A Discursive Look at Large Bodies- Implications for Discursive Approaches in Nursing and Health Research

Ingrid Ruud Knutsen, PhD, RN

Advances in Nursing Science, Vol. 38, No. 1, pp 45-54

This article illuminates discursive constructions of large bodies in contemporary society and discusses what discursive approaches might add to health care. Today, WHO describes a current "epidemic of obesity", and classifies large bodies as a medical condition. Texts on the obesity epidemic often draw upon alarming perspectives that involve associations of threat and catastrophe. The concern we see for body size in contemporary discourse is not new. Understandings of body size in Western societies are highly cultural and normative and could be different. The way we approach large bodies affects health care practice as well as subjects' self-perceptions.

Key words: *discourse analysis, health promotion, obesity*

Introduction

The purpose of this article is to take a critical look at contemporary understandings of large bodies in nursing and health sciences. By employing a discursive approach to this field, I wish to illuminate constructions within what we could term a debate on obesity and discuss some consequences of the ways large bodies are perceived and discussed today. Discourse affects

and is affected by the way health professionals talk and think about phenomena and clients in health care[1]. Furthermore, discursive constructions affect individuals' understandings of themselves and their situation. A discursive perspective is not the most common or acknowledged approach within health care research or practice. The natural sciences have a dominant position in health care, and there are basic distinctions between these sciences and discursive perspectives when it comes to epistemological questions[2]. A discursive approach encourages researchers to question implicit "truths" about a phenomenon, and by challenging knowledge that is taken for granted it also provides the opportunity to increase awareness and enrich current understandings[2,3]. However, such an approach might also generate certain challenges and discussions.

Why question contemporary understandings of large bodies?

In the *International Classification of Diseases, Tenth Revision,* E 66 is a code for overweight and obesity and the coding system thereby puts large bodies into a system of medical diagnosis. Within this system, a large body is explained as a medical condition that entail high amounts of excess body fat leading to reduced life expectancy and increasing health challenges[4]. There are several grounds to discuss contemporary understandings of large bodies but one obvious reason for doing so is the attention large body size attracts in research and health care today. The research field of obesity has veritably exploded during the past 30 years: in 1985 a search in Ovid Medline on publications with "obesity" as keywords produced 1365 hits, while a similar search in 2013 gives 13 824 hits. The publication rate on large bodies is thus approximately ten times higher today than it was 30 years ago.

According to Zweiniger-Bargielowska [5], large bodies was first acknowledged as a medical challenge in the 1930s. Today obesity is described as a primary medical condition that is usually progressive and lasts for years[6,7]. Medical research focuses mainly on the incidence, causality and correlation of obesity, as well as on approaches to treating or dealing with the condition for the individual. As such, research underlines the dominant understanding of a large body as a chronic disease in need of individual oriented treatment. Even though most medical focus is on obesity as a condition demanding treatment and interventions, recent statistics question the understandings of the health challenges resulting from large bodies. Epidemiological studies, for example, point to lower mortality in several chronic conditions among persons with large bodies, indicating an "obesity paradox" that questions whether a large body protects patients from unwanted complications[8,9].

The purpose of this article is to take a critical look at understandings of large bodies by deconstructing and challenging knowledge that is to a large extent accepted today as "true". The intention is to illuminate the consequences of contemporary discursive understandings of large bodies and more generally to reflect upon opportunities of discursive approaches in health care and research.

Theoretical approach

The study employs discourse theory, which is a theoretical approach that emphasises the importance of viewing the development of knowledge and practice in its cultural, societal and historical context[2]. There are various ways of using the term discourse, but I have turned to the French philosopher Michel Foucault and his descriptions of how we produce rules and practices in meaningful *statements* in our language. Foucault related understandings of

discourse to how statements function in constituting social realities, thereby pointing to a close connection between language and knowledge[10,11]:

> "We shall call discourses a group of statements in so far as they belong to the same discursive formation; [ ] it is made up by a limited number of statements for which a group of conditions of existence can be defined." [12] (p131)

We structure our language in patterns when we talk and take part in different social arenas. Discourse imposes order on reality in certain ways, which comprises what statements can be made, what rules govern statements and what we understand as true and false. The historical rules with which discourse is imbued limit what statements give meaning and can be expressed. The regular communication that produces discourses or establishes the order of truth in a practice is termed discursive formation[11].

Foucault [13] pointed to how discourse creates norms and regulates society, and he challenged what are seen as "true" or "evident" understandings and practices. An example is his portrayal of how psychiatry developed historically as a medical specialty, defining normality, deviance and illness. He pointed to how madness was created in a cultural context, and hence how the history of psychiatry is as shifting as society itself. He aimed to destabilise myths by writing the stories of the present, and demonstrated that discursive truths in the history of madness worked at the expense of the mad themselves[14]. Epistemologically, a discursive perspective opens for other truths and for alternative perspectives to exploring practice and knowledge. I suspect that the contemporary understandings and approaches to large bodies deserve to be challenged and questioned to improve knowledge and practice.

A discursive perspective involves understandings that themes and approaches are included in and excluded from discourse, and that there is a close connection between power and

knowledge[10]. In health and illness, a discursive perspective encourages critical questions and greater reflexivity by challenging norms of illness, health and health care by employing lenses that open up wider perspectives. Foucault argued that discursive regimes of knowledge are established within human and social sciences and influence our understanding of who we are and how we approach each other and our surroundings[15]. In line with this, Rosenberg [16] describes how discourse and power in modern health care increasingly operate through created, standardised, abstracted and specific disease entities. Power is played out, enforces norms and defines deviance; it fits humans into constructed and constricting patterns which shape the everyday life of individuals. Thus, discourse creates objects, such as "the obese", and accordingly it creates frameworks for how subjects understand themselves and how they can position themselves when they talk about themselves and their situation. Even though this leads to an understanding that individuals are "captured" in discourse, Foucault nevertheless argues that discourse should not be understood as determining. In his later works he pointed out how humans understand and create their self and subjectivity within cultural discourses, for example as sexual subjects.[13,15]

Methodology

A discursive approach to a phenomenon represents a critical view of social and cultural relationships. Our use of language draws on culturally created understandings, and language therefore plays a major role in the construction and reproduction of meaning. Generally one can say that the approach entails taking a step back to apply a critical and analytical perspective on "truths" by questioning why we speak or write about things as we do[2]. Hence, we can ask questions that challenge implicit assumptions to approaching

perspectives that we easily overlook and take-for-granted. What we see as "true" is explored and challenged with humility, thereby pointing to how we might understand a phenomenon differently [2]. The field of discourse analysis is a large interdisciplinary field, and discourse analysis involves several different approaches[17-19].

Discourse analysis involves a close study of language in use [20]. When analysing discourse, the researcher questions what lies behind certain understandings by querying why things are said in certain ways, how rules are explained in a specific area, and what makes something "true" or "false". This perspective rejects truths as objective or given since social practices do not consist of "natural" or neutral categories[2]. The field of research includes different traditions and in a general view one can say that some traditions focus on the language itself, others on language in situated use e.g. in interaction, others again on use of language within a particular topic and finally on patterns of language in larger contexts, such as society or culture.

In this study, we analyse language within the contemporary field of obesity. To analyse contemporary discourses of obesity I turned to the Worlds Health Organization (WHO). WHO is an influential organisation with power to line out the agenda on health issues. As WHO during the last 20 years has shown growing concern for the prevalence of large bodies in populations, I turned to their published reports and fact sheets to investigate patterns in statements. In the first part of the analysis, the intention is to illuminate and discuss linguistic patterns, implicit assumptions and consequences of specific statements and expressions in WHO's approach. The examples are highly relevant and are reflective of a discursive formation concerning large bodies, taken up in media as well as nursing literature. After looking into contemporary constructions, I will go back in history to reflect on how

understandings of "normal" body size have developed. Moreover, I will discuss the subjects' position in the contemporary discourse of body size. In the final part I will address alternative ways of approaching large bodies.

The contemporary obesity discourse

In several publications the last 20 years, WHO show a concern for prevalence of large bodies[4,21-24], arguing that "an escalating global epidemic of overweight and obesity – "globesity" – is taking over many parts of the world"[24]. Obesity has since the late 1990s routinely been described as an epidemic[25]. A search in publications in the database Ovid Medline shows that the phrase *obesity epidemic* in a title in a medical publication first occurred in 1996. From 2003 until today *obesity epidemic* appears more than 400 times in publication titles in Ovid Medline's database. Within a discursive view, we can see this as a pattern in language, and there are reasons to question the use of the term "epidemic" related to individuals' body size. "Epidemic" is a medical term described to involve "a sudden outbreak of infectious disease that spreads rapidly through the population, affecting a large proportion of people"[26]. Large body size is however not a contagious disease dramatically spreading death and illness like cholera and tuberculosis. The choice of the term "epidemic" creates a sense of alarm and the linguistic elements provide associations of a threat to populations and result in an image of a pending catastrophe.

To underline the seriousness of the global situation related to large bodies WHO state:

> "Overweight and obesity are leading risks for global deaths. Around 3.4 million adults die each year as a result of being overweight or obese. In addition, 44% of the

> diabetes burden, 23% of the ischaemic heart disease burden and between 7% and 41% of certain cancer burdens are attributable to overweight and obesity." [24]

When linking large bodies to large numbers of deaths and serious diseases, WHO call for attention and warn about a global threat by depicting a dramatic situation that much resembles doomsday.

When picturing subjects in large bodies WHO explain how obese subjects "suffer from social bias, prejudice and discrimination, on the part not only of the general public but also of health professionals, and this may make them reluctant to seek medical assistance."[4] The quote illuminates that people in large bodies represent a group that *suffers* (my italics) and are in need of help. Health professionals' prejudice (as well as prejudice from people in general) adds to their burden with the result that people in large bodies do not seek help (which one might well understand!). The text paints a picture of the subjects in large bodies as vulnerable, suffering and discriminated against, as well as avoidant.

Words and perspectives influence our understanding and creation of knowledge. In discussions on large body size, the choice of words is significant and it invites analysis to discover how language is formed and forms a discourse on obesity. I will illuminate some consequences of the situation that WHO portray and of where it leads us.

A discursive formation

We have seen how the WHO text paints a picture of a dramatic situation related to individuals' body size and warns of serious consequences. This approach draws a discursive formation, which many have taken up and passed on. Boero[27] argues that the media took over the term "obesity epidemic" without challenging the existence of an epidemic. When

analysing a large amount of newspaper articles, she has found how perspectives of an "obesity epidemic" has led to a moral panic related to body size, and she argues that other understandings of the situation has been silenced.

From a health perspective, we should ask what such discursive formation generates and what these constructions create among health professionals. Nursing organisations have taken up the prophecies of doom; in headlines ANA (American Nurses Association) underlines the need of professional nurses to "Fighting childhood obesity, Taking a stand to control an epidemic"[28], while UK's Nursing Standard writes: "Every nurse urged to wage war on obesity"[29] and Norwegian Nurses Association argues that "Nurses should start a war against fat"[30]. The words in these quotations underline the crisis much as we have seen in the WHO text, but they build on the inflammatory language by making use of terms like *fighting* and *war*. The examples of headlines illustrate that such writings are not neutral reflections of reality. These headlines show that in today's discursive formation of obesity, one image at the front line is a war against large bodies. Such rhetoric is not consistent with the traditional picture of nurses as soberly judicious or carefully approaching the helpless or ill.

From an ethical perspective, one could ask whether portrayals of nurses as soldiers fighting against the patient's body serve the patient. When scrutinising texts concerning nurses "fight on obesity", one can see that they share many features[28-33]. One central argumentation for nurses' obligation to act relates to societal cost following large bodies. The severely long lists of illnesses following large body size emphasise the hazards for the individual. The one and common goal for nurses and large individuals is weight reduction. When it comes to nurse's actions, the focus is at encouraging individual's capability to

monitor intake and increase physical activity. At the final stage, we can see how the approaches share an individualistic focus involving that individuals in large bodies are made responsible to solve their problems themselves. Those who are stricken by "the epidemic" seem to be the ones responsible to fight it. Later on, I will address what these constructions create among individuals in large bodies.

Instead of blind acceptance of "an epidemic" and a "war", a critical view of language provides the opportunity to acquire a reflective and analytical distance. This approach might create a counter-balance in favour of a view of nurses as fighters and patients as fat.

Looking back – what is "normal" body-size?

When asking why WHO creates such a dramatic view of large bodies as unhealthy, it is tempting to seek how we understand "normal" body weight, and furthermore to discuss the background for how we come to understand body weight as normal or abnormal. A look back in history reveals that understandings of ideal body weight have varied. Rubens' pictures from the 16th century portrayed plump and buxom bodies as representations of sensual ideals of beauty[34]. In Christian traditions, however, appetite has been related to sin, involving lust and bodily pleasure, and ethical practices involved sacrifices to stay pure[35]. There is reason to ask where today's norms of "normal" body weight come from.

Fletcher[25] explains how insurance companies in the US developed weight tables early in the 20th century based on growing use of statistics, after identification of increased risk of mortality associated with high body weight. Concern of the increasing heart disease rates led to the funding of studies investigating risk factors after the Second World War. In the 1960s and 70s different and competing definitions and measures of overweight were applied. A

need for a common numeric measure ended up with BMI-based definition of obesity in the US, even though the index had weaknesses. Researchers in Britain and later on the rest of Europe adopted BMI as the standard measure[25].

BMI is defined by calculating a person's body weight in kilograms and dividing the result by the square of his/her height in metres (kg/m^2). BMI measurements between 19 and 25 are today understood to indicate individuals with *normal* weight, while values below and above categorise individuals as respectively under- or overweight[22]. Nevertheless, one can ask what the background for the BMI scale is and from where it comes. Eknoyan [36] describes how what we know today as BMI was developed in 1832 by Adolphe Quetelet, a Belgian mathematician, astronomer and statistician. Quetelet studied human characteristics and measurements of normal human beings in population studies. The Quetelet ratio was taken up and given the name Body Mass Index in 1972 by the epidemiologist Ancel Keys who studied how diet influenced populations' body weight[36]. Neither Quetelet nor Keys intended to apply BMI as a measure at an individual level.

When taking advantage of BMI around 1980 as a shared standard, statisticians got the opportunity to compare data from grand surveys. Cut-off points did however vary in the 1980s and 90s, and lack of standardisation led to major discussions[25]. Change of cut-off points had major consequences for the ratio of populations considered to be at risk because of high body weight.

Today Body Mass Index (BMI) is a well-known concept to describe the relationship between an individual's weight and height. We can find BMI calculators on web-sites inviting individuals to diagnose and categorise their bodies as underweight, normal weight or overweight.

Subject in discourse

As BMI calculators are presented on web-sites and in the fitness industry today, people of different ages and for different reasons are invited to interpret their bodies with resulting concern, actions and guilt according to their size. Discursive understandings affect our perceptions of who we are, and consequently one could say that subjects are created in discourse. Discursive approaches to research also invite an analysis of how subjects understand and position themselves in the light of discursive truths (see for example [37,38]). In a project focusing on how obese subjects discursively created their identity while undergoing a treatment programme with weight-loss surgery (author yyy), one woman who looked back after a loss of approximately 50 kilos explained in an interview:

> *"I felt very depressed when I was obese. I now realise how depressed I was. Just think about going to work, it was such an effort to meet and relate to so many people. It was horrible [...]. What happened was that people who had never said hello, suddenly started to acknowledge you. Earlier, people in a way looked through you. You were almost invisible, even though you were quite visible, or felt so visible... It might also be that I detested myself."*

The quotation reflects how the woman's large body affected her self-perception as well as others' perception of her. She described other people's gaze, the discursive gaze, as challenging. A consequence was that she detested herself and she wished to be invisible in her rather visible body. The body represented a challenge: she was visible in the wrong way and the shame made her keep a distance from other people, and she felt depressed. This reflects the power of discourse - a discourse saying that a large body is wrong. The quotation illuminates how subjects constitute themselves within discursive frameworks. It was not only

her large body that challenged this woman but also the judgemental gaze of others and the ensuing self-contempt and shame created in discourse. One can thus ask oneself whether the depressed feelings described were caused by her heavy body or by discursive perspectives of body size in Western societies today. One can question whether depression and desperation are a result of the obese body or a result of discursive norms.

Things could be different

A discursive perspective opens up for alternative truths or perspectives of large bodies more than the one that we often take for granted and do not question. Kersh and Morone [39], for example, illuminate the possible consequences of different explanations of the contemporary obesity situation. If one explains large bodies as the result of an unhealthy food environment, policy focuses on a powerful food industry and its objective to sell products and thereby feed populations. The policy is thus traced to the food environment, which involves control of advertising, the regulation of fat content in foods and various forms of taxation. One considers c*hoice* important in cultures based on individualistic and liberalistic values as many Western societies are. Free to make their own choices, obese individuals are blamed for their lack of will power. Individuals must deal with their situation themselves, and policy involves an understanding of the importance of making people take what are described as "informed choices" [39].

Obesity research today often correlates large bodies and depression[40,41] and patients in large bodies are treated with antidepressants and bariatric surgery to deal with their condition. From a discursive viewpoint, the contemporary medical approach to large bodies seems rather shallow: one can understand the invasive forms of treatment as an approach

developed to make individuals comply with discursive norms. If health professionals are to promote and improve health, one should ask what would be best: to encourage people to calculate their BMI and continue a “war” against large bodies, or to abandon standards of “normal” body size?

Discussion

Terms and constructions affect our understanding in the field of body size, as well as in other fields. As health professionals, we are actors well placed within discourses, and we often associate ourselves with mainstream definitions in our professional field. This involves understandings of what is healthy and what is not. Health professionals are important groups as administrators of “truth” when it comes to health. In health care nurses and other health professionals encounter patients individually, and in line with the medical tradition we seek to help patients solve their personal challenges such as encouraging healthy eating and physical activity to deal with obesity. This is in line with discourses of individualism in Western societies, which are different from the approaches directed at the societal conditions that were quite evident in combating epidemics in earlier times. Gandya and Zumlab [42], for example, point to how combating the tuberculosis epidemic has failed within the modern bio-medical discourse. The unsuccessful approach to tuberculosis is individualistic and focuses on compliance to a strict medical regimen. Gandya and Zumlab demand a look back in history at the social and economic reforms used to control the tuberculosis situation in the last century. Several societal conditions today contribute to the increasing weight in populations - for example how cheap food is often unhealthy, the high amount of sugar, salt and fat in ready-made food, the use of private cars instead of public

transport because of high prices. The time has come to argue for nurses and other health professionals to approach the context surrounding the individual.

The examples from the field of obesity illustrate that a discursive approach provides an opportunity to examine how constructions, truths and power are inter-woven, to question why things are understood as they are, and furthermore to ask whether the situation has to be as it is. The approach encourages researchers to draw complex pictures of health, society and power, as the examples above exemplify. By questioning our understandings, a discursive approach offers opportunities to develop critical perspectives, to reformulate normative understandings and to explore power in knowledge and society. Questioning discourse is definitely relevant in other areas of health care too, with its invitation to challenge mainstream truths and to open up for alternative ways of understanding and approaching a phenomenon, object, group of patients.

Despite these obvious opportunities, there are challenges that accompany a discursive approach to nursing and health research. One obvious challenge is the epistemological foundation of viewing knowledge as created in and through language and culture. Such perspectives are in themselves demanding and hard to access intellectually, and they represent a challenge for researchers and readers who work within, or are to relate to, discourse theory. One consequence is that discursive studies in the nursing field are criticised for lack of theoretical and methodological consistency and rigour[43,44]. These challenges represent an obvious limitation to discourse analysis. Discourse analysis is developed and more widely used among social scientists, and there are grounds to question whether discursive approaches are somewhat more challenging for health professionals. Health professionals are raised within traditional discourses in medical research, most of

which are based on the logic of natural sciences. Perspectives of knowledge in discourse breaks with basic ideals in the natural sciences by rejecting truths as "objective" and seeing knowledge as constructions without a core of essence. These epistemological perspectives are different and impossible to unite.

Even though discursive perspectives are on the increase in health sciences, the approach and its epistemology is unaccustomed. It demands courage to engage in scientific discussions when an approach breaks with dominant principles and when the perspective contradicts mainstream approaches. Even though several researchers criticise contemporary understandings of large bodies (see for example [45,46,47]), it is demanding to challenge medical tradition and authority with a worldview based on another fundament. There are long traditions and established authorities with the power to define valid truth in medicine and health care. Discourse analysis easily falls outside these traditions, making it challenging to legitimate these perspectives in research.

In traditional nursing and medical research one important objective is to bring answers and solutions to clinical questions and challenges on health in clinical practice. Students and colleagues are educated to acknowledge and distinguish what we regard as healthy from unhealthy, to react to patients' signs of deviance and morbidity and to be aware of patterns of illness. One intention of discourse analysis is to destabilise our understandings of truth by questioning our perceptions of what we view as normal and abnormal, healthy and unhealthy etc. One objective in a discursive approach is to disassemble valid understandings[2]. As everything is understood as constructions, the intention in discursive research is not to find a core of truth or *the real* truth. One consequence of discursive approaches is that what we see as rational might be rationalised away, and our

understandings of reality thus disappear. Questioning and challenging truths in discourse poses a risk of demolishing well-established practices and perspectives. One could therefore ask where discursive approaches leave us or what they lead to with regard to clinical practice. When the essence, or the "truth" - in the form of guidelines and safe recommendations in a practice – is disassembled, this may cause a situation of hopelessness or that of being an anarchic outsider. What about health challenges in the face of the obesity epidemic, for example? Are they merely constructions? Should we help people to reduce their large bodies, or are they better off left in peace? A discursive approach will seldom give directions for action or advice on conclusions.

Concluding remarks

The examples from the obesity debate show that studies of discourse challenge broader aspects of our understandings by asking why we understand and talk about a phenomenon in the ways we do. In clinical health-care settings where actions is demanded, it is hard to argue for a research perspective that does not (necessarily) advise action or "best practice". Nevertheless, even though effect and intervention studies focusing on best practice represent the "ideal" construction in mainstream health care research, it may well be argued that the intense focus on rationality and effectiveness in today's health care makes the kind of reflexivity promoted by discursive approaches even more important. Even though analysing discourse may not support us with appropriate clinical interventions or explanations, it is important to overcome narrow or limited perspectives or to avoid overlooking important issues in contemporary health care. Discursive approaches challenge current logic and consequently open for other approaches and insights, as we have seen in the critical view of large bodies today. Nobody can be beyond language, but recognition of

discourse can nevertheless make nurses more aware of language. When it comes to approaching individuals in large bodies, a focus on for example experiences can avoid nurses becoming part of the patients' problem. The approach may provide important contributions to research in health and illness by encouraging further exploration and the establishment of new perspectives and by inviting complex understandings and perspectives that involve historical and cultural dimensions of knowledge. This provides an opportunity to improve reflexivity among health professionals, which again can influence our understanding of particular phenomena and situations. Accordingly, this might influence our knowledge and practices in health care, and furthermore our attitudes and understanding of patients' situations. As a continuation of this, discursive approaches in research bring opportunities for encouraging change in practice and society.

References

1. Cheek J. *Postmodern and Poststructural Approaches to Nursing Research.* Sage Publications, Inc; 2000.
2. Phillips L, Jørgensen MW. *Discourse analysis as theory and method.* London: SAGE Publications; 2002.
3. Cheek J. Influencing Practice or Simply Esoteric? Researching Health Care Using Postmodern Approaches. *Qual health res.* 1999;9(3):383-392.
4. WHO. *Obesity: Preventing and managing the global epidemic.* Technical Report Series, No894, 2000 http://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=10&codcch=894 Accessed January 2014;2000.
5. Zweiniger-Bargielowska I. The Culture of the Abdomen: Obesity and Reducing in Britain, circa 1900-1939. *J Brit Stud.* 2005;44(2):239-273.
6. Rippe JM, McInnis KJ, Melanson KJ. Physician involvement in the management of obesity as a primary medical condition. *Obes Res.* 2001;9(4):302s-311s.
7. Vogt T, Stevens V. Obesity Research: Winning the Battle, Losing the War. *The Permanente Journal.* 2003;7(3):11-20.
8. Hainer V, Aldhoon-Hainerová I. Obesity Paradox Does Exist. *Diabetes Care.* 2013;36(2):S276-281.
9. Kvamme J, Holmen J, Wilsgaard T, Florholmen J, Midthjell K, Jacobsen B. Body mass index and mortality in elderly men and women: the Tromso and HUNT studies. *Epidemiol Community Health.* 2012;66(7):611-617.
10. Foucault M. Truth and power. In: Gordon C, ed. *Power/knowledge: selected interviews and other writings 1972-1977*. New York: Harvester Press, 109-133; 1980:XI, 270 s.
11. Foucault M, ed *Power Essential works of Foucault 1954-1984 vol 3.* London: Penguin Books; 2002. Faubion JD, ed.
12. Foucault M. *The Archaeology of Knowledge.* Padstowe, Cornwall: TJ International Ltd; 1972.
13. Foucault M. *The History of Sexuality vol 2: The Use of Pleasure* London: Penguin; 1992.
14. Foucault M. *History of Madness.* Oxen: Routledge; 2006.
15. Foucault M. *Ethics subjectivity and truth.* New York: The New Press; 1997.
16. Rosenberg CE. The Tyranny of Diagnosis: Specific Entities and Individual Experience. *Milbank Q.* 2002;80(2):237-260.
17. Cheek J. At the margins? Discourse analysis and qualitative research. *Qual Health Res.* 2004;14(8):1140-1150.
18. Wetherell M. Debates in Discourse Research. In: Wetherell M, Taylor G, Yates S, eds. *Discourse Theory and Practice. A reader* London: SAGE Publications Ltd; 2001.
19. Smith JL. Critical discourse analysis for nursing research. *Nurs Inq.* 2007;14(1):60-70.
20. Taylor S. Locating and conducting discourse analytic research. In: Wetherell M, Taylor S, Yates SJ, eds. *Discourse as data. A guide for analysis*. London: Sage Publications 2001:5-48.
21. WHO. *Obesity and Overweight.* Fact sheet No 311 Updated March 2013 http://www.who.int/mediacentre/factsheets/fs311/en/index.html Accessed January 2014.
22. WHO. *Physical status: The use and interpretation of anthropometry.* Geneva: http://whqlibdoc.who.int/trs/WHO_TRS_854.pdf [accessed March 2014];1995.
23. WHO. *Diet and physical activity: a public health priority.* http://www.who.int/dietphysicalactivity/en/ [cited 23 May 2011];2004.
24. WHO. Controlling the global obesity epidemic. 2014.
25. Fletcher I. Defining an epidemic: the body mass index in British and US obesity research 1960-2000. *Sociology of health and illness.* 2014;36(3):338-353.
26. Oxford Concise Medical Dictionary. Oxford University Press

27. Boero N. *Killer Fat: Media, Medicine, and Morals in the American "Obesity Epidemic".* New Brunswick, NJ: Rutgers University Press; 2011.
28. ANA. Fighting Childhood Obesity. In: American Nurses Association, ed. *ANA issue brief*. http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/Issue-Briefs/Childhood-Obesity.pdf2010.
29. Gillen S. Every nurse urged to wage war on obesity and high blood pressure. *Nursing Standard.* 2013;27(44):5-6.
30. Sykepleien. On the path towards Homo Maximus [In Norwegian: På vei mot Homo Maximus]. 2010;98(3).
31. Ingram RR, DeCelle G. Obesity: Managing an emerging health crisis. *Nurs Manage.* 2012;43(7):26-33.
32. Small L, Lane H, Vaughan L, Melnyk B, McBurnett D. A systematic review of the evidence: the effects of portion size manipulation with children and portion education/training interventions on dietary intake with adults. *Worldviews Evid Based Nurs.* 2013;10(2):69-81.
33. Tripp S, Perry J, Romney S, Blood-Siegfried J. Providers as weight coaches: using practice guides and motivational interview to treat obesity in the pediatric office. *J Pediatr Nurs.* 2011;26(5):474-479.
34. Klein R. Fat Beauty. In: Braziel JE, LeBesco K, eds. *Bodies out of bounds. Fatness and Transgression*. Berkeley and Los Angeles: University of Californias Press; 2001.
35. Coveney J. *Foods, moral and meaning: the pleasure and anxiety of eating.* London: Routledge; 2006.
36. Eknoyan G. Adolphe Quetelet (1796–1874)—the average man and indices of obesity. *Nephro Dial Transpl.* 2008;23(1):47-51.
37. Wetherell M, Taylor S, Yates SJ, eds. *Discourse as Data. A Guide for Analysis.* London: Sage Publications LTD; 2001.
38. Edwards D, Potter J. *Discursive psychology.* London: Sage Publications; 1992.
39. Kersh R, Morone JA. Obesity, Courts, and the New Politics of Public Health. *J Health Polit Polic.* 2005;30(5):839-868.
40. Morris AA, Ahmed Y, Stoyanova N, et al. The association between depression and leptin is mediated by adiposity. *Psychosom Med.* 2012;74(5):483-488.
41. Folope V, Chapelle C, Grigioni S, Coëffier M, Déchelotte P. Impact of eating disorders and psychological distress on the quality of life of obese people. *Nutrition.* 2012;28(7-8):e7-e13.
42. Gandya M, Zumlab A. The resurgence of disease: social and historical perspectives on the 'new' tuberculosis. *Soc Sci Med.* 2002;55:385-396.
43. Buus N. Nursing scholars appropriating new methods: the use of discourse analysis in scholarly nursing journals 1996-2003 *Nurs Inq.* 2005;12(1):27-33.
44. Traynor M. Discourse analysis: theoretical and historical overview and review of papers in the Journal of Advanced Nursing 1996-2004. *J Adv Nurs.* 2006;54(1):62-72.
45. Oliver JE. The politics of pathology: how obesity became an epidemic disease. *Perspect Biol Med.* 2006;49(4):611-627.
46. Campos P, Saguy A, Ernsberger P, Oliver E, Gaesser. The epidemiology of overweight and obesity: public health crisis or moral panic? *Int J Epidemiol.* 2006;35:55-60.
47. Jutel A. The emergence of overweight as a disease entity: Measuring up normality. *Soc Sci Med.* 2006;63:2268-2276.