

Shame, Blame, and Status Incongruity: Health and Stigma in Rural Brazil and the Urban United Arab Emirates

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Abstract Stigma is a powerful determinant of physical and mental health around the world, a perennial public health concern that is particularly resistant to change. This article builds from sociologist Erving Goffman's classic conception of stigma as a unitary social phenomenon to explore the stigma attached to two seemingly dissimilar conditions: food insecurity in rural Brazil, and obesity in the urban United Arab Emirates. Our analyses underscore that both conditions are stigmatized because they represent a departure from a deeply-held social norm, and in both cases, self-stigma plays an important role. Furthermore, in both cases, the stigma associated with food insecurity and obesity is likely at least as harmful to personal wellbeing as are the biological consequences of these conditions. Finally, evidence increasingly links obesity and food insecurity causally. Our analyses suggest that these forms of stigma transcend individuals and are largely structural in their origins, and therefore that they are most likely to be improved through structural change.

Keywords Stigma · Food insecurity · Hunger · Obesity · Fat · Brazil · United Arab Emirates

Introduction and Theoretical Grounding

Stigma, commonly defined as a mark of disgrace indicating physical-moral-social taint, is a powerful determinant of physical and mental health. Stigma may be externally imposed by others, and in such cases is referred to as external or felt

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stigma, and it may also be internalized and self directed, in which case it is referred to as internalized or self-stigma (Goffman 1986[1963]; Martin, Lang, and Olafsdottir 2008; Pescosolido and Martin 2015; Schwartz et al. 2006). Both forms of stigma can arise from, and give rise to, feelings of shame and embarrassment on the part of the stigmatized person. Sociologist Erving Goffman, who many consider the father of stigma studies, devoted an entire monograph to the subject in the 1960s (Goffman 1986[1963]). He described stigma as a single social process uniting a dizzying range of conditions and behaviors, including congenital missing body parts, deafness, alcoholism, cerebral palsy, epilepsy, homosexuality, prostitution, stuttering, criminal history, hearing or vision impairment, facial scarring, amputation, dwarfism, colostomy, and mental illness. According to Goffman, stigma is stigma because it is “fundamentally discrediting”—that is, it is perceived to index something inherently negative about a person. While Goffman himself did not address the health consequences of stigma directly, his description of stigma has been extended by later scholars to explore how stigma shapes health and wellbeing at the population level (Hatzenbuehler et al. 2013, 2009; Link and Phelan 2001, 2006; Pescosolido et al. 2008; Pescosolido 2013).

Research has successfully identified many of the ways in which stigma operates socially to damage mental health and wellbeing (Hatzenbuehler et al. 2013; Link and Phelan 2001, 2006; Pescosolido et al. 2008; Pescosolido 2013; Puhl and Heuer 2010, 2009; Puhl and Suh 2015; Sikorski et al. 2015; Sutin et al. 2015; Weaver and Hadley 2009). Increasingly, scholars are also documenting the biological consequences of experiences of stigma as, for example, the epigenetic consequences of felt stigma upon obesity, stigma’s effects on pre-term birth and cortisol levels, the role of leptin in the co-occurrence of depression and visceral body fat, and the interplay between weight, teasing/bullying, and specific exercise- and eating-related behaviors (Carter 2013; Crayton 2012; Haines et al. 2006; Jequier 2002; Lawson et al. 2012; Lewis et al. 2011; Neumark-Sztainer et al. 2012; Salvy et al. 2011; Schvey et al. 2011; Vartanian and Novak 2011; Vartanian 2008; Wott and Carels 2010).

Stigma has consequences for both physical and mental health, and is therefore a public health concern (Barrett 2008; Link and Phelan 2006)—or rather, it should be. Stigma has proven remarkably intractable to health interventions across contexts; indeed, health interventions often unintentionally exacerbate both external and internal stigma (e.g., Corrigan 2014; Corrigan et al. 2009, 2004; Pescosolido 2013). This is precisely because stigma draws on core beliefs held by mainstream society, beliefs that are often adhered to by the stigmatized, not just by the stigmatizers (Schwartz et al. 2006; Sikorski et al. 2015; Tarasuk and Beaton 1999). In particular, the powerful emotional impacts and structural exclusions involved in stigmatized conditions such as food insecurity and obesity are often overlooked in popular and medical spheres in favor of more “concrete” outcomes such as associated developmental consequences and comorbidities. Stigmatized traits thus pose a continual challenge for both the medically oriented social sciences and for public health.

This article aims to apply the idea of stigma as a unitary phenomenon to two culturally distinct instances of stigma. We take as our starting point the observation, drawn from Goffman (1986[1963]), that stigma can usefully be thought of as a

single social process with many outlets (see also Link et al. 2004). This unitary conception of stigma can be operationalized as *status incongruity*—that is, the potentially measurable difference between culturally held perceptions of what people should be or should achieve in a given realm, and what they are *actually* able to be or to achieve. While status incongruity is only one way of theorizing stigma (for just a few alternatives, see Link and Phelan 2001; Link et al. 2004; Pescosolido et al. 2008; Yang et al. 2007), we find it useful to focus on the concept in this article because our research involves two cases where status incongruity is at play.

Status incongruity can serve both as a theoretical model to explain how stigma occurs, as well as a way to assess stigma both qualitatively and quantitatively. Theoretically, Veblen's 2009[1889] classic discussion of conspicuous consumption and the social penalties associated with a failure to demonstrate it serves as the foundation upon which contemporary ideas of status incongruity have been built. More recently, Barrett (2008) has posited that stigma directed toward illnesses is an expression of humans' deeply engrained anxieties about death; that is, those who seem "close to death" because of health problems are viewed as fundamentally inimical to life. Similarly, Yang et al. (2007) assert that stigma is an inherently moral experience, powerful because it represents a threat to what matters most in people's social worlds. Goffman himself recognized the moral threat inherent to an experience of stigma as a social transaction centered around the fact that a person does not match others' expectations of how (s)he should be (1986[1963]).

Status incongruity has also been operationalized quantitatively using cultural consensus and consonance methods (Bernard 2011, pp. 346–385). These methods have been used to measure the relative degree to which individuals express, within their own lives, collectively-held norms, including commonly deployed racial classification systems in Puerto Rico (Gravlee, Dressler, and Bernard 2005), ideas about what constitutes appropriate lifestyle and social support in Brazil and the US (Dressler and Bindon 2000; Dressler, Baleiro, and Dos Santos 1998), beliefs about family life in Brazil (Dressler et al. 2007), and socioeconomic status in the US (Dressler, Bindon, and Neggers 1998a), among others. This body of literature reliably demonstrates that status incongruity in any of these realms is profoundly stressful and related to suboptimal physical and mental health outcomes, such as hypertension, depression, and long-term morbidity and mortality.

Given that the literature on status incongruity demonstrates robust links to physical and mental health, we posit that stigma is *always* "health stigma"—that is, it always has consequences for both physical and mental health, even when the stigma is not specifically attached to a health condition. In this article, we explore the implications of the idea that stigma surrounding food insecurity and body size may be considered part of the same "health stigma" phenomenon (Link and Phelan 2001, 2006; Pescosolido 2013). Below we introduce two (seemingly) divergent cases: food insecurity in rural Brazil and body size in the urban United Arab Emirates.

Food insecurity, defined as a lack of secure access to safe and culturally appropriate foods at all times (Bickel et al. 2000), is often stigmatized because it may be a particularly "honest signal" of poverty (Weaver and Hadley 2009); that is, people usually do not evince publicly observable symptoms of food insecurity until

they are truly destitute. Anthropological theory asserts that in most late capitalist societies, signs of poverty, including food insecurity, are fundamentally discrediting because they make visible one's failure to fulfill the capitalist imperative of accumulation of wealth (Veblen 2009[1899]). Inherent to the definition and measurement of food insecurity is the stigma associated with having to obtain food in socially unacceptable ways, and this is one of the key features that differentiates it from the more straightforward concept of hunger (Bickel et al. 2000): one may experience food insecurity *without hunger* by having uncertain access to food, having to eat foods considered unfit for human consumption, or having to obtain food in socially unacceptable ways. Those experiencing food insecurity in developing countries often describe it as a key source of stress in their lives (e.g., Avotri and Walters 1999; Piaseu et al. 2004; Pike and Patil 2006). Food insecurity can thus involve sequelae that extend beyond the traditional indicators of hunger (e.g. wasting, stunting, micronutrient deficiency), particularly for mental health (Weaver and Hadley 2009).

Even when food insecurity is not visible to social others, the ethnographic evidence suggests that it can feel deeply shameful to those experiencing it and thus generate self-directed stigma. People report feeling ashamed picking food out of the trash, even if no one observes them doing it (Piaseu et al. 2004), and embarrassed by not being able to slaughter an animal during a celebration (Nordanger 2007). Indeed, our own research on food insecurity points to the possibility that its most damaging impacts are not nutritional but rather psychological, deriving from external and internal shame and stigma associated with having to engage in non-normative food behaviors—in short, experiencing status incongruity. The relative importance of shame, guilt, and self-stigma, as opposed to felt stigma resulting from interactions with outsiders, is not known and probably varies from situation to situation, but is likely a key player. This is also true for people with obesity.

Obesity, clinically defined as having a body mass index above 30 kg/m², is an especially strong attractor of stigma worldwide. Although obese bodies are becoming an epidemiological norm, they are rarely socially normalized; on the contrary, evidence suggests that obesity stigma has increased along with increasing global obesity (e.g. McCullough and Hardin 2013; Brewis et al. 2011). Public health measures to combat obesity and chronic disease have appeared to increase the stigma of obesity without having an equally significant impact on its prevalence (Bell et al. 2011; MacLean et al. 2009). Obesity cannot easily be hidden, and therefore stigma acts through both internal shame and external blame, which distinguishes it in profound ways from food insecurity (Alonso and Reynolds 1995; Goffman 1986[1963]; Joachim and Acorn 2000; Pescosolido and Martin 2015; Schwartz et al. 2006; Smart and Wegner 2003).

Typically, obesity stigma derives from a combination of Western beauty ideals of aesthetic thinness (Becker 1995; Bordo 1993; Nichter 2000; Taylor 2015) and perceptions that obesity is not only aesthetically displeasing but also signals lack of control and increased risk of ill health (Brazier and Lebesco 2001; Lebesco 2011; Lupton 2013; Rogge 2004; Rothblum and Solovay 2009). This marks a significant departure from cultural models that were once common across globe and which privileged fat as both aesthetically pleasing and as a signal of wealth and abundance

(e.g. Becker 1995; Popenoe 2004). Obesity now serves as a visible marker of poverty in many cultural settings (e.g. Brewis 2011, 2014; Drewnowski 2009; Hatzenbuehler et al. 2013; NBC News 2010; Popkin 1999, 2009, 2011). It also signals status incongruity, resulting in external blame levied against individuals perceived to be obese and internalized shame by those same individuals over their perceived failure to meet (conflated) health and body standards.

Both obesity and food insecurity stigma can therefore be explained as forms of status incongruity. Importantly, research increasingly links these two conditions causally. For instance, there is a clear association between exposure to undernutrition during periods of key development in early life and higher risk of chronic disease and obesity later in life, possibly through epigenetic pathways (Barker 2004; Gluckman et al. 2008; Schulz 2010) or through the development of early food preferences (Daniel 2016; Widome et al. 2009). Other research has documented the ways in which early experiences of hunger increase the likelihood of over-eating when food becomes more abundant, including across generations (i.e. grandparents who lived through hunger stuffing their grandchildren with energy-dense foods) (Cheng 2013; Chesler 2005). Taken together, this research suggests some common social pathways that may be implicated in these two processes. In particular, food insecurity is linked with obesity in many populations, as a result of intertwined social and biological pathways of exclusion (Popkin, Adair, and Ng 2012).

There are thus several compelling common threads winding through food insecurity and obesity stigma. Below we offer the results of a two-site qualitative comparison designed to take seriously the theoretical proposition that shared elements across divergent stigma experiences are significant enough to consider them all a single form of health stigma. We use two radically different case studies—Brazil and the UAE—specifically because the starkness of the differences between the settings illustrates the powerful underlying similarities in the ways in which stigma influences health and well-being through feelings of shame, blame, status incongruity, and social isolation.

Methods

The cases below are drawn from our original research on stigma associated with food insecurity in rural Brazil and with obesity in the United Arab Emirates. The Brazil study, begun in 2013, is still ongoing, while the UAE study took place from 2009 to 2011.

In Brazil, Weaver conducted a community-based study using a multi-stage set of qualitative and quantitative methods to develop tools for assessing food prestige and normative food behaviors in the local context, alongside standardized measures of food insecurity and mental health. Methods included freelist interviews about common food items followed by food ranking exercises to identify shared ideas about food prestige, a survey assessing food insecurity and mental health, an assessment of key food items consumption and food prices, and participant-observation in food related activities such as cooking, food shopping, and communal meals. Food insecurity was assessed using the Brazilian version of the

USDA Food Insecurity module (Pérez-Escamilla et al. 2004), and depression was assessed using a Brazilian version of the CES-D (Silveira and Jorge 2000). The main sample consisted of 300 randomly-selected household heads.

In the UAE, Trainer collected semi-structured interviews (45–120 min in length); anthropometric measurements that included high, weight, and body fat percentages; and 24-h food and activity recalls. The main sample consisted of 103 young Emirati women attending university in the UAE. Over a year of extensive participant observation on several university campuses and other urban settings in the emirates of Dubai, Abu Dhabi, and Sharjah, as well as informal interviews with professionals working in higher education and healthcare, all documented in fieldnotes, complemented the data drawn from the young women. Full methods for each study can be found elsewhere (Trainer 2012, 2016).

To develop the comparisons described in this paper, the two authors read each other's work (both published and unpublished), including some of the original ethnographic data from each study. Both authors co-developed the theoretical framework based on existing anthropological literature and mutual discussions of our fieldsites, our methods, and our separate observations of enacted stigma in those sites.

Results: Cultural Frameworks and Case Studies

Brazil

Weaver's research in rural Northern Brazil focused primarily around food insecurity and mental health, and it draws from a substantial existing body of research that ties together foodways, body norms, and notions of modern success. Brazil is a country with great disparities in terms of socioeconomic status, urbanization, and land ownership. Though the country has long been depicted as a sensual, tropical melting pot, the existing rhetoric about loving all bodies, all colors, and all types disguises significant racial, socioeconomic, cultural, and body-based intolerances rooted in the country's colonial and slave history (Edmonds 2010). Ethnographic research conducted in urban Brazil demonstrates that bodies are read as high or low status, and weight and body shape are a key part of that (Dressler et al. 2012; Edmonds 2010). Brazilian body norms consist of an amalgam of "modern" ideals that valorize a slim waist along with "traditional" Afro-Brazilian ideals that prioritize round hips, butts, and thighs (Dressler et al. 2012; Edmonds 2010). The perceived socioeconomic benefits of having a body that meets these multiple ideals are so strong that rates of plastic surgery among women of lower socioeconomic status have grown astronomically in recent years (Edmonds 2010).

What does this have to do with food insecurity? Scholars studying status incongruity in Brazil have clearly demonstrated that there is an agreed-upon set of factors that signal the "good life." These signals include things such as the ownership of a television and a computer, engagement in leisure activities such as sports and reading for pleasure (Dressler et al. 2005a), the attainment of a desirable body shape (Dressler et al. 2012), and shared ideas about what constitute ideal diets

(Weaver, Meek, and Hadley 2014; Newkirk et al. 2009; Oths, Carolo, and dos Santos 2003). Such habits relate directly to body shape. Moreover, Dressler and colleagues have demonstrated a clear association between attainment of signals of the “good life” and reduced risk of hypertension in Southern Brazil (Dressler et al. 2005b). Taken together, this research builds a strong case for linkages between stigma, stress, status, and health in Brazil.

Across Brazil, there is a clearly identifiable “base” cuisine around which most regional variations revolve: white rice, a liquidy bean soup, and meat (most often beef, but also chicken, fish, or pork). In rural areas like Weaver’s study community, a farming community located in north-central Brazil consisting of about 600 households, this rice-bean-meat trifecta comprises most lunches and dinners. There are some food items that signal luxury and abundance and others that carry stigma because they signal humbleness, if not outright poverty. Status foods include meat, pasta, and vegetables, which people reportedly value because they provide a *mistura* (mixture)—that is, these items prevent one from having to eat plain rice and beans. Also included in this group are international foods, such as lasagna, ice cream, and pizza, as well as salty snacks and candies, which serve as little luxuries for children. Humble foods include cheaper protein sources that can replace meat to create a *mistura*, such as eggs, *mortadella* (baloney), or tinned sardines.

In the tight-knit study community, people regularly declared that there was no true poverty because neighbors see to one another’s needs. As Fatima, an adult woman, explained:

To be honest, I think that around here people always have something because everybody helps each other. When someone doesn’t have the resources to be buying something, the neighbors see our condition and offer to help. Just like here, it’s me, my mother-in-law and some other neighbors. When one of us kills a pig, we share with the other neighbors. Or when someone kills a cow, this person will share with everyone else as well. Everyone helps everyone.

People in this community are indeed highly generous with food, for instance by setting aside plates for their neighbors when special meals are prepared or by inviting others for an impromptu meal if they stop by around a mealtime. For those facing food insecurity, however, this food sharing may impose as much of a burden as it does a social safety net: full participation in this norm requires that people maintain a surplus of excess cooked food, since visits between households are frequent but rarely announced in advance. Food kept overnight is usually considered only fit for animal consumption, even though refrigeration is widely available. Thus, ideally, food should be sufficiently abundant at every meal to provide for unexpected guests and be freshly cooked, and families should have sufficient means to discard food not consumed from one day to the next.

Despite what appears to be a normative and quite public performance of food abundance in which people regularly give away or discard food, a significant number of people in the community (27 of the 56 households surveyed during pilot research in 2014, or 48%) reported moderate to severe food insecurity using standard scoring guidelines. One particularly impoverished informant, Luisa, who

lived in an isolated cabin surrounded by a dark, cool garden, explained, “We do what we can. Sometimes we have to eat only rice with nothing on top of it. That’s it. That’s how it is for us. We don’t have to be ashamed of how our situation is, it is normal.” Luisa’s account, in contrast to Fatima’s statement, suggests that food insecurity is a very real lived phenomenon here, though not one that is always visible to others. Luisa’s normalizing statement, “We don’t have to be ashamed,” actually suggests the opposite, implying that eating only plain rice is in fact considered shameful. Indeed, this was one food pattern that violated the rules of the *mistura*. Like Luisa, others who were suffering from great food insecurity were often socially isolated, living on the edges of town and staying home more than others in the community because they lacked employment that might take them out of the house. Thus, it is quite possible that people like Fatima were simply unaware of their neighbors’ hardship.

How, then, might food insecurity stigma work in a place where public and abundant food consumption appears to be so important? The study is still underway, but preliminary results from pilot phases in 2013, 2014, and 2016 suggested three intriguing points. First, household food insecurity scores were associated quite strongly with symptoms of depression among heads of household, even when controlling for other covariates ($p < 0.001$; reported in Weaver, Meek, and Hadley 2014). The depression associated with food insecurity in this setting might be a direct result of the obvious stresses of having limited resources, but potentially also a result of the shame associated with having to eat low-status foods or engage in non-normative food behaviors (e.g., not being able to invite neighbors to eat or reciprocate sharing food). Qualitatively, social isolation seemed to be an important factor in food insecurity, and one that would presumably interact recursively with depression. Indeed, one woman who was herself quite socially isolated, though not food insecure, remarked when Weaver asked her in a freelist interview how she might be able to tell if one of her neighbors was in need, “[S]ometimes we think that that a person is not going through any difficulties, but they actually are. They just don’t show it. It’s complicated. I think that it’s hard because we don’t know much about each other.” This woman’s statement conveys the surprising depth of social isolation that is possible even in a small, tight-knit community, and hints at its relationship with hidden food insecurity.

Second, as one might expect, people reporting food insecurity generally consumed fewer prestige foods and spent less money on food overall than those in food secure households. Those food insecure individuals who did consume more prestige foods had especially high depression scores (though this difference was not statistically significant in the small pilot sample; Weaver, Meek, and Hadley 2014), suggesting that it may be particularly stressful to maintain prestige food consumption when food insecure. When attending birthday parties or other events (where full meals or heavy snacks were invariably served), guests often reflected amongst themselves about the financial burden the hosts must be feeling, but such events were still held regularly, and people ate heartily at them. In this setting, the public nature of food consumption may pressure food insecure individuals to serve and/or consume luxury foods that stretch their budgets to the breaking point.

Third, our preliminary results did *not* demonstrate that consumption of non-preferred foods mediated the relationship between depression and food insecurity, as we expected it might (Weaver, Meek, and Hadley 2014). Existing research on food prestige in southern Brazil demonstrates that even when people identify a food as prestigious, they do not necessarily consume it (Oths, Carolo, and dos Santos 2003). The converse—that people do not necessarily seek to avoid foods they identify as stigmatized—might also be true, and if so, might be the cause of this negative result. In other words, non-food-insecure people might be aware of the stigmatizing nature of some foods but consume them anyway. It may also be the case that as long as the basic food items are present to create a *mistura*, what matters most is where and with whom the food is consumed, rather than whether or not prestige food is served.

It appears in this setting that the harmful effects of food insecurity on mental health might derive more from self-stigmatization surrounding one's own food insecurity than from active stigmatization by social others. Many people reported that they were unaware of food insecurity in the community, despite our documentation of its high prevalence. We suspect that shame and self-stigma surrounding food insecurity motivates people to hide it, and stems from the fact that it limits one's ability to reciprocate the sharing of food, a key social activity in the community.

The United Arab Emirates

In the United Arab Emirates, our discussion of stigma focuses on intertwined behavioral and aesthetic norms, and stigma associated with perceptions of deviations from these norms. The UAE is a small country—a federation of seven states (emirates) united in 1971—on the southern end of the Arab Gulf. The entire Arab Gulf has experienced intense economic growth since the 1950s, fueled by revenues from the huge natural gas and oil fields in the region, but the UAE's project of modern nation building did not shift into high gear until several decades later (e.g. Mitchell 2002; WHO-EMRO 2015). This means that intense socio-economic, structural, and cultural change has taken place over the course of only twenty or thirty years, with profound repercussions for the UAE's inhabitants, particularly those who live in its large coastal cities such as Dubai and Abu Dhabi. Food and eating patterns, as well as bodies and body norms, have seen especially profound changes during this timeframe.

The foods available in the coastal cities, and even in the small interior towns, are diverse. They include transnational fast food outlets (e.g. Dunkin' Donuts, Baskin Robbins, Pizza Hut, Nando's); expensive restaurants with big-name chefs; food courts in malls offering everything from Lebanese *mezze* to Chinese stir fry; cheap "cafeterias" serving Indian food (primarily aimed at male Indian migrant workers); petrol stations selling packaged foods such as frosted doughnuts; old market places offering local fish, camel meat, and oasis-grown vegetables; supermarkets stocking imported produce and packaged foods; and, of course, family homes, which draw from all of these sources. Debates can be passionate among the small proportion of the population who are Emirati citizens over what constitutes their national cuisine,

which dishes signal “Emirati-ness,” and the importance of consuming such dishes to keep local culture alive. Among young locals, consumption of “Emirati” foods with one’s family in the traditional manner typically only occurs once or twice a week. The 24-h food recalls Trainer collected from young Emirati women in their late teens and early twenties indicated weekday preferences for foods that could be speedily eaten and were high in sugar and/or caffeine (e.g., cold cereal with milk, noodles, rice, french fries, potato chips, chocolate, juice, coffee, lattes, tea, and Red Bull). No clear consensus emerged as to what constituted a high-status food, since some women favored foods such as *majbus* (a spiced chicken/meat and rice dish they viewed as quintessentially “Arab”), while others said they preferred international foods like sushi. Indian food was often considered low-status by the young people with whom Trainer spoke, but this was also an unclear category, since foods seen as “Emirati” often showed signs of centuries of South Asian influence as a result of trade and exchange across the Gulf.

Despite the conspicuous consumption and wealth on display in the UAE, poverty and food insecurity are also present within the local population (as well as among foreign workers, e.g. Gardner 2013; Malit and Youha 2016; Sönmez et al. 2013). Government subsidies to Emiratis, including free healthcare and education, eliminate some of the issues associated with inequality, but not all of them. Food insecurity, in particular, tends not to be discussed, and thus is very difficult to study. Most of the participants and other locals with whom Trainer became well acquainted over the course of fieldwork stated that poverty and hunger existed within some Emirati families, but that the social pressure to hide such deprivation was intense. Based on Trainer’s data from interviews with participants, and from her extensive participant observation, food insecurity appeared to be both present and stigmatized, but received little official recognition or social attention. One recent food policy report, for example, speaking about the intertwined issues of food security and poverty reduction in the Middle East region, noted with palpable frustration that although the economic indicators for the Arab Gulf show economic growth, these statistics are likely to be based on estimates by local officials rather than on broad-based surveys (Breisinger et al. 2012).

Much more publicly discussed in the UAE is the growing concern over obesity and associated chronic diseases, which have increased dramatically since the 1990s (e.g. WHO-EMRO 2015). This stands in contrast to the area’s epidemiological profile of fifty years ago, when wasting, stunting, and infectious disease were far more prevalent (*Persian Gulf Administrative Reports* 1950, 1951). A recent WHO report, for example, had no data on stunting or wasting in children under 5 but indicated rates of overweight in adults at 74% and rates of obesity at more than 37% (WHO-EMRO 2015). Aesthetic body norms in the Emirates have changed along with its epidemiological transition. While “fatness” was once a desirable physical trait, especially in women who were expected to “fill out their skins” in order to reflect familial abundance (quoting a research participant), today, young people consistently express physical female beauty ideals that aspire to an hour-glass, thin-waisted shape, while stigmatizing bodies identified as too fat or too skinny. As Trainer (2012) has noted elsewhere, her own sample of participants reflected the drastic shift in body norms and concern with thinness, with a pronounced skew

among the young women towards intentional food restriction and lower body weight (falling into the category of underweight, based on BMI and body fat percentage, or in the very low end of the normal weight range).

Emiratis report somewhat conflicting attitudes towards the nation's recent economic development: on the one hand, the material advantages and the power and influence that accompany it are appreciated. A common theme emerging out of Trainer's conversations with both young and older people, however, was a critique of youth as collectively "spoiled" and/or "lazy," along with a concern with what the future holds for them. As one of the participants remarked, "We are all too reliant on foreigners to do our work and can't get anything done without them... but what happens if we run out of oil money?" Thus, foreign money is viewed in many ways as a "necessary evil"; one that allows for desirable lifestyles but that also threatens to "ruin" the morality of young generations. There is a great deal of concern that material wealth and cosmopolitan influences have had a polluting effect morally, religiously, and in terms of respect for traditional and local culture. As Trainer (2012, 2016) has reported elsewhere, Emirati women's perceptions about body size map onto this larger ambivalence about economic development. Large bodies were viewed as a physical manifestation of the younger generation's laziness, while very thin bodies were interpreted as an indication of preoccupation with Western values. Women's bodies are thus expected to reflect both cosmopolitan and traditional values simultaneously by being neither too fat nor too thin. This is a rather intractable situation reminiscent of the "in-betweenness" that Talukdar (2012) found in her work on body image ideals in India: "Women with access to modern worlds but who are nevertheless expected to satisfy traditional definitions of feminine propriety, create "in-between" rationales to partake in both worlds. These rationales, however, are premised on both a critique of traditional and modern practices" (4).

At issue here are "bodies that don't conform" (Taylor 2015). The implications of lack of cultural consonance with body norms in this context are serious, based on the teasing and bullying reported by interviewees (although it should be noted that Trainer did not formally measure cultural consonance or status incongruity). One young woman, Amirah, for example, reported that she had attended a promotional event on her college campus, where a company was selling shoes and testing for flat feet. In order to run the test, each woman had to stand on a glass plank, and when it was Amirah's turn, she overheard some students behind her laughing about how the glass was going to break when she stood on it. Several other women said that they were subjected to a great deal of teasing and critical comments from family members; one said that the critiques were so bad that she no longer removed her *abaya* overgarment when all of the women in her family were together in an attempt to reduce the body commentary she dreaded from her relatives. Another woman, Samirah, reported ruminating nearly constantly about her weight. "I will tell you the honest truth: I am thinking about my weight every second of every day." On the other hand, very thin women like Reema reported frequent commentary from their peers that they were "not normal." Amirah, Samirah, and Reema conveyed a strong sense of feeling betrayed by their biologies, their genetics, their habits, and their behaviors.

In the UAE, body size and shape are read as symbolic of larger moral dilemmas. Though large body size is now the norm in the UAE, fat stigma is acute, as is the stigma associated with excessive thinness. Unlike the Brazil case, much of the stigma in this setting appears to be externally imposed, although internal stigma is important as well.

Discussion and Cultural Problematization

What, then, makes the case studies of Brazil and the UAE similar? Equally importantly, what makes them different? First, some form of what we refer to as “health stigma” appears to be present at each site. In the UAE, the recipients of stigma are very thin or obese bodies, and in Brazil, the recipients are people experiencing food insecurity. The moral discourse around these issues, the ways in which this stigma is enacted, and the importance of specific types of stigma over others varies in important ways between research sites, however. In Brazil, Weaver never witnessed an individual being verbally disparaged for his or her poverty; on the contrary, people often labeled themselves as impoverished and appeared to have no problematic association with being considered *pobre*. Yet, though food insecurity was strikingly common in the study community, many people seemed to elect not to report it. It was particularly important in this setting to demonstrate food *abundance* even in the face of (or perhaps partly in response to) economic challenges. In preliminary research, those who spent the most on food but had the lowest food security were the most stressed individuals. This all points to the possibility of self-stigma associated with food insecurity that results in compromised mental health and is countered by significant efforts to mask food insecurity. This is important because the propensity to hide food insecurity in many settings around the world undermines conventional interventions designed to address it (Coates et al. 2006), and this behavior also encourages social isolation, which can further impact health and well-being. Weaver’s preliminary results suggest that self-stigma may be as significant as externally-applied stigma in this setting. The combination of uncertainty surrounding food access, self-stigma, and potential social isolation resulting from food insecurity appears to have clear and consistent negative effects on mental health (Weaver, Meek, and Hadley 2014).

In the UAE, body size was a key source of external and internal stigma and was publicly debated, in contrast to food insecurity, which was hidden in most discussions. Large-bodied women reported being harassed and changing their everyday habits to avoid criticism (e.g., wearing an *abaya* at all times, dieting to lose weight). Although Trainer did not quantitatively measure the impact on mental wellbeing of such bullying, teasing, and shame, reported distress was qualitatively quite high. In this setting, obese bodies were also medicalized and pathologized (McCullough and Hardin 2013).

In both settings, then, stigma appears not only to be externally imposed, but also to be internalized to a great degree. This is evident among women identified as obese in the UAE who themselves view obesity as a sign of moral failure. It is also evident among people with food insecurity in Brazil, who appear to feel compelled

to hide their condition despite a lack of obvious external stigma directed toward people in poverty, and despite the fact that community members are accustomed to helping one another through regular food sharing. This is no surprise, as Goffman's original work on stigma pointed out that stigma is quite often internalized by the stigmatized, but it is of concern from a health-outcomes perspective. As Pachankis (2007) notes, concealment of stigma can be highly damaging to mental health because it adds another layer of stress—the burden of maintaining the secrecy—to the already stressful situation of coping with a stigmatized condition.

The relative importance of internal versus external stigma in each case is likely related to the fact that one condition (food insecurity) can be hidden, while the other (obesity) cannot. The visibility of physical body size potentially magnifies the effects of weight-based stigma on women's wellbeing. A recent study (Hackman, Maupin, and Brewis 2016) based in Guatemala found that weight-related teasing directed at women perceived as either too skinny or too fat was an important contributor to the development of depression among those surveyed—equally as important as food insecurity and domestic abuse in their statistical models. They conclude that in this scenario food insecurity is stigmatized, but because it can be more easily disguised, the stigma is often internal, whereas weight- and body shape-related stigma is both externally and internally generated.

A second common element that links these two cases of stigma is the fact that each represents a departure from a social norm, accompanied by profound social isolation. Indeed, social isolation may be one of the key aspects linking *all* forms of health stigma. In Brazil, that social norm is one of generosity, abundance, and commensality, and it is particularly important in this rural agricultural setting where food has *not* always been abundant. Here, food insecure individuals are often isolated (or perhaps self-isolate) because they cannot repay social debts through food sharing and because of unemployment, which creates both food insecurity and isolation. This isolation likely results from and exacerbates food insecurity, since it effectively removes individuals from the social safety nets in which some (more prosperous) individuals participate through reciprocal food sharing. In the UAE, the violated social norm is properly regulated consumption: obesity signals laziness and moral weakness, while skinniness signals vanity and abnormality. Women whose bodies did not conform to norms were often the target of bullying and reported avoiding social events such as family gatherings out of fear of being teased.

A third common element that unites these cases is the fact that both food insecurity and obesity have well documented consequences for physical health (reviewed in Kopelman 2007; Olson 1999), as well as serious but poorly understood consequences for mental and social health (e.g. Heflin, Siefert, and Williams 2005; Major et al. 2012; Sikorski et al. 2015; Weaver and Hadley 2009; Whitaker, Phillips, and Orzol 2006). Indeed, this was the initial reason that led us to compare the cases side-by-side. Weaver and colleagues' work on food insecurity (Weaver and Hadley 2009; Weaver, Meek, and Hadley 2014) has suggested that food insecurity is at least as harmful to mental health as it is to physical health, and indeed the stigma related to food insecurity may be one of its most health-harming aspects. Similarly, Trainer and colleagues' prior work on obesity (Trainer et al. 2016, 2015) has hypothesized that stigma is a key piece of the obesity-health puzzle. Brewis and Wutich point out, "There is good theoretical reason

to expect that the stigma associated with being obese could shape, exacerbate, or even create the oft-reported negative physical effects of obesity via its psychosocial stress effects. In this case, the implied pathway of obesity stigma to physiological adjustments is perhaps suggestive of an iterative relationship between the physical body and the social context in which that body finds—or fails to find—identity and meaning” (Brewis and Wutich 2012, pp. 337–338). It may be impossible to separate the health consequences of being obese or food insecure from the health consequences of long-term stress associated with the stigma that these states attract. There is no question, however, that each stigmatized state is harmful for individuals in large part because of the stigma attached to them, not merely because of the health-harming effects of food insecurity or obesity.

These common threads suggest that stigma around food insecurity and obesity could be conceptualized as two “outlets” for the same social phenomenon, which for convenience we termed “health stigma” in the introduction. Both cases of stigma are directly related to nonconformity to social norms and can therefore be thought of as status incongruity, or a form of “keeping people in line” (Bell et al. 2011; van Hollen 2010). In both cases, social isolation is likely a recursive cause and consequence of the conditions and their associated mental health sequelae. At issue in both cases are questions of individuals’ ability/inability to achieve cultural norms surrounding food, eating, and body size.

The next logical question is, so what? What are the implications of placing these two instances of stigma under the same conceptual umbrella of “health stigma”?

The first useful implication of considering stigma as a single social phenomenon is that it refocuses us away from the individual and toward structural causes of stigma. While the everyday business of stigma is played out on the individual level (felt by individuals, directed toward individuals, because of a characteristic possessed by the individual), stigma is only stigma because people agree at a larger population level that a state is stigma-worthy. Focusing on the commonalities between stigma experiences serves as an important reminder that stigma is not personal but rather collective in its origins (Barrett 2008). This is not a novel conclusion, but is one that stigma theorists are increasingly exploring (Link et al. 2004; Pescosolido et al. 2008; Yang et al. 2007). Our effort to bring together conceptual frameworks about stigma and research that quantifies “status incongruity” was intended to demonstrate one way in which the collective origin of stigma can be accounted for in research.

The idea of stigma-as-structure also bears repeating because the policy implications of this have largely been overlooked, probably because intervention at the level of the individual in stigma is easier to achieve than macro-level change, but also because policymakers are often unable to step away from their own stigmatizing beliefs. Policymakers have, for instance, been surprisingly slow to implement policies to eliminate hunger, obesogenic environments, and unrealistic beauty ideals. These discussions continue to run aground on notions of individual agency, shame and blame, and visibility. Viewing stigma as a common element of the human condition refocuses the analytic lens toward structural-level factors that need to be addressed in order to improve human wellbeing.

A second result of comparing instances of stigma is that it exposes the similarities and the differences in forms of stigma. While there is enough common ground to

justify considering these two cases together, there do remain important differences and, as Yang et al. (2007) caution, we should not collapse all forms of discrimination into a unidimensional category of stigma. In this regard, we wish to underscore the indisputable geographic, economic, and cultural differences that exist between the two research settings. In the UAE, for example, whose inhabitants have far greater material prosperity than do those in Brazil, anxieties about food insecurity and too-thin/too-fat bodies map onto anxieties about development and modernity writ large across the local landscape. Individuals are expected to successfully negotiate the associated pitfalls or face social- and self-censure. In Brazil, the official rhetoric is more ostensibly forgiving: all body types are welcome, poverty is understandable and not the fault of the individual—and yet, shame and self-stigma still appear when we take a closer look at people's attitudes and actions around food insecurity.

Stigma around food insecurity versus obesity stigma also differs from one another. For instance, people in the UAE and Brazil perceive individual agency differently when it comes to each of these stigmatized conditions. The question of agency is especially acute when it comes to physical bodies, where again and again, individual lifestyle change is prioritized over all other interventions in the global rhetoric (public health and media) centered on weight, shape, aesthetics, and nutrition. Choices about food consumption and activity levels are assumed to be entirely independent (Brown and Krick 2001), and therefore, the control of body weight should also be a matter of choice. Food insecurity, by contrast, is not always viewed as within individual control—particularly in Weaver's Brazilian research context. In other words, imposed food restriction to avoid obesity is overwhelmingly framed as being within individual control, both in the UAE and elsewhere (e.g., Becker 1995; McCullough and Hardin 2013), while food restriction as a result of material need might be framed as a result of laziness on the part of the individual in some contexts, including in the United States (Gunderson 2013), but not inevitably so elsewhere. Is it particularly fascinating that individualized body "improvement" projects—and accompanying individualized stigma associated with failed projects—have become normalized in both Brazil and the UAE, which once had more collectivist interpretations of health and beauty relative to the West (Becker 1995).

Finally, we wish to reiterate the point that all stigma should have policy implications because no matter its source, it *always* exerts effects on individuals' physical and mental health through the activation of stress responses. This perhaps is the ultimate argument for considering stigma from a unified rather than a divided perspective.

Conclusions

In this article we have illustrated a theoretical approach that considers various forms of stigma as manifestations of a single underlying social process, which we termed "health stigma." This effort, part thought experiment and part critical analysis, was conceptually based on sociologist Erving Goffman's seminal monograph on the topic (1986[1963]), which examined a wide variety of health, behavioral, and physical conditions under the umbrella of "stigma." It also grew out of the

increasing recognition that all forms of stigma, regardless of their sources or targets, are harmful for health—particularly with respect to emotional and social health—and therefore ought to be considered health problems even when they have not previously been framed in this manner (Link and Phelan 2001, 2006).

Our analysis had two key goals. One goal was to revisit longstanding ideas about stigma and its relationship to health with two contemporary examples: food insecurity in rural Brazil, and obesity in the urban United Arab Emirates. The second was to draw an explicit link between food insecurity and obesity, two highly stigmatized states that are often conceptualized as diametrically opposed and almost always targeted with separate interventions. This remains so despite the fact that they co-occur much of the time and could potentially be addressed by common interventions aimed at structural change. Moreover, progress in both realms is impeded by the assumption in global development and aid discourses that each can be solved simply by making healthy food available. While this is an obvious first step (and one, it should be noted, that has yet to be achieved in either of our study sites or in our home country, the USA), not only must this food be available, it must be affordable and appealing. Indeed, it must be sufficiently affordable and appealing to “outcompete” the calorically dense processed foods that are cheap, fast, and tasty in today’s global markets.

Our analyses emphasized the social constructedness of both food insecurity and obesity. While there is an undeniable material reality to experiencing food insecurity or living with large body size, some evidence suggests that the most damaging effects of each state are the psychosocial consequences of their associated stigma rather than the biological consequences of having an obese body or experiencing food insecurity. There is persistent political and social tension between those who locate the blame for food insecurity or obesity on society’s failure to provide adequate and healthy food for its people, versus in individual negligence or laziness. We conclude that a refocus on health stigma as a structural rather than a personal problem might contribute to increased efficacy of food insecurity and obesity policy by focusing on the fundamental causes of these conditions.

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Compliance with Ethical Standards

Conflict of interest Lesley Jo Weaver and Sarah Trainer declare that they have no conflict of interest.

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent Informed consent was obtained from all individual participants included in the study.

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