses alternative ways to think about why some people fail to lose weight permanently.

Key words: fatness, lived experiences, qualitative study, grounded theorizing, causes of weight regain, fatness as symptom, the body project

Introduction

During the last century, measuring body weight was established as a central element in assessing people's health status. Normal weight is associated with health, and being overweight with ill health (Jutel, 2001; Rail *et al.*, 2010). Ever since ancient Greece, very fat bodies have been defined as a threat to an individual's health (Gard and Wright, 2005). What is newer is that overweight has been defined as a medical problem (Murray 2008b; Sobal, 1995). Obesity, the medical definition for large amounts of overweight in relation to body weight norms, has been constructed as a public health problem in Sweden and other countries (SBU, 2002). It has even been defined as a global epidemic (WHO, 2000), and has led to a 'war' on obesity (Rail *et al.*, 2010; Fraser *et al.*, 2010). Measures to fight obesity involve both prevention and individually-focused treatments (Rome, 2011). Whether it is a question of diet, behavioral and lifestyle changes, medication or surgery, the goal is the same - to help people reduce their body weight. Weight reduction methods are based on the idea of energy balance, meaning that body weight will be reduced if bodies are supplied with less energy than they burn (Gard and Wright, 2005; Hafekost *et al.*, 2013).

Weight loss is seldom sustained when people with fat bodies are engaged in weight-centered, energy-regulating methods to lose weight (Gaesser, 2009; Mann *et al.*, 2007). On the contrary, many become fatter following such practices (e.g. Foster *et al.*, 1997; Jeffery *et al.*, 2000; Pietiläinen *et al.*, 2012; Hill, 2004). Considering the high failure rates of 95%, Aphramor (2005) questions whether it is ethical to recommend weight loss as a medical treatment (see also Monaghan 2005; ten Haven *et al.*, 2011; Bacon and

Aphramor, 2011). Empirical studies show that weight loss treatments tend to make people fatter (e.g. Pietiläinen *et al.*, 2012; Hill, 2004), but such treatments also have other downsides. Rich and Evans (2005) argue that weight loss practices can result in disordered relationships with food, exercise, and the body. Owen (2008) is also skeptical of weight loss practices and has shown that diets can be experienced as both physically and mentally painful or can be perceived as not worth the effort. Weight-centered methods can even be considered risky. In their analysis of medical research, Cogan and Ernsberger (1999) conclude that diets and weight loss methods can be dangerous since they often result in weight cycling, which itself constitutes a risk factor for developing cardiovascular diseases (see also Simkin-Silverman *et al.*, 1998). Despite research highlighting the inefficacy and potential dangers of weight-centered methods (e.g. Pietiläinen *et al.*, 2012; Cogan and Ernsberger, 1999), they are widely used and seldom questioned in medical care (Aphramor, 2005). Blame is put on an individual's behaviors and mindsets when people fail to lose weight permanently (see review in Elfhag and Rössner, 2005). The construction of individuals as failing is part of a well-established sociocultural blaming-the-individual approach (Dumas *et al.*, 2014; Rail *et al.*, 2010), and can be traced in the research of fatness and weight regain from different perspectives.

The 'insider perspective' focusing on people's subjective experiences of weight changes and causes of fatness/overweight is an understudied phenomenon (see Smith and Holm, 2011; Temple Newhook *et al.*, 2013; Bombak, 2015). Drawing on interviews with Swedish men and women who live in fat bodies, this article explores causes of failure to lose weight permanently from an 'insider perspective'. The participants theorized around why they are, and continue to be, fat despite numerous weight loss

attempts. These theorizations, here called *theorizing failure*, are characterized by an expanded cause-and-effect relationship regarding fatness. The aim is to give a glimpse into a system of explanations where eating is perceived as a way of handling other problems, fatness is considered as a symptom of something else, and where weight reduction practices are seen as contributing to fatness.

In line with critically-oriented research that attempts to release fatness from its medical hegemony, the terms ‘fat’ and ‘fatness’ will be used instead of the medicalized and normatively informed concepts ‘overweight’ and ‘obesity’ (see Colls and Evans, 2009; Cooper, 2010). When referring to the participants or people who live in bodies considered above normal weight in general, the wording, ‘people with fat bodies’ will be used instead of the more common ‘fat people’ or ‘people who are fat’. The latter terms indicate that people *are* their body size. To convey that the fat body is just one among several aspects influencing a person’s identity (e.g. having a sex and a sexual orientation, an age, an ethnicity, a social class, etc.), the term ‘people with fat bodies’ is used here. This is used to describe this group of participants, but is not a term they would necessarily use to describe themselves.

The social and cultural adversities of living with a fat body are often, and for good reasons, theorized as a matter of gender (e.g. LeBesco, 2004; Murray, 2008a; McKinley, 1999). It has for example been widely demonstrated that gender is of importance for understanding experiences of body weight and fatness (e.g. Orbach, 2006; Monaghan, 2007). It seems clear that weight is a ‘bigger’ issue for women, that overweight women are more prone to social adversities because of their shape, that the tolerance level for overweight is lower for women, that they usually suffer more from their bodily condition and to some extent ‘cope’ with it differently than men. However, the well

noted importance of gender does not mean that different genders also differ in their views of weight regain. In order to avoid illicit ‘genderfication’ and the resulting premature theoretical closing (Glaser, 1978) the study started without the assumption of differences, and with the ambition to analytically find out if important differences exist. However, no such differences were discerned in the analysis, but this may of course be because the sample was limited.

Regainers as failing individuals

In medical care, people with fat bodies have been divided into two categories (Elfhag and Rössner, 2005) or types of patients: *maintainers*, those who succeed in maintaining weight lost, and *regainers*, or unsuccessful weight maintainers, those who regain weight after treatment. Research has explored factors associated with successful or unsuccessful weight maintenance (Elfhag and Rössner, 2005; Chambers and Swanson, 2012). A factor that is often discussed is the individual’s ability to control the energy taken in and the energy consumed by their bodies (Macfarlane and Thomas, 2011). Weight maintenance has been linked to ‘psychological strength and stability’ (Elfhag and Rössner, 2005: p. 67). Maintainers are, in other words, constructed as both behaviorally and mentally able. Regainers are described as the opposite. For example, Byrne, Cooper and Fairburn (2004) write, ‘relapse in obesity is often attributable to individuals’ inability to persist with the weight-control behaviors that they have adopted to achieve weight loss’ (p. 1342). Regainers are also described as less motivated or unmotivated, less responsible or irresponsible, having low self-efficacy, poor coping strategies, and low ability to handle life stress (see review by Elfhag and Rössner, 2005). They are also described as having ‘unrealistic’ expectations and weight goals (Linné *et*

al., 2002; Foster *et al.*, 1997; Byrne *et al.*, 2004), as more likely to evaluate self-worth in terms of weight, and as having a ‘dichotomous (black-and-white) thinking style’ (Byrne *et al.*, 2003). Accordingly, regainers are constructed as ‘failers’ in their mindsets. Chambers and Swanson (2012) exemplify this in the following way:

... unsuccessful weight maintainers display negative cognitive factors, including erratic or inconsistent weight vigilance, failure to respond to warning signs of weight gain, and failure to restrict weight unless in a positive mindset. Further, their coping strategies for weight gain or failed actions are poor. (Chambers and Swanson, 2012 p. 223)

Failure or function?

The construction of regainers as failing can be viewed as a matter of how empirical evidence is interpreted:

Subjects who were emotionally distraught may have been strongly motivated to overeat as a means for coping with their feelings. Alternatively, strong emotions may have interfered with their ability to cope effectively with the temptation. The present data do not distinguish these two mechanisms, but further studies may favour one of the two (Grilo *et al.*, 1989 p. 493)

This quote, by Grilo and colleagues (1989), demonstrates a constructionist understanding (Hacking, 1999). Firstly, it indicates that empirical data are interpreted. Secondly, two types of interpretations of coping are highlighted: one of eating to cope with emotions; the other seeing emotions as enabling people to cope effectively with temptation. Thirdly, the authors predict that one interpretation will be favored in further studies. Today, almost 30 years later, the second interpretation is the most

common. Regainers are described as behaviorally and mentally incapable (Kayman *et al.*, 1990; Elfhag and Rössner, 2005; Chambers and Swanson, 2012).

However, Spoor *et al.*, (2007) come closer to the first approach when they address emotion-oriented coping, as do Tice and Bratslavsky (2000) when they conclude that emotional regulation takes precedence over other self-control behaviors. Eating can be interpreted as a coping strategy, and as having a function in people's lives (Salomon, 2001). This interpretation is reflected when Byrne and colleagues (2003) discuss eating among regainers as a way to regulate mood, to avoid negative affect, or to cope with adverse life events (see also Elfhag and Rössner, 2005; Sarlio-Lahteenkorva *et al.*, 2000; Freeman and Gil, 2004). It is striking that the functional/coping dimension of eating are mainly overlooked and analytically neglected. Instead, emotions and negative moods are interpreted as triggers for overeating, or defined as 'bad' coping strategies (Kayman *et al.*, 1990; Elfhag and Rössner, 2005), thus reproducing the construction of regainers as failing.

Understanding the failing individual approach

The construction of regainers as failing indicates that individuals are blamed when treatments fails. Kirk *et al.* (2014) have shown that blame permeates the discourse among health care practitioners working with patients experiencing fatness, as well as among policy makers and individuals living with fat bodies. The predominant individual-centered, blaming-the-individual approach to fatness is a crucial part of the dominant 'obesity discourse' (Monaghan, 2005; Rail *et al.*, 2010; Dumas *et al.*, 2014) and a part of neo-liberalism (LeBesco, 2011; Tischner and Malson, 2012). Those who cannot lose weight tend to be constructed as moral failures and failing citizens

(Cahnman, 1968; Sobal, 1995; LeBesco, 2004, 2011). Fatness as a moral blemish is linked with the view of individual responsibility for changing lifestyle to lose weight and embody health (Rich and Evans, 2005; Fullagar, 2009). It is also linked with the common construction of fatness as a matter of choice and ignorance (Herdon, 2008), something that can be resolved with proper education, strengthened motivation, and individual willpower (Brownell *et al.*, 2010; ten Haven *et al.*, 2011). Several studies have shown that people with fat bodies are viewed as both responsible and guilty (e.g. Cahnman, 1968; Crandall, 1994).

Individual failure, responsibility and guilt can, in turn, be understood in relation to the notion of the body as a project.

In the affluent West, there is a tendency for the body to be seen as an entity which is in the process of becoming; a *project* which should be worked at and accomplished as part of an *individual's* self-identity. (Shilling, 2003 p. 4).

The type of body project that surrounds body size and fatness is weight-centered and intimately linked with behaviors. By constant surveillance of their body weight and self-control of food intake and physical training, individuals are supposed to attain the culturally desirable body shape – the thin(ner) body. Those who keep their bodies thin or those who maintain lost weight are viewed as responsible and morally worthy citizens (LeBesco, 2011; Murray, 2008a), simultaneously taking care of their appearance and health (Crawford, 1984). They are consequently ‘successful weight maintainers’ (Chambers and Swanson, 2012) and thus viewed as conducting *successful body projects*. They are associated with culturally-valued and desirable traits of rationality, self-discipline, self-control and willpower (Lupton, 1996; Crawford, 1984). The fat body, on the other hand, is constructed as an unsuccessful body project, a body without

willpower and individual mastering (LeBesco, 2004; 2011; Rich and Evans, 2005), a body driven by desires and emotions (McKinley, 1999; Kupperts, 2001), a physical proof of lack of self-discipline and lost control over the balance between energy-in and energy-out of the body. The wording ‘unsuccessful weight maintainers’ (see Elfhag and Rössner, 2005; Chambers and Swanson, 2012) exemplifies the construction of fatness as an *unsuccessful body project*. People with fat bodies are constructed as failing because of their body size and their behaviors. The level of success is in fact measured and confirmed with the scale (Ekman, 2012). The fat body project is therefore often reduced to a matter of weight control.

The insider perspective: failure *and* function

In the insider perspective, fatness is often seen as a complex issue (Temple Newhook *et al.*, 2013; Sawkill *et al.*, 2013; Smith and Holm, 2011), including structural, cultural, social and organizational conditions (see for example Kirk *et al.*, 2014). The functional dimension of eating, and the conception of over eating as grounded in other problems, is recurrent in research using people’s own accounts. For example, eating is described as a tool for managing inner conflict and discomfort (Sawkill *et al.*, 2013) or as being a way of handling important life events, such as pregnancy and motherhood, occupational changes, injuries, illnesses, family problems stress, traumatic events or deficiencies (Parker and Keim, 2004; Monaghan, 2006; Throsby, 2007; Brogan and Hevey, 2009; Smith and Holm, 2011; Temple Newhook, *et al.* 2013). Nevertheless, fatness tends to be reduced to a matter of personal responsibility and self-blame. Kirk *et al.*, (2014) describe weight loss as a complex problem and yet conclude:

Despite this insight, however, they place the final explanation for their weight status on themselves and expressed immense feelings of guilt and shame. (Kirk *et al.* 2014 p. 793)

Greener *et al.*, (2010) and Temple Newhook, *et al.*, (2013) have also studied lay perspectives on weight gain and causes of being overweight, and note that fatness is explained in terms of self-blame, responsibility and personal failure. The blaming-the-individual approach toward fatness is accordingly reproduced and confirmed in such analysis.

Research from an insider perspective contains two clusters of explanations to weight regain. Some explanations are within the frame of self-blame while others reproduce the notion of eating as having a function in people's lives or as grounded in other problems. This article pays attention to the second cluster of explanations. Findings similar to those in the article have, as will be touched upon, to some extent been reported previously. What this article adds is partly elaborations and refinements of previous findings but also a glimpse of the complexity and full range of lay-understandings of weight regain, and of such understandings as a part of the process of coming to terms with a socially and self-considered failing body project.

Methods

This article is an empirically grounded theorization based on open-ended, semi-structured interviews with 15 individuals – ten women and five men with fat bodies. A constructionist grounded theory approach, as outlined by Kathy Charmaz (2006), was taken. In accordance with the grounded theory approach, data collection and analysis were conducted alternately (Glaser and Strauss, 1967).

All participants were born in Sweden and had Swedish ancestry, except for one person whose parents were from another northern European country. The ages ranged between 30 and 75 years, the majority being under 50. All participants defined themselves as fat, and they were defined as obese by weight-measuring technologies. All but one woman with a Body Mass Index (BMI) of 35, had or had had a BMI of 40 or more, which counts as morbid obesity (WHO, 2016). Several had a BMI of 50 or 60. They had all experienced weight regain after weight loss treatments.

Individual interviews, conducted by the author, lasted around two to three hours; some were divided into two interview sessions a few weeks apart. Participants were encouraged to determine the flow and content of the interviews. Interruption and guiding questions were avoided by the interviewer (see Charmaz, 2006). Invitational follow-up questions were used (Kvale, 1996).

The research project was approved by the philosophical ethical board at Linköping University, Sweden. Interviews took place at a time and location chosen by the participants. The participants were informed about the study and gave their consent to participate orally. They were free to withdraw their consent at any time during the research process (but no one did). The interview material has only been reviewed by the author. The interviews were conducted in Swedish, recorded and transcribed verbatim for analysis. Text quotes were translated by the author. Names that appear in the text are fictitious.

Given that the aim of the study was to explore a system of explanations, the goal was to stay as close as possible to the participants' own understandings. However, theorization requires a certain amount of abstraction from actual speech (Charmaz, 2006). The categories were found to be overlapping in the participants' narratives.

Empirical illustrations from the interviews are used to exemplify and clarify the reasoning for the proposed concepts. The selection of quotes has favored the well-formulated statements instead of the more diffuse ones, and, as a result, some participants have their voices heard more than others. This article makes no claims to convey generalized conclusions, but highlights this group of people with fat bodies who view the causes of failure to lose weight permanently in a common way.

Theorizing failure

Theorizing failure refers to when people formulate their own explanations of why they are fat, and continue to be so, despite numerous weight loss attempts. Personal failure is reflected in the term ‘theorizing failure’. If weight loss practices worked for everybody, there would be no reason to create alternative explanations of weight regain. The participant’s explanations are therefore always preceded by failure, and theorizations evolve because of failure to lose weight permanently. In line with what others have shown (Greener *et al.*, 2010; Temple Newhook, *et al.*, 2013), self-blame and personal responsibility were addressed in the participants’ explanations for being fat. All participants said that they ate themselves fat. However, the ‘theorizing’ explored here moves beyond this by considering other understandings. More precisely, explanations the participants used to understand *why* they *fail* to lose weight permanently.

Theorizing failure, as it was expressed in the interviews, are characterized by two types of shifts in focus concerning weight and fatness: *cause-shifting* and *problem-shifting*. The first seeks to attribute fatness to causes outside the received view, focusing on

behaviors and energy consumption. The second redefines the problems people with fat bodies have to solve *and* questions the means of solving the problem. The two shifts in focus do not reject the logic of the energy model and the common view of fatness as a behaviorally focused lifestyle issue. The explanations are rather complementary, and as such challenge the simplifications of the received view.

Cause-shifting and *problem-shifting* are the two analytical categories in the participant's theorizations around weight regain and failure to lose weight. Together, they make visible a system of explanations where eating is perceived as grounded in other problems, fatness is considered as a symptom of these other problems, and where weight reduction practices are seen as part of a person's weight problem.

Cause-shifting

Cause-shifting adds one more link to the causal chain of why people become fat compared to how causality is characterized when fatness is framed as a lifestyle issue, in the sense of eating wrong and poor exercise habits. Looking back on their own weight and eating history, the participants created their own explanations for regaining weight. The details of the explanations may vary, but it was common that 'wrong' eating was not regarded as the primary cause of fatness. The participants expressed that there was a fundamental 'real' reason that makes them eat themselves fat. Cause-shifting simply means that overeating is seen as grounded in underlying problems.

During reflections on eating and the causes behind their fatness, the participants found that food and eating had a function in their life. At the most basic level, food is, of course, a precondition for biological survival. This role of food was, however, not at the center of the participant's reflections. Instead, the following four explanations

were offered: *eating as a means of dealing with painful feelings*; *eating to fill an existential void*; *eating as a means of enjoyment*; and *eating and food as addictions*. These explanations constitute the sub-categories within the analytical category of cause-shifting. Together they exemplify a cluster of explanations where eating behaviors are made secondary and other problems are constructed as the main cause for failure to achieve permanent weight loss.

Eating as a means of dealing with painful feelings

In accordance with previous findings (Byrne *et al.*, 2003; Smith and Holm, 2011) where eating is described as a way of regulating negative feelings, Linus said: ‘When I get angry, I get hungry.’ He noted that he could immediately regulate his anger by eating and become ‘calm’ again. Linus concluded that the cause of his fatness was not his eating per se; it was rather the emotions that he needed to regulate by eating that he regarded as the problem.

Lisbeth, who began to put on weight in her 30s, had discovered a connection between her weight gain and an abortion she had. She perceived this period as difficult and noticed that she handled adversity during this period by ‘comfort eating’. When comfort eating made her gain weight, she began, as she said, eating to console herself: ‘I think everything was a circle. I was alone and I felt sorry for myself. I was fat and I was ugly and then I ate, because then I became calm.’

Malin also related personal adversity with eating. ‘I eat on emotion,’ she said. She described eating as ‘anti-anxiety’ and to deal with emotional pain. ‘When I look back, I see personal tragedies, and I see the correlation that I’ve gained weight.’ She explained how she had gained a lot of weight after a late miscarriage. Then she became pregnant

again and, to her great joy, gave birth to a son. Shortly after she experienced painful losses. Within two years both her parents died. Her husband also left her. Eating helped her through this period.

Linus, who could observe that he became ‘calm’ by eating had also concluded that eating had a function in his life. He argued that the calming effects of food can be compared with the calming effect of psychotropic drugs:

When I do not feel well, for example, I use food as comfort. I do not drink and I do not smoke, but food has a certain psychotropic effect on me.

A common thread runs through his, Malin’s, and Lisbeth’s explanations of why their bodies are fat. They eat to relieve mental pain and discomfort. A similar understanding of eating is also discussed in other studies based on first-hand accounts of fatness and weight gain (Smith and Holm, 2011; Sawkill *et al.*, 2013). A similar function works for physical pain. Ruth said that she used food to alleviate the physical pain of her arthritis. ‘When I eat, I do not feel the pain; then I feel good,’ she said and continued, like Linus, to equate eating with other options to relieve or divert pain: ‘Some drink, some get help from painkillers and some take a walk when they have pain.’ For Ruth, like the rest of the participants, it was eating that gave the best relief for physical and mental pain.

Eating to fill an existential void

Some participants believed that their eating had to do with some deficiencies in their lives, or a kind of void that needed to be filled (see parallel in Parker and Keim, 2004; Smith and Holm, 2011). What was lacking varied, but the agony and the tangible sensation that the void had to be filled was common. For some, it was a lack of love

and closeness in childhood that created a permanent void, for others it was a lack of meaning, or tension, that now and then manifested itself in an unpleasant way. During life, they had learned that they could fill the void with food to subdue discomfort.

The closeness, love and security that children can feel in the arms of their parents were things Mia was missing. Mia said that as a child she solved the shortage of closeness and security by opening the refrigerator door so the light inside went on. Then she seated herself between the refrigerator and an electric heater:

It was safe, and it was light and warm there from the electric heater, and it smelled good.

No one saw me, and I was hidden there and I was safe. I was in mother's arms in some way. The fridge was mom.

‘The fridge was mom,’ said Mia. Originally, it was the refrigerator with its contents that was a substitute for her mother. But long after Mia stopped sitting next to the fridge, eating continued to fill the ‘void’ of a lack of ‘closeness and love.’ Rickard said that he ate when he was alone. For him, eating worked as a substitute for socializing:

I know that loneliness is not good for me. Loneliness is a kind of trigger. I don’t know where it started, but loneliness equals eating. When I'm alone I eat or when I have nothing to do, I eat.

Eating was also described as filling more diffuse and elusive voids. Solbritt had found a pattern between when she ate unnecessarily, and not. She did not eat anything unnecessary when she had things to do. When nothing happened, she ate to fill the lack of activity and, perhaps, meaningfulness (see parallel in Monaghan, 2006). Torsten identified a similar link, saying that he ate when ‘under-stimulated’ or ‘bored.’ Börje described his eating in a similar way, ‘When I think life is boring and nothing is

happening, then I take a sandwich now and then.’ He developed this further: ‘In my current life empty moments are the worst for me.’ He exemplified this with a recurring situation: ‘I take half a sandwich with a cup of coffee now and then just because I have a half hour left. Then I fill that time.’ Over the years, the participants had learned to master feelings of loneliness, emptiness, passivity, boredom or meaninglessness by turning to food and eating. Such negative feelings can easily be associated with something unpleasant. It is not, however, as obvious that a stable and good relationship can have the same associations. Somewhat surprisingly, Jeanette discovered this. She said that her overeating had increased when she started to live in a ‘stable and good relationship.’ Her reflections had led her to the conclusion that it was due to the lack of something ‘unexpected and exciting.’ Perhaps, after all, this was not so essentially different from meaninglessness and boredom.

Eating as a means of enjoyment

Food as a means of enjoyment is another functional explanation for eating ‘wrongly’. Food for many, overweight or not, can be a pleasure and a delight (Coveney, 2006). Olle had not found food to be a substitute for something missing, or a means to deal with unpleasant feelings. Food offered him simply pleasure (see Parker and Keim, 2004). To treat himself to goodies and high calorie food gave, as he expressed it, a ‘silver lining’ to life. Goodies and tasty food made him feel good and he described himself as having a ‘sweet tooth.’ Gudrun held the same view. ‘I love food’ she said. Food and eating was for her a way to ‘enjoy life and to socialize with others.’ Olle and Gudrun were far from alone in emphasizing the positive aspects of food or eating. Rickard stated:

Means for enjoyment of life are, to me, everything that one has to improve the taste and so on. Sweet drinks, candy, pastry, crisps and snacks. It is actually relatively easy to discern these extra products that give a silver lining to life.

For those who are overweight, the relationship to such means of enjoyment is often complex; it is about far more than giving a silver lining to life. For those who feel they have lost control of this means of enjoyment, food also appears as a blight that evokes love *and* hate. Rickard explained:

When I cannot take a piece of milk chocolate and then put it away. ... I'm always drawn like a terrible magnet to it until it is finished. When I cannot resist the cookie jar until it's finished, when I cannot resist the ice cream package until it's finished, when I cannot not help such things. That is a love-hate.

There were participants who both enjoyed food, and used it as means to manage emotions and discomfort in life. Linus, who handled his anger with food, admitted that he both loved and hated tasty food. Food was a sedative, an enjoyment and a 'curse' for him, all at the same time:

I can only conclude that food, real food is also somehow a curse. It would be much better if I could do without it; then I would not be as fat as I am.

Eating and food as addictions

Loss of control over food and eating was a recurring theme in the participants' statements (see also Chapman, 1999). Personal reflections around this matter lead several participants to view both their eating and themselves in a new way. They described themselves as food addicts (see also Temple Newhook *et al.*, 2013). Food is a wide category, so to describe more precisely what specific category they belonged to,

participants added their loved food category before the word addict. Ulrika, Ruth and Carina called themselves 'sandwich addicts' and Solbritt spoke of herself as an 'ice cream addict.' Olle and Torsten considered themselves to be 'chocolate addicts' or 'sugar addicts.' By describing themselves as addicts, they defined their relationship to eating as an addiction.

Anyone who is dependent on something has lost control of the craved substance or means of enjoyment. By making comparisons with alcoholics and drug addicts who have the potential to stay away completely from temptations, Ruth argued that 'food addicts' have it worse in a way:

As an alcoholic, you do not need to go to the liquor store. As a drug addict, you do not need go to a pharmacy and buy the pills. But as food addicts, you are always forced to go into a grocery store and shop.

As Ruth points out, food addicts will inevitably and constantly be in direct contact with the substance they abuse (see similar reasoning by participants in Monaghan, 2006). Wherever food addicts go, they come into contact with, or are reminded of, food or goodies. Some participants even discussed how food addicts are attracted by extraordinary prices. When Rickard makes the following comparison between food addicts and drug addicts, he is focusing, ironically, on the sales strategy where customers are offered to buy three pieces of chocolate for the same price as two:

I'm a chocolate addict. So, if one were to compare me with a drug addict, one would go into the supermarket, the petrol station or whatever, and there it says, 'Three shots for two.'

Lisa had reflected about similar problems and defined food as ‘a necessary evil.’ It was necessary since she must have food to survive, and evil since she would gladly have avoided eating at all because it caused problems.

For Lisbeth, food was both a necessity and a source of enjoyment, but also became a source of anxiety and fear. ‘I’m afraid to cook, I am afraid to go shopping.’ she said. When asked why she was afraid, she replied: ‘I’m afraid that if I can cook tasty food, I will eat it all up.’ She was afraid of tasty food because it caused her to lose control of her eating. Defining food and eating as an addiction gave Lisbeth and other participants a reasonable explanation for their experiences.

Problem-shifting

The participants had repeatedly lost weight and even though they wanted to maintain the weight loss they had not succeeded. The regained weight was something of a mystery to them. Reflections on this mystery resulted in a shifted focus.

Problem-shifting means that the focus of the challenge of weight regain is shifted away from simply energy balance or wrong lifestyle. Instead, it is the ‘real’ problem that needs to be solved and treated according to the participant’s reasoning. Problem-shifting occurs through two shifts of focus; *re-defining the problem – fatness as a symptom* and *weight-centered practices as part of the problem*. The first is closely related to the previously described cause-shifting, where underlying problems are addressed, which in turn defines fatness as a symptom. The second shift is based on this assumption (fatness as a symptom). But, it goes a step further by defining the weight-centered methods as contributing factors to fatness. These two shifts direct attention towards the weight

centered methods as part of the problem. They also give meaning to the ‘mystery’ of why people fail to lose weight permanently.

Re-defining the problem –fatness as a symptom

During attempts to lose weight, the interviewees became aware that fatness was experienced as a symptom, they regained weight back as soon as treatment stops. Reflections on their own weight and slimming history had made them question the weight loss treatment they had so diligently been practicing. Linus was critical and had concluded that clinicians and those who develop methods of treatment ‘seem to think that it is always the overweight which is the origin of evil.’ That was, according to him, the very foundation of the problem. By problem-shifting, the participants regarded the core issue of being fat as a symptom of the real problem. The assumption of fatness as a symptom is discussed in Susie Orbach’s (2006) work on women and dieting. In this study, both male and female participants understood their fatness as a symptom. According to Rickard, most obesity treatment in Sweden combats symptoms, and he regarded this as the basic error:

The goal is to lose weight, and that is wrong, completely wrong. I have not had as my goal to be this fat, and everyone understands that. But they [the ones who are treating him] still require that I should aim to become slim. I have become this fat as a result, as a consequence of a way of living. A way of having maybe a disease which is sugar addiction, or food addiction. So, the consequence is obesity.

It was not only the weight-centered treatment in health care which was questioned by the participants, but weight loss treatments in general. Rickard continued his argument:

What Weight Watchers and all the others do, that's what we get this yo-yo effect from.

When I have reached my weight goal – ‘Yippee!’ And then you go back to your old life, and then you gain weight again.

Rickard said that during all periods of dieting or weight loss treatment that he had participated in, they had only treated the symptom. When he returned to his ‘old’ life he had gained weight again. Other interviewees and participants in Chapman’s (1999, p. 75) study expressed similar standpoints. Weight-centered methods do not solve the real problem.

Since the participants defined their fatness as a symptom the underlying ‘real’ problems are regarded as the primary cause of fatness. Such an understanding gives reasonable explanations for why they have failed to lose weight permanently. The frequently used weight-centered behavioral treatments are only treating the symptom leaving the core problem unsolved. According to this understanding, weight can be maintained only when the ‘real’ problem is treated. Some even considered it to be enough to treat the underlying problem, ‘Weight loss should be a result, just as the weight increase has been a result. Not an end in itself,’ said Malin. It was against this background that Malin, Rickard and others thought that weight loss could be a result of having solved the underlying ‘real’ problem (see parallel in Orbach, 2006).

Weight-centered practices as part of the problem

Departing from the understanding of fatness as a symptom, the participants argued that the focus on weight loss causes more problems than it solves. They thereby took a further step in re-defining the problem by defining diets as contributing to their fatness (see also Temple Newhook *et al.*, 2013). The reason behind this consideration was that the diet itself generated impossibilities. Looking back on their own weight and

dieting history, they had realized that the ‘total control’ they had during their diets sooner or later was changed to ‘total loss of control’ (see also Chapman, 1999).

The sub-category: *weight-centered practices as part of the problem*, includes three types of explanations. The first two: *the diet takes over* and *eating as a bodily dictate* are explanations for why total loss of control eventually occurs. The third type is called, *the diet reprograms the biological mechanisms* and offers explanations for why diets themselves are problematic. Together these explanations provide a basis for understanding weight-centered practices as part of a person’s fatness.

The diet takes over. Diets were described as unsustainable in the long term because they do not involve living as usual. Lisa and several others stressed that dieting is not an activity among others. The diet becomes the main activity in life and dominates all other pursuits (see also Byrne et al., 2003). The diet more or less takes over the person’s life. Torsten made it clear that it is not only individual activities that can be affected but the whole of life. He explained that he could not manage to both diet and study at the same time as the slimming requires great effort. He simply had to choose.

Others described how they became obsessed with food and eating when they were on a diet (see also Kayman et al., 1990; Byrne et al., 2003). Mia described her fixation like this:

Then [when I’m dieting], I focus only on the food, and what I can eat and what I cannot eat. I cannot eat this and I cannot eat that.

In retrospect, Mia discovered that she always exercised strict control during weight loss periods. Rickard had similar experiences and said that control led to him becoming ‘terribly obsessed with food.’ Sooner or later, however, the collapse occurred. The total

control ended in ‘the total loss of control.’ It was then, said Rickard, that he ate himself fatter again. When Richard was asked, what made him move from control to non-control, he replied:

It is the frustration. Frustration to have total control, I mean you stop living. When you have so much control that you control the smallest things then you stop living, and in the end, you have to start living.

Rickard described how the control the diet required of him made life impossible. It was his answer to why diets and weight loss practices are unsustainable in the long run. Lisa described her experiences slightly differently, but the meaning was the same. To have total control was devastating for life:

When you are on a diet it’s incredibly easy; it’s the only thing that exists, and it takes away lust, pleasure and enjoyment. I cannot describe how devastating it is.

The participants in Byrne *et al.*’s (2003) study who gained weight again after weight loss treatment described similar experiences. One of the women in that study described it as highly problematic to have to spend the rest of her life in control of her eating. To highlight the problem, she made the following comparison, ‘It’s like having to spend the rest of your life driving. You have to be conscious of it all the time.’ (p. 959) For her, dieting was as demanding and attention-demanding as driving a car.

Eating as a bodily dictate: Diets were described as unsustainable because bodily habits or bodily needs are so deeply rooted in the human organism that they cannot be suppressed forever. Linus, based on past experiences of only being able to control his eating for limited periods, had come to understand the loss of control as a bodily reflex. He used an analogy with people who are in a gas chamber to emphasize the strength

of the reflex. 'They know that they will die when they take a breath, but the breathing reflex is so strong that it does not care if your brain knows that you will die by the next breath, it forces you to breathe anyway', he said, and went on to compare the breathing reflex with what happens at starvation:

My opinion is that it is exactly the same when it comes to eating. You can to some extent resist and you can withstand for a while. In my case, it's about six, seven months that I can keep to a diet to lose weight. That's what I'm capable of, and then something happens, and then suddenly I discover one day that I am eating as much as before, again. And I have no idea why, it just happens ... As far as I understand, your body is not finding it okay anymore. I mean, a person living in the Stone Age who lost 40 kg in four months would obviously be in danger of death. So that's probably what the body senses. And it does not care what I say about the situation. It (the body) controls a great deal, and it's still me who is doing the shopping and so on and I'm eating. But if you look from this perspective, that the body actually perceives that it is dying of hunger, that's what you should resist, just as you should resist breathing, if you are in the gas chamber, so it's not so easy to overrule it.

Linus described his reflex to eat as so strong that it could not be suppressed forever. Eating, according to his argumentation, is as hard to resist as the urge to stop breathing. Bodily dictates can also be viewed in terms of learned routines so strong that the body does things on its own. Börje said that it is not a conscious act when he eats. He said that he became aware of it when his refrigerator was empty. 'Well, I took a little,' he could afterwards recall, but why everything in the fridge was gone remained a mystery to him. Rickard described the same phenomenon as a habitual bodily action that is so firmly programmed that it is equal to 'reflexes' that work on their own.

When Jeanette was asked to describe how it feels to binge eat, she had a hard time putting into words what happens. 'I do not know if I can. Thus, I almost do not remember anything when I do it. It's just like, 'Wow,' afterwards. It becomes a big 'oops!' she said. For Linus, Richard, Börje and Jeanette, eating occurred when the body took over and operated on its own. It did not matter what they wanted or thought.

The diet reprograms the biological mechanisms: Diets were questioned and described as contributing to the participant's fatness. In line with medical research on fat cells (Ramsay, 1996), participants argued that diets reprogram some biological mechanisms. Solbritt said:

Yes, but I absolutely believe that I have ruined my fat cells by allowing them to expand too much. They do not curl up and disappear. They are still there and as soon as they can, they absorb and store body fat. Actually, today I have to eat very little to be able to maintain my weight.

According to medically influenced reasoning, fat cells are emptied during dieting, and whenever the body is given more energy, it is converted into fat. Solbritt's statement also deals with another problem, namely that the fat cells are programmed, making it harder to maintain weight. Rickard had a similar view when he said that 'we have to go down to 25% less energy to reclaim approximately the same weight.' He meant that with time, it not only got harder to keep the weight off, but also became more difficult to lose weight. With this understanding, the body is seen as reprogrammed by periods of strict diets. Based on this, periods of strict diets contribute to people's fatness, and previous diets make it harder both to lose weight and maintain reduced weight.

Concluding remarks

The lived/experienced challenges of losing weight and maintaining the weight loss are not addressed when weight regain is regarded as a matter of failing behaviors and mindsets (Elfhag and Rössner, 2005) and/or lack of motivation and willpower (LeBesco, 2011; Dumas *et al.*, 2014) to control the flow of energy in and out of the body. By analyzing individuals' own understandings of why they fail in their efforts to lose weight and maintain a reduced weight this article has provided insights into a complementary understanding of weight regain. It shows that weight regain can be interpreted and theorized within the occasionally noted, but often neglected, frameworks of eating as grounded in other problems or eating as having a function (Sawkill *et al.*, 2013; Temple Newhook, *et al.*, 2013). Similar empirical findings and the kind of reasoning that participants used have partly been addressed before (e.g. Cahapman, 1999; Praker and Keim, 2004; Byrne *et al.*, 2003; Trosby, 2007; Smith and Holm, 2011). What this article adds is a glimpse of the richness, complexity, and partially shared and processual character of such understandings. Additional interviews, further probing and interviews with people living in different social and cultural contexts as well as gender analysis would probably add to and enrich the understanding.

Cause-shifting and problem-shifting means that the energy model is challenged from two angles: from the side of causes for fatness/weight regain and from the side of the remedy, and thus they provide a covering explanation for persisting fatness and weight regain. However, they do not necessarily oppose the energy model, but could better be understood as standing within and beyond the received view of fatness as a lifestyle

issue. Within, because the participants did not oppose to the prevalent view of fatness as a matter of unbalanced energy and failing behaviors -they were of the opinion their eating behaviors made them fat. Beyond, because they shifted the focus from the biomedical to the lived body. The explanations can be understood as efforts to explain why 'T' (and others) tend to regain weight. They also seem to fill other functions in the participants lives.

A strong and un-reflected advocate of the energy model would probably dismiss cause- and problem-shifting as mere efforts to whitewash fatness and weight regain and accordingly reproduce a general tendency for victim-blaming. However, such an understanding disregards many circumstances, such as the experienced-based nature of the participants' accounts, the amount of self-reflection needed to reformulate the problem, the scientific ingredients in the explanations, the fact that many of the explanations put forward could be considered as equally discrediting as weight-regain itself and, most of all, the positive functions that cause-shifting and problem-shifting may have on different levels in the participants' lives. A function on the cognitive level is that the explanations contained in these overarching categories helped the participants to understand themselves and their experiences in a way that made sense to them. A probable emotional function is that they reduced the intensity of guilt and self-blame. A social function is that they provided participants with socially acceptable explanations of weight regain and persisting fatness, thus potentially reducing shame and providing a means to counteract accusations of laziness and lack of will-power.

From a process perspective, the expressed understandings are reflections of personal trajectories, stretching from trust in the energy model and its advocates, to distrust and on to liberation and emancipation from the initial tyranny of the

mainstream view. Cause-shifting and problem-shifting enabled the participants to challenge and distance themselves from the predominant weight-centered methods and the blaming-the-individual approach to reduce fatness (Dumas *et al.*, 2014; Aphramor, 2005). It was the participant's opinion that weight-centred methods are failing to assist regainers. Political activism and outright opposition to the idea of fatness as unwanted and unhealthy are radical consequences of such a view (Germov and Williams, 1999). It has also been noted that liberation can imply less 'dramatic' re-orientations, such as allowing oneself to be less focused on food consumption, by increased acceptance of one's body size, avoidance of strict dieting and experimentation with self-defined means to maintain or possibly to reduce weight (Ekman, 2012). It is also implicitly but sometimes explicitly highlighted in the previous analysis that the participants asked for a shifted perspective where behavioral focused, weight-centered *methods* and *assumptions* are problematized instead of *patients*, when weight reduction treatments fail.

Common to all kinds of re-orientations, whether dramatic or less noticeable, is that they transform 'their people' to active agents trying to affect change instead of being unreflected followers of the energy model. As an extension of such a change the participants had turned to a weight-related body project which might be called 'living with fatness'. In such a project, the importance of weight reduction is played down in favor of other weight-related issues, such as coming to terms with physical and socio-material limitations, stigmatization, discrediting behavior and stereotypical understandings of fatness. The participants may be unsuccessful weight maintainers but could be considered successful from another perspective. Too much focus on weight-reduction can miss dimensions and issues that people deal with in their

everyday lives, and the skill and energy it takes to deal with these. An open eye and an open mind to the insiders' perspective allow theorists and practitioners to consider the drawbacks of a thought style for fatness, which leave out the person living in the fat body, as well as to reconsider its blessings.

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