Mortality, Morality, Science, and Social Inequality
Framing Contests and Credibility Struggles over Obesity [*]

Abigail C. Saguy
Assistant Professor
UCLA Dept. of Sociology

Kevin Riley
PhD Candidate
UCLA Dept. of Sociology

February 2005

Draft: Do not quote or cite without permission of the first author

Mortality, Morality, Science, and Social Inequality
Framing Contests and Credibility Struggles over Weight and Health

INTRODUCTION

In the 1980s, when AIDS was ravaging communities of gay men, the latter formed social movements and interest groups to raise the public profile of this "epidemic." ACT-UP and other groups demanded more money for research, wider availability of drugs, and greater public awareness (Epstein 1996). Gay men condemned government inaction as evidence of homophobia and used scare tactics to shock the government and country into action. In contrast, in the late 1990s and early 2000s, when obesity is a leading killer, according to the Surgeon General, "fat activists" have been calling for *less* public awareness and intervention regarding obesity. Fat activism has reclaimed the word "fat," much like the Civil Rights movement re-appropriated the word "black" and the gay movement reclaimed "queer." It has denounced fat prejudice since 1969, when the National Association to Aid Fat Americans (NAAFA, later renamed the National Association for the Advancement of Fat Acceptance) – a "human rights organization dedicated to improving the quality of life for fat people" – was founded. According to the NAAFA website, "'*fat*' is not a four-letter word. It is an adjective, like short, tall, thin, or blonde. While society has given it a derogatory meaning, we find that identifying ourselves as *'fat'* is an important step in casting off the shame we have been taught to feel about our bodies." Rather than rallying behind calls to stamp out the "obesity epidemic," of which this group is arguably the greatest victims, the "fat acceptance movement" has countered such claims by saying that one can be healthy at any size and that claims about obesity being a health risk are used to justify discrimination against fat individuals. Why have these two identity movements responded so differently to health risks facing their constituencies?

In this paper, we argue that to answer this question and to understand more generally collective responses to health threats, one must investigate the moral implications of the different ways health and illness are framed. We develop this argument by drawing primarily on the obesity case, although we draw on strategic comparisons to other cases throughout the paper. These comparisons supply an analytical tool to identify what is specific about the obesity case and, as such, provide a basis for sociological generalizations. We also show throughout the paper how researchers and activists use strategic comparisons to illnesses and health risks like cancer, smoking, and alcoholism to convince the interviewer that obesity should be understood in specific ways. Understanding the underlying logic of those comparisons is important for clarifying basic assumptions made about health and morality.

Obesity provides a "strategic research site" (Merton 1987) for studying these questions because, since the turn of the 20th century in the United States, fatness has been both highly stigmatized (on stigma, see Goffman 1963) and considered evidence of moral turpitude (see Stearns 1997). This issue is particularly prone to moralizing and blaming since gluttony and sloth have long been considered sins as well as contributors of weight gain. People talk with shame of how they were "bad" because they ate a second piece of chocolate cake or because they haven't exercised in weeks. They speak of having "cheated on a diet" or having "indulged" in a high-calorie desert. Fat children are considered a negative reflection on their parents, who are seen as providing bad role models if they are themselves heavy or being overly indulgent or neglectful if they are thin.

The intersection of medicine and morality is a longstanding interest in medical sociology and bioethics. Work on "medicalization" has argued that, compared to treating a behavior as sinful or criminal, medicalizing it fundamentally "diminishes or *removes blame* from the

2

individual for deviant actions" (Conrad & Schneider 1992:246, emphasis in original). However, other social scientists examining the process of medicalization have argued that the language of medicine merely extends moral judgment in a new guise (Zola 1972; Illich 1976), and more recent health surveillance scholarship (Armstrong 1995; Crawford 1980; Lupton 1995; Nettleton and Bunton 1995) has demonstrated how concerns about health risk can offer a thinly veiled language through which to extend judgments of responsibility, blame, and morality.

Sylvia Noble Tesh's work offers a possible solution to this impasse by suggesting that different theories of disease may have distinct consequences for moral blame. Popular lifestyle theories – which locate personal behavior as responsible for illness – are more likely to shift blame for illness to individuals, for instance, than are germ theories. This important insight provides analytical leverage for understanding why the fat acceptance movement is clamoring for *less* – not more – public attention to obesity. For while "risky health behavior" – i.e. promiscuous homosexuality – was initially blamed for the spread of AIDS, ultimately public health focused on treating the HIV virus and AIDS themselves, rather than combating homosexuality (although messages about "safe sex" or condom use has been central in containing the *spread* of HIV). In contrast, there has been no such distinction made in the case of obesity. Research money and public health warnings have focused on obesity itself and not just the diseases associated with obesity like type II diabetes or heart disease. Working within the AIDS analogy, it would be as if public health authorities and researchers had approached AIDS prevention by asking why men become homosexuals and how best to reform them. In the case of obesity, (highly moralized) personal behavior – eating and exercise – are seen as both the *cause* and *cure* for illness. In that African-Americans and Mexican-Americans – especially

among women – are more likely than whites to be categorized as overweight or obese (Flegal et al. 2002), this issue potentially has important implications for social inequality.

In what follows, we review the literature on framing and credibility struggles, which provides the theoretical framework for the analyses that follow. After briefly reviewing our data and methods, we introduce the main claimants discussed in the paper: 1) obesity researchers; 2) obesity activists; 3) Health at Every Size (HAES) researchers; and 4) fat acceptance activists. This discussion provides the necessary background for the subsequent discussion of how these different groups frame weight, especially in regards to health and morality and the disparate impact of these discussions on people based on their gender, social class, race, and ethnicity. We discuss in a subsequent section the ways in which interview respondents establish their own credibility and discredit opponents, including by suggesting that their opponents are corrupted by financial greed or making excuses for their weight. Surprisingly, we found that HAES and fat acceptance arguments are actually having quite a bit of influence on authoritative approaches to weight. We investigate how fat acceptances activists and HAES researchers exploit available opportunities social change, including political traditions of anti-discrimination and institutionalized avenues for patient influence in medical expert bodies.

COMPETING FRAMES AND CREDIBILITY STRUGGLES

Work on social problem construction has identified two levels at which competition among social problems occurs (Hilgarten and Bosk 1988: 58). First, for each topic, there is competition between different ways of framing the situation. For example, in the area of road-traffic safety, claims about reckless drivers compete with claims about unsafe vehicles (Irwin 1985, quoted in Hilgarten and Bosk 1988:58). Second, diverse social problems – from poverty to smoking to obesity – are in competion with one another for pubic attention.

4

Sometimes, one framing of a situation suggests that intervention is needed while another implies that no intervention or opposite action is needed. For instance, in the abortion debates, pro-choice contingencies frame abortion as about women's right to freely choose if and when they would reproduce, while pro-lifers frame abortion as murder of unborn babies (Luker 1984; see also Gamson 1992; Snow and Benford 1988; Tarrow 1992).[1] Pro-choice advocates argue that a "woman's right to chose" needs to be protected, while pro-life advocates argue that abortion should be newly outlawed. Likewise, competing frames of fatness as either a sign of body diversity or as a health risk/illness suggest very different public action. If fat bodies are best understood as a form of diversity, then "diversity training," greater social tolerance, and less discrimination on the basis of size is needed. If, on the other hand, fatness is a preventable health risk or an illness in and of itself, then less tolerance and more public vigilance is needed.

The body diversity frame draws on U.S. traditions of anti-discrimination and civil rights. In contrast, the health risk frame draws on public health initiatives against behaviors like smoking. The health risk frame additionally draws authority from medical research demonstrating the negative health risks associated with heavier weights. Advocates of the body diversity frame have a burden that advocates of race or gender diversity do not: they have to argue against medical expertise that what they assert as normal and healthy diversity is actually medical pathology. This means that framing contests over weight are likely to move out of the political realm and into a medical terrain: is weight determined by personal behavior? Is weight itself – as opposed to something associated with weight – directly responsible for negative health outcomes? Are there any benefits of added weight? These debates have important moral implications about blame and responsibility, but they depend on scientific evidence. Scientific facts – such as that weight is at least somewhat under personal control – make it possible to

blame people for their weight, but moral assumptions – such as that people *should* manage their weight – also determine how different and conflicting scientific facts are prioritized. So, someone may argue that, even though weight is determined by a host of factors many of which are outside of personal control, one should focus on personal behavior because personal behavior is easiest to change and because trying in and of itself is a morally good thing to do.

As work on "credibility struggles" (Epstein 1996) demonstrates, debates over scientific claims are as much about the credibility of the claimants as the plausibility of the claims. This literature leads us to expect that participants in framing contests over obesity will engage in strategies to establish their own credibility and to discredit their opponents. These strategies may include referring to academic prestige and authority or personal experience to establish one's own credibility and the credibility of one's allies, while referring to various forms of conflict of interest to discredit opponents.

DATA AND METHODS

This study draws on a mix of secondary and original data sources. These include analyses of the scientific and popular literature on obesity and fat acceptance; participant observation in the 2001 National Association to Advance Fat Acceptance (NAAFA) annual convention; participant observation from Summer 2001 through December 2004 in a HAES listserv that has several postings daily; and a series of in-depth interviews with leading fat acceptance activists (N=9) and researchers embracing a weight focused (N=6) or Health at Every Size (N=6) paradigm and who have taking part in public debates over the issue of obesity. As such, I consider them "cultural entrepreneurs," whose views are important not because they are representative of the larger research community, which they are not, but because they are likely to have particular influence on public discourse. The interviews lasted from 45 minutes to over

two hours. They were semi-structured and open-ended, meaning that a series of open-ended questions were asked in each interview but respondent-initiated questions were also encouraged and pursued.

During the interview, respondents were asked to respond to some of their opponents' claims. This served to artificially reproduce and probe deeper into the logic of different positions in public debates over the obesity science and policy. The inductive interview analysis involved reading each of the interviews several times and constructing "theme sheets" as different themes emerged.

CLAIMANTS

INSERT FIGURE 1 HERE

Obesity researchers include scientists trained in a variety of academic backgrounds, including epidemiology, psychology, nutrition, and neuroscience, and involved in diverse kinds of research (from statistical analysis to rat experiments) and clinical practice (especially obesity treatment although one – Kelly Brownell – also treats eating disorders). Some obesity research seeks to determine the nature, extent, or causality of health risks associated with obesity while other work investigates the determinants of higher weights or patterns and causes of population trends towards higher weights. Recently, economists have begun estimating the economic costs of obesity as well and at least one sociologist has analyzed the social determinants contributing to weight gain in modernity (Crossley 2004). As is shown in Figure 1, (medical) obesity research has ballooned since 1995, although at a slower rate than has popular reporting on obesity.

Issues involved with weight, weight gain, and health are complex and there is great debate over why people gain weight, if and/or why higher weights have adverse health consequences, what is an ideal weight does a universal ideal weight even exist, why some weigh

more than others, why the U.S. population as a whole is heavier now than it was in the past, and whether weight loss improves health. Despite the complexity of the scientific issues, two groups have dominated public discussions of obesity in the media and have framed these issues in competing and simpler terms. On one hand, there are a small group of researchers who have issued alarmist predictions about the "obesity epidemic." Paraphrasing Gusfield (1981), I call this group the "anti-obesity crusaders." This group is waging a moral "battle of the bulge." They are often quoted in the major papers, serve on NIH panels, FDA panels, and WHO advisory boards. Many publish in peer review medical journals like *JAMA* or *NEJM*, which are frequently covered by the press. A few, like Marion Nestle author of *Food Politics* (Nestle 2002) or Kelly Brownell author of *Food Fight* (Brownell and Horgan 2003), have published books destined for a wider public. There are also anti-obesity crusaders with backgrounds in journalism who have published widely selling treatises on obesity, such as Eric Schlosser's (2001) *Fast Food Nation*, Michael Fumento's (1998) *The Fat of the Land*, or Greg Crister's (2003) *Fat Land.*

There are also several organizations promoting the war on obesity, for instance, through funding obesity research, such as the North American Association for the Study of Obesity (NASSO, founded in 1982), the International Association for the Study of Obesity (IASO, founded in 1986), the American Obesity Association (AOA, founded in 1995), and the International Obesity Task Force (IOTF, founded in 1996 and joined IASO in 1997). Since the 1970s, there is a medical specialty of "bariatric medicine," (Sobal 1995) represented by associations like the American Society of Bariatric Physicians and the American Society for Bariatric Surgeons which has a professional interest in raising public concern and priorities regarding obesity. Specialty journals dedicated to obesity include the *International Journal of*

Obesity, IASO's official journal, founded in 1976 and *Obesity Reviews,* founded by IASO in 2000.

At the other end of the spectrum are self-identified Health at Every Size (HAES) researchers – also working in a range of scientific disciplines – who consider "obesity" a false problem and the focus on weight loss dangerous. They urge a focus on health living – including more movement and better nutrition – not weight. As with the obesity crusaders, members of the "HAES movement" see themselves as having a mission to spread an alternative message about weight and health, not only through scientific publications, but through the mass media as well. Many researchers fall somewhere between these "ideal types" (Weber 1949:89), at least some of the time. Whereas researchers and medical professionals led the anti-obesity movement, with journalists and policy makers following, "Health at Every Size" (HAES) medical research followed in the wake of the fat acceptance movement.

The fat acceptance movement has long rejected the term "obese" because it pathologizes heavier weights and argues that weight is a political, not medical issue. Unlike other identity movements, however, the fat acceptance movement has run into resistance from medical researchers who argue that what they claim to be a largely immutable aspect of identity (fatness), is actually a preventable health risk (obesity). This has forced the fat acceptance movement into scientific debates over obesity. It is here that the work of HAES researchers has taken on an important political role for this movement. Leading fat acceptance activist Lynn McAffee, who is Director of Medical Advocacy for the Council on Size & Weight Discrimination and takes part in obesity conferences and government panels on obesity, explains why she became involved in debates over medical activism:

I'm not actually particularly that interested in [health] and God I hate science…but I

recognized very early on that if we are ever to succeed, we have to get a, a foothold in the

medical world and make them understand. And that's what I've tried to do because,

when it comes down to it, the last argument is, "oh but it's so unhealthy for you…."

People get to discriminate against us because they're just trying to help us with our

health.

A precursor to HAES was AHELP (Association for the Health Enrichment of Large People),

founded in the late 1980s. HAES also has some points of affinity with the non-diet approach and

eating disorders specialists, both groups that consider focusing on weight and weight loss diets

potentially harmful but do not necessarily fully embrace size acceptance.

Like the anti-obesity approach, the HAES perspective is also institutionalized, although it

is smaller. *Health at Every Size Journal* (formerly the *Healthy Weight Journal,* founded in 1988,

renamed the *HAES Journal* in January 2004) publishes work in this paradigm although it has a

small distribution of about 300 subscriptions in 2005 according to the publisher. Many of these

researchers exchange ideas and discuss research on a list serve called "showmethedata."

FRAMING WEIGHT, HEALTH RISK, AND MORALITY

Why would "helping someone with their health" be perceived as providing a justification

for "discrimination"? We argue that many assume body weight to be under personal control so

that fatness is seen as a marker of risky health behaviors. The fact that overeating and inactivity

– the behaviors assumed to be at the root of fatness – are considered indicative of immorality and

that fat bodies are stigmatized in contemporary United States only heightens the anger directed at

people who fail to achieve a "good body" and the indignation felt by those who try to point out

the evil of their ways. In the words of Michael Fumento, a science reporter and author of *Fat of*

the Land: "When somebody shows prejudice to an obese person, they are showing prejudice toward overeating and what used to be called laziness. It's a helpful and healthful prejudice for society to have (Lasalandra 1998)." This is admittedly an extreme position, but as long as fatness is considered *as if* it were a chosen behavior with negative health consequences, claims about tolerance and diversity seem like excuses for bad behavior. If weight is under personal control and is a strong predictor of health, then accepting higher body weights is both personally reckless and socially irresponsible. To quote Fumento (1997: 245) again:

> Remember that obesity is a socially contagious disease. If you improve your eating and exercise habits, there's an excellent chance other members of your family will, too. Other people will see you and if they are fat they will no longer be able to take comfort in thinking, 'Oh well, there goes another person who's as fat as I am.' You will serve as proof that, even in the America of the late 1990s, it is possible to be in good shape.

In that "bad lifestyles" are seen as socially transmissible and the economic costs of ill-health at least partially shared, fat bodies are framed as a public menace.

Research clearly shows that weight is determined by a range of biological and environmental factors. Some of these – such as diet or amount of physical activity – are subject to personal control, but others – like genetics or prenatal nutrition – are not. Social structural and cultural factors, such as availability of fruits and vegetables or how much physical movement is required as part of one's daily activities, also influence body size. People vary by such biological/genetic factors, by social location, and by personal behavior. They also vary in how these three levels interact. So certain groups, like the Pima Indians, are genetically predisposed to gain a lot of weight when they encounter "American lifestyles" of fast food and sedentary lifestyles, while other groups seem to be less affected by the same environment (Baier and

Hanson 2004). And losing weight can be difficult. Empirical studies consistently show intentional weight loss to be elusive for 75-95% of participants of commercial weight-loss programs in one to three year follow-ups (see, e.g., Garner and Wooley 1991; Goodrich and Foreyt; Kramer, Jeffery, et al. 1989; Miller 1999; Stunkard and McLaren-Hume 1959),

Even the most strident anti-obesity crusaders admit that body weight is determined by many factors beyond personal control. JoAnn Manson is a Harvard epidemiologist who has published numerous articles about the dangers of obesity and weight gain drawing mainly on the Nurse's Health Study, a longitudinal study on which she is the co-investigator, and is often quoted in the mass media on this topic. In an interview, she said:

> I'm going to be the first to say that I think obesity is tremendously complex in terms of its etiology. I think there are important genetic factors. I think that there are important [factors with] signaling… in terms of food intake and satiety…. Association with sedentary lifestyle can obviously be more than just a willpower problem.

This state of affairs makes it tricky to directly translate body size into personal behavior. For instance, two women weighing 150 pounds at 5'5" (the official cut-off for overweight) may have drastically different lifestyles. One might be maintaining a weight that is low for her body by exercising every day for 90 minutes and restricting her food intake, while the other might weigh more than she would if she were moderately active and ate fewer calories.

Yet, despite a general recognition that body weight is not completely under personal control, anti-obesity crusaders tend to focus on personal choices. Given the moral context of body weight, eating, and physical activity, this means that fat bodies are read as evidence of preventable illness and moral failings. Size acceptance becomes tantamount to accepting bad behavior that knowingly contributes to ill-health. In the words of Michael Fumento (1997:130):

The fat acceptance people have been very resourceful. But make no mistake about them. Some may be very nice as individuals, but they are doing very bad things to our society and especially to those struggling with weight problems. They have turned what had been two of the Seven Deadly Sins – sloth and gluttony – into both a right and a badge of honor…. That's a sin in and of itself.

While recognizing that empirical studies of weight-loss diets point to high failure rates, several researchers expressed the personal opinion that most people could lose weight if they tried hard enough. One (1)[2], who is on the board of Weight Watchers Inc. and who runs his own weight-loss clinic argued that fat acceptance activists are a special case of people who "are probably genetically programmed to be very heavy, so they have a lot of trouble with diets." He says this is very different from "the average guy out there who gains a half, a pound a year from the time he's twenty until the time he's sixty, stopping off at McDonalds for breakfast and lunch, and having snacks as he watches the football game every night."

According to Manson, people "know if they were to get up off the couch and do some more walking…it would be helpful to them, but they just don't feel like it." Every day, she says, they *make a choice* to buy "the Big Mac and French fries instead of a salad or roasted chicken." Harvard Epidemiologist Walter Willett is co-investigator, with Manson, of the Nurses Health Study and has an impressive list of publications on the health risks of obesity and weight gain and is often quoted in the mass media. According to him, very few overweight people "are seriously thinking of weight loss," and those that are can and do "lose weight and keep it off," but it requires making dietary changes and being physically active "for at least an hour a day" for the rest of their lives. "There's no permanent fix here." Willett says he's "yet to be convinced that there are very many people that if they are really serious about controlling their weight, can't

get their weight down under a BMI of 25." He adds: "The main excuse regardless of why they don't get exercise is because they don't have enough time, and you look at all the national surveys, and they say the average amount of television watching per week is 29 hours."

Obesity as Risky Behavior

Those who assume that "obesity" is directly attributable to risky health behaviors see it as their ethical duty to draw attention to the problem, even if this might worsen the stigma associated with larger bodies. According to Walter Willett, "We don't want to have discrimination, but I think that can't possibly be used as an excuse to censor information about the… cold reality of excessive overweight." This comment only makes sense in the context that "excessive overweight" is assumed to be preventable, so that by censoring information about the associated health risks, one would be contributing to more such cases.

When asked about the problem of size discrimination, obesity crusaders often argued that obesity was like smoking (a behavior). In the words of Theodore VanItallie, Professor Emeritus of medicine at Columbia University and founder of the Columbia weight-loss center that bears his name: "Well I think I'd put this in the category of smoking. I don't discriminate against people who smoke, even though I know it's bad for them, and I may really regret the fact that they smoke, but that doesn't mean that I treat them badly." It is because he is conceptualizing weight as a behavior, or the direct and immediate result of behaviors, that he can maintain that it is fair for those categorized as morbidly obese to be denied health and life insurance policies, just as smokers are: "I mean the same thing is true of smokers. Why should I have a, pay a high life insurance [premium]because of all the deaths that are caused by cigarette smoking?" Such a position would be more difficult to defend if he were thinking of obesity as a more immutable form of body diversity like race or height.

14

Similarly, another prominent obesity researcher (1) agreed that fat people are subject to discrimination:

> The equipment do not fit them…. They're not treated as well psychologically in a doctor's office or in a clinic. You know, they are given short shrift. I mean, there have been some studies that suggest [that obese] women don't get pelvic exams; they get them much less often than thin people.

But he used an analogy with alcohol consumption (a behavior) to argue that this should not preclude discussion of the "obesity epidemic": "I think that's like saying you can't talk about alcohol being bad because somebody's who's an alcoholic is going to feel bad about it."

JoAnn Manson said in an interview: "[Obesity is] often associated with gluttony and sloth in a lot of people's minds, and so I think that can foster discrimination and bias." However, she cautioned: "I think we cannot ignore the issue of obesity and sacrifice the public's health in order to be politically correct." She argued that a doctor who does not point out the health risks of obesity to an obese patient for this reason is analogous to one who does not report a patient's markedly elevated blood pressure, out of concern "that it would not be politically correct to label that patient as having high blood pressure." She asked why it is so readily accepted as "grossly negligent" not to report on elevated blood pressure but we consider it "fine to just sweep [obesity] under the rug and let patients be at increased risk of hypertension, diabetes, heart disease, [and] stroke, because we want to be politically correct and not mention body mass index?" The use of the term "politically correct" simultaneously acknowledges and trivializes implications that discussions of obesity have for civil rights. The analogy of obesity to hypertension implies that obesity is not so much a behavior as a biological condition highly influenced – but not entirely determined – by behavior.

Yet fat activists, who have failed at diet after diet, do not experience warnings about obesity as helpful reminders to slim down. Marilyn Wann is the author of *Fat!So?* (Wann 1999) – a fun and humorous challenge of "fat phobia" – and a vocal "fat rebel," a label she prefers to "size acceptance activist" which, to her, sounds apologetic and "still carries within it the kernel of this is a negative thing that we have to accept or tolerate." She explained: "When someone says, "You're fat and you're going to die," I don't take that as like a genuine concern for me, I take that as a death threat. Or as wishful thinking; they kinda wish that I would go away." In the words of Lynn McAfee:

> They continue to write epidemiology, scare epidemiology, and all these horrible associations. There's nothing practical and useful that comes out of that except more funding from the NIH for this disease, and that is 100 percent the purpose of that. But what they don't understand is that there are social repercussions. Who's going to hire me if they think it's so expensive to have me on their health plan?… They're supposed to be advocating for fat people, [but] they simply don't understand that a direct result of that is an increase in the discrimination that we suffer and people saying all the time, "it's just too expensive to hire fat people, you're going to cost me too much money."

Fat activists also pointed out that alarmist claims about obesity are used to justify dangerous and ineffective weight-loss remedies. For the analogy of obesity to smoking or alcoholism breaks down when one realizes that, in the case of food, quitting or abstinence is not an option. Everyone – even those with an ample supply of body fat – needs an adequate food supply to thrive. Fat activists further complained that when treating very fat patients, doctors often over-attribute any illness or condition to their weight and urge weight loss, rather than performing adequate exams and offering medical care that does not involve weight loss.

While recognizing that good nutrition and physical activity are important contributors to health, fat acceptance activists and HAES researchers rejected assumptions that body size is a reliable indicator of one's diet or level of physical activity. They pointed to research that one can be "fit and fat" (Gaesser 2002: xviii; see also Katzmarzyk et al. 2005; Blair and Church 2004). They further argued that a focus on weight loss may be counterproductive by leading to "yo-yo dieting" and to people giving up physical activity or positive nutritional changes when they do not see immediate or dramatic weight loss, despite independent benefits of exercise. According to this view, a focus on weight can also falsely reassure thin people who are sedentary that they do not need to exercise (see, e.g., Gaesser 2002).

Respondents on both sides of the anti-obesity/fat acceptance debate agreed that science has not sufficiently teased out the health consequences associated with body weight from those associated with nutrition or physical activity. However, they disagreed about how important this is. For fat acceptance and HAES, it was crucial, but for obesity researchers it was, in the words of James Hill, an "issue of semantics." Hill is Professor of Pediatrics and Director of the Center for Human Nutrition at the University of Colorado Center for Human Nutrition and the co-founder of the National Weight Control Registry, which follows over 5000 people who have lost weight and kept it off permanently. He was a member of the Expert Panel that developed the National Institutes of Health Guidelines for Management of Overweight and Obesity and was chair of the first World Health Organization (WHO) Consultation on Obesity. He has served as president of the North American Association for the Study of Obesity and as Vice-President of the International Association for the Study of Obesity. According to Hill, "we're getting all hung up in the words…. I'm happy if you want to focus on nutrition, on physical activity, on obesity,

on diabetes; it's all one cascade…. It's really hard to separate out what's causing what." In the words of Van Itallie:

I don't think it's possible at the moment to completely disentangle the adverse effects of a sedentary lifestyle from those of obesity…. Whether [obesity is] a risk factor because it is, in part, a marker for lack of exercise…needs further investigation, but obesity is something we can measure.

The respondent above does not see the need to distinguish public health messages about fitness from those about body weight, because he sees the two as inextricably linked for most people. In the words of another obesity researcher (1): "The public health message either way is to decrease your calories and increase your physical activity. So I don't think practically it really makes much difference. And if you're cutting calories you're losing weight." Likewise, Hill said:

Let's say that…we go out and we get everybody's diet perfect and we get everybody physically active, because of genetic differences, there are still going to be obese people, and those people then would be fit and fat [which would be great]…. I think, however, that for the majority of Americans, we could…with the proper diet and physical activity patterns, have the majority of people in a healthy body weight range.

An Alternative Morality?

Glenn Gaesser (2002:xxiv), Professor of Kinesiology, specializing in exercise physiology has articulated, in his book *Big Fat Lies,* a "Health at Every Size" alternative to public health messages about weight: "People should be physically active, eat healthy foods, and not obsess about the numbers on the scale." Gaesser wants to decrease the attention given to weight both because he believes that the science suggests that physical activity and a diet high in fiber and complex carbohydrates and low in fat and sugar are more directly linked to good health than is

weight and that improving diet and becoming more active do *not* always translate into weight loss for all people. Strategically, it is therefore dangerous to focus on weight loss because such a focus may lead people to abandon changes to diet and activity when they do not experience weight loss, even though these changes independently improve overall health.

Thus, while he rejects a focus on weight loss, Gaesser strongly recommends improving personal lifestyles to improve health. He recommends that people get at least 140 minutes of exercise (including yard work and playing actively with children) per week and eat a diet low in fat and sugar and high in complex carbohydrates. Quoting Ernsberger and Haskew (1986), Gaesser (2002: 165) explains that "obesity may not be a direct cause of disease, but may serve as an imprecise marker for an *imprudent* lifestyle" (emphasis added). While rejecting moralizing of body weight, Gaesser does make moral judgments about "lifestyle," which he maintains has an adverse effect on health. "Imprudent lifestyle" can also lead to accumulation of "bad body fat," which is visceral (or deep) abdominal fat, as opposed to "good body fat," which accumulates on the buttocks and thighs:

> If you want to create a lot of bad body fat, over and above that which is your destiny because of genes and gender, do the following: Exercise as little as possible, eat fiber-depleted foods loaded with fat (especially saturated fat) and refined sugar, drink a lot of alcohol, smoke cigarettes, and subject yourself to as much stress as possible. In other words, do as a great many Americans do. The effects of each of these behaviors is cumulative, so do them all for maximum effect. But if you can't indulge in every one of these behaviors, one or more will still be effective – especially if you choose physical inactivity and fat and sugar-laden food, the behaviors of choice for millions of Americans (Gaesser 2002:124).

The moral language in this passage is striking: "bad" body fat, "indulge," "choice." "Imprudent lifestyles" are clearly not being condoned, despite support for size acceptance. Moreover, there is no discussion of how such lifestyles are constrained by factors beyond personal choice.

Marilyn Wann's discussion of the indignation she felt about being denied health insurance at the age of 23 because of her weight, similarly challenges the equation of fat with unhealthy without challenging the moral imperative to seek health by, for instance, not smoking, eating well, and wearing a seatbelt. She explains how she responded when she was denied health insurance at the age of 23: "So I'm 23 years old, a non-smoker, I have no history of any major illness at all, no hospitalizations, nothing. I exercise, I eat my veggies, I live in San Francisco, [and] I wear my seatbelt. And they're not going to give me health insurance!"

Some fat acceptance activists and researchers who identify with the HAES approach have taken a more radical line. Jon Robison is co-editor of the *Health at Every Size Journal* and holds a doctorate in health education/exercise physiology and a master of science in human nutrition from Michigan State University, where he is Adjunct Assistant Professor. In his book (Robison and Carrier 2004), *The Spirit and Science of Holistic Health: More Than Broccoli, Jogging, And Bottle Water More Than Yoga, Herbs, and Meditation,* Robison and Carrier dispute the traditional approach to health and illness that focuses on individuals trying to control epidemiologically based risk factors – including weight, nutrition, and physical activity – rather than addressing social phenomena that detract from health, such as violence, prejudice, social isolation, and materialism. Robison is thus wary of substituting concern about weight with concern with nutrition and/or fitness. In a spirited debate on the "showmethedata" listserv about whether HAES professionals should talk about foods as being "good," "bad," or "better" than others, Robison wrote on 11/11/04:

What is really absurd in my opinion, is suggesting that one food is "better" than the other.

Good and bad is a moral judgment - it has nothing to do with science and nothing to do

with nutrition. From a nutrition science perspective, some foods are more nutrient dense

or have more fiber or have less fat than others. Good and bad relating to these foods (with

the possible exception of spoiled foods) adds nothing to our understanding of the foods

themselves, establishes a slippery slope from which there is no escape, and sets people up

for continued confusion and anxiety about eating….

The following day, in response to protests that science has established that there are foods that

most people would probably be better off eating more of and others they would be better off

eating less of, Robison reiterated his argument about "good" and "bad" being moralistic terms:

Words are very powerful - perhaps the most powerful tools we have - and good and bad

are not scientific terms - they are moralistic terms, and I would argue there is no way to

separate out their moralistic implications when it comes to food. At HAES we don't use

the term overweight (commonly used elsewhere) to describe people because it is

unscientific (over what weight?) and moralistic. And we avoid using the word obese

(meaning to get too fat from eating too much) even though it is commonly used

everywhere because it is unscientific and moralistic. I am suggesting we be just as careful

with our words when it comes to food, perhaps even more so because there is so much

confusion and anxiety out there about eating and it is so inexorably tied in with confusion

and anxiety about bodies.

Similarly, on a HAES a listserv dedicated to exchanging data about weight and health, a

person identifying as engaged in "fat liberation," weighing "somewhere around 400 pounds,"

fifty years old, and having worked in the restaurant business for most of her life, wrote:

Health is the new morality. And people who fall from grace are either heroes or villains. Michael Fox and Christopher Reeves become national spokes-persons. I am to blame for the pain in my knees… I am not saying that the fat revolution means that I should be able to eat junk food and lay on the couch. But, ya know, I should be able to eat junk food and lay on the couch. My health care concerns should be between me and my HAES savvy medical professional.

Disease as Removing Blame?

It is often assumed that treating a condition as an illness removes blame for the condition because an illness is seen as outside of personal control. There is a large body of literature on "medicalization" that makes precisely this point. In Peter Conrad's (Conrad and Schneider 1992) classic work, he argued that by redefining alcoholism as a medical rather than a moral problem, alcoholics were transformed from "bad" to "sick" and gained sympathy and understanding in the process.

Advocates of making weight loss tax-deductible or covered by Medicare have argued that obesity should be considered a disease in its own right and not just a risk of other illnesses (see Kolata 2004). Noting the general trend towards medicalization of body weight, sociologist Jeffery Sobal has argued that, whatever negative moral tinge obesity still has is but a vestige of "the overwhelming interpretation of obesity *in the past* as a moral and not medical problem" (Sobal 1995:84, emphasis added). Similarly, Kelly Brownell said that if calling obesity a disease "takes away some of the blame from the people who have it…, then "disease" is probably a good way to characterize it for the time being."

Yet, interviews with obesity researchers show that treating obesity as a disease does not necessarily remove blame, especially if the disease is seen as caused by personal behavior.

When, during an interview, obesity crusaders used an analogy to disease rather than health risk, they most often chose the analogy of cancer. For instance, VanItallie used the analogy to cancer to argue that, despite the low success rates of weight-loss diets, if one is obese, it is still better to diet than to simply accept one's weight: "If I had a patient with cancer I would usually recommend treatment for it even though the patient might ultimately succumb to the cancer. You do the best you can with the tools that you have at hand." In the words of Hill:

> I think…the analogy [to fat acceptance] would be [to say] "let's have a cancer acceptance movement…. You've got cancer; just accept it and live with it…." I can't do that because I know this is a disease…that has the potential to have devastating societal consequences. So I can't do fat acceptance although I can certainly be sympathetic to [the idea that] we've got to deal with the discrimination issues.

Kelly Brownell makes the same analogy: "If somebody has a disease that really can be horrible for them, like cancer, and the treatments don't work very well, you don't give up treating, because you try to do the best you can."

The analogy to cancer – a deadly disease that can kill quickly and with great pain – suggests that obesity too is in itself a killer disease and not just a "risk factor" that might make one more likely to become ill. In terms of the issue of moral blame, cancer is an interesting choice of analogy, since patients – and especially smokers – are often blamed for lung cancer (see Sontag 1990). Yet, blame plays an even more central role with weight than it does for cancer, especially when one considers treatments for each. Cancer cures include surgically removing the cancer or killing the cancer cells with radiation or chemotherapy, technological procedures themselves relatively devoid of moral meaning. Similarly, while people – especially gay men – are often blamed for contracting AIDS and "safe sex" is urged to contain the spread of

the HIV virus, treatment – namely drug treatment – is not particularly moralized. In contrast, "obesity cures" involve changes to personal behavior, the same ones that are often seen as causing the "disease" in the first place. If changing personal behavior can correct the "disease," the individual's responsibility for his or her condition is reaffirmed. Warnings about obesity inevitably return to messages about "lifestyle" and personal behavior.

Indeed, the main component in all available weight-loss remedies involves changing personal behavior. Weight-loss diets require "discipline" and "healthy choices" and are viewed as a test of character and will-power. Weight loss drugs and weight loss surgery could potentially offer more of a disease-model of treatment, but current drugs and surgery ultimately do not. Available weight loss drugs are only effective for small amounts of weight loss, either by reducing appetite (Meridia) or by blocking the absorption of fat (Xenical). Neither of these corrects or recalibrates a faulty biological process and both are intended to be used in combination with a weight-loss diet and physical activity, thus still requiring individuals to "reform their evil ways."   Similarly, weight-loss surgery is said to assist people in changing their eating behaviors by reducing appetite and making it physically uncomfortable (even gastro-intestinally excruciating) to overeat. This is better understood as a physically enforced weight-loss diet, rather than surgery that corrects a faulty stomach. Indeed, a stomach that has been surgically altered in this way is unable to perform many of its functions, such as properly absorbing nutrients (Alvarez-Leite 2004), and thus is less anatomically correct than before.

In other words, in the case of obesity in the contemporary U.S., the medical cure *is* moral reform. The idea that not only moral character but also medical health is on the line, increases the urgency of such moral reform and brings on the obligation of the sick person to get well,

what Parsons (1951) referred to as the "sick role." It seems that rather than removing the moral tinge, as Sobal has argued, medicalization of obesity may actually intensify it.

Sylvia Noble Tesh (1988) has shown that different disease models have distinct social implications. Popular lifestyle theories of disease place blame squarely on individuals for their ailments, as illness is conceptualized as the result of engaging in "risky" behaviors within an individual's conscious control. In contrast, germ theory absolves individuals of responsibility for their condition and depersonalizes disease.[3] Although Tesh does not discuss them, genetic medical models similarly absolve individuals of responsibility for their ill health since genes are considered outside of an individual's control.[4]

Indeed, genetic models have been popular in the fat acceptance movement precisely because they are perceived as removing blame from obesity. In the words of a 57-year-old NAFFA member who is trained as a nurse**:**

> Disabled people approach a problem thinking, well, I'm okay, something happened to me
> that I became disabled, and I deserve as much as the next guy. Fat people come out in
> the world thinking, I'm *not* okay. I don't deserve this, and they don't figure out how to
> get what it is that they need. Somebody like me has to tell them in a workshop what
> you're entitled to and what you can do, and what amenities you can use that are made for
> the disabled but they're gonna be okay for you, and that you deserve it just as well,
> because you were born this way too, you were born to have this tendency to be the way
> you are. *It's not your fault*, people want to tell you it's your fault, society wants to *blame*
> it on you. *It's not your fault.* If it was your fault then everybody that over-ate would be
> big, and that's not true because you see tons of people who eat constantly and remain
> thin. *It's their genetics and their metabolism*, and you look at them scarfing down stuff

all the time and they never seem to gain an ounce, whereas you have to just smell the

fumes from [fattening food] and you put on ten pounds [emphasis added].

Arguments that homosexuality is not a choice but determined by genetics are similarly politically

attractive in a homophobic society because people are less inclined to fault others for something

that is beyond their control. However, as many fat acceptance activists recognize, theories of

genetic inferiority can also provide justification for structural inequality and persecution, as is

demonstrated by the history of racism and anti-Semitism. One NAAFA member worried that, if

researchers did locate a fat gene, expectant parents would abort fat fetuses. This alerts us to the

fact that removing blame does not automatically remove stigma. As Lynn McAffee explained:

Obesity researchers keep working so hard to turn this into a disease. And when I

complain, they go, "Well I don't understand the problem, Lynn, because if you have a

disease then it's not in your control and people won't harass you." I say, "Well you're so

wrong…." This is exactly the issue that handicapped people [and] people with disabilities

face…. By having something biologically wrong with them, number one they're

biologically inferior and then number two, they're…caught at that liminal position, where

they're not adults and they're not children. And with that liminal position, you lose your

sex life, you lose a lot of responsibility for things, you lose a lot of the adult stuff,

because you have to be taken care of by society…. So it's not a free ride.

McAffee recognizes that the social condemnation she experiences as an extremely fat woman is

not due solely to people's assumptions that she eats too much and exercises too little, but that her

weight is also is taken as evidence of a "spoiled identity" (Goffman 1963). While a genetic

model might challenge assumptions of personal responsibility, it reinforces the sense that she is

biologically flawed (see also Wang 1992). Moreover, embracing the "sick role" (Parsons 1951)

carries the added cost of infantalization.

Marilyn Wann agrees with McAffee. Marilyn Wann has sat in on several obesity

conferences and meetings to share her subversive views with conference participants. She said

that it was difficult to stay quiet during these meetings because of the rage she felt towards the

implicit judgment against fat people made by the researchers:

> It's very challenging to sit still and not just scream a lot of the time. First because I feel
>
> like the word "obesity" is, like "overweight." I understand that it seems polite to people,
>
> but it's a judgment term…. "Obesity" is like putting a medical layer of nicety over fat.
>
> Fat is just the thing to me, it's just "fat," "thin," "young," "old." It's just a word, and
>
> "obesity" sounds like such a diagnosis, a pathology.

Even if treating obesity as a disease could remove blame associated with the condition, Wann

points out that the term "obesity" still implies that large body sizes are pathologic, rather than

simply a sign of diversity. In that she experiences her body as healthy, despite being categorized

as morbidly obese by official weight guidelines, she personally rejects the sick role and publicly

rejects arguments that obesity is a disease.

Viewing obesity as a biomarker for certain illnesses (but not others) might offer a morally

neutral means of conceptualizing some of the health risk associated with higher weights.

According to this analysis, people who are biologically predisposed to gain a lot of weight are

also biologically predisposed to certain illnesses. Weight would thus be conceptualized as a

neutral biological property that is largely (but not necessarily entirely) outside of individual

control. The associations with certain diseases would be used as screening devices to test for

these diseases and begin treatment early, but would not be grounds on which to urge weight loss.

It could be used in the same way that family histories are used to screen for illness. Although some of the epidemiological literature on weight and health risk is compatible with such an approach, this perspective has not dominated public discussions, precisely we would argue paraphrasing Susie Orbach (1978), because fat *is* a moral issue.

Weight and Social Inequality

Given the social epidemiology of weight, with higher weights inversely correlated with social class in heterogeneous and affluent societies like the United States (Brown and Bentley-Condit 1998:149) and that African-American and Mexican-American women are especially likely to be categorized as obese (Flegal et al. 2002), this issue is likely to have implications for social inequality. There are many reasons why poor minority groups have poorer health outcomes than do wealthier whites, including worse access to health care, discrimination, and living in areas with high pollution and high crime. Science journalists and author of *Fat Land* – in which he argues that obesity is an urgent health crisis – Greg Crister (2003: 111) comments thoughtfully on the structural factors that contribute to a higher level of obesity among disadvantaged groups:

> The poor, after all, lead lives that are more episodic than those of the more affluent. They are more likely to experience disruptions in health care, interruptions in income. Food, and the ability to buy it, comes in similar episodes – periods of feeling flush, periods of being on the brink of an empty pantry. The impulse is to eat for today, tomorrow being a tentative proposition at best… There is another factor driving the D.C. poor toward obesity as well, one rarely talked about in public health circles, let alone in the mainstream media. It is what might be called the pain of poverty.

One could imagine these insights leading to what Tesh (1988:78-82) calls a "structural perspective" of illness, in which social systems of inequality and poverty are seen as the underlying causes for both chronic and infectious diseases. This kind of account shifts blame away from individual ill people and provides a health rational for prodding the government to enact policies designed to relieve poverty. However, while Crister evokes structural *causes* of obesity at points in his book, he does not use this analysis as a basis for demonstrating the urgency of relieving poverty in the United States. Instead, his final chapter, entitled "What Can be Done?" focuses on the importance of lifestyle changes, particularly for the poor.

Discussions of lifestyle changes often return to the need for education and knowledge, thus reinforcing the idea that poor fat people are ignorant. In discussing a nutritional program aimed at poor children and their parents in Los Angeles, Crister (2003:162) comments: "During the three sessions I attended, it was not unusual to witness a parent walk into the class eating French fries from McDonald's or sipping thirty-two ounce Big Gulp Coke from the local convenient mart." Likewise one of the researchers interviewed (1) attributed weight gain to lack of information: "Why does the average American woman gain weight with each pregnancy and end up [after] four kids, fifty pounds heavier? It's because nobody alerts her to the fact that this may happen and it may not be good for her to end up fifteen-twenty years later fifty pounds heavier." This same researcher explains why these problems are more common among minority and poorer women as follows:

> A lot of the obesity problem in America…is in the minority [and] poorer groups. It may be that they have other priorities. Some woman who's living in the housing projects and has no husband and is trying to take care of four kids and is now off welfare and has to work and has all kinds of problems: for her, diet is not [a priority]…. I'm not saying

they're wrong, but I'm saying I don't think they're really connected to the idea that they

need to lose twenty-five pounds, and so they don't try it. But the problem is their

daughters are not geared to the idea that they should try to prevent becoming as heavy as

their mothers…. You'd like to catch them before they gain weight, but that requires a lot

of sensitization to the problem.

Such a focus on weight, without addressing the "other priorities" of this hypothetical single poor

woman, ultimately draws attention to individual behaviors rather than structural inequality.

Likewise, VanItallie acknowledged how it is difficult to exercise when one lives in a

high-crime area, but returned to self-discipline as the solution for obesity:

In an environment like ours it's very hard to overcome the impediments to regular

exercise. It requires a lot of self discipline to exercise in an environment where you don't

have sidewalks to walk on or where it's unsafe to go out. After working all day, you

don't want to go out at night in a setting where you might be attacked.

VanItallie also referred to self-discipline and "peer pressure" to explain why upper-class women

tend to be thin: "Peer pressure is what helps keep upper class women thin, so that part of it is

fine. The fact is that there is a relationship between education, socioeconomic status, and

thinness. Women who are well-educated and affluent are unlikely to be obese." If health is a

question of self-discipline or peer pressure, ill-health is easily blamed on the individual or that

individual's immediate social network.

In that blacks and Mexican-Americans – especially among women – are more likely to be

categorized as obese, the stigma associated with their weight can reinforce their subordinate

social position. Sometimes, the reference to class is implicit, as when Fumento (1997:31)

situates the "extremely obese" in WalMart, well-known for its cheap prices and popular

clientele: "during a three-day visit to Vienna I saw only two people that would be considered extremely obese, a fraction of the number I would see in any WalMart in America." Fumento (1997:18) shares another glimpse he gets of middle America on a popular talk show, a genre in which the poor and minorities are extremely visible (Gamson 1998):

> One day while sitting in a doctor's office I caught an installment of Leeza Gibbon's show, *Leeza.* I swear, I do not watch talk shows unless I'm a captive audience. This show featured three mothers and their obese children. [Two of the mothers] wrong their hands in desperation over their children's habit of overeating. Perhaps because everybody in the audience was as fat as the mothers, nobody bothered to point out that both of these mothers were terribly obese themselves. But how can a mother expect her child not to overeat when she, the prime role model does?

At another point, Fumento (1997:127) – who is adamant about self-control as the solution to obesity – evokes misguided cultural values among blacks to explain the heavier girth of African-American women: "There's strong evidence that one reason black women are so much fatter than black men or white women is that their culture simply considers their obesity to be acceptable."

Paul Campos, University of Denver Law Professor and an active participant in the "showmethedata" listserv argues (2004:68):

> The disgust the thin upper classes feel for the fat lower classes has nothing to do with mortality statistics, and everything to do with feelings of moral superiority engendered in then people by the sight of fat people. Precisely because Americans are so repressed about class issues, the disgust the (relatively) poor engender in the (relatively) rich must be projected onto some other distinguishing characteristic. In 1853, an upper-class

Englishman could be quite unselfconscious about the fact that the mere sight of the urban proletariat disgusted him. In 2003, any upper-class white American liberal would be horrified to imagine that the sight of say, a lower-class Mexican-American woman going into a Wal-Mart might somehow elicit feelings of disgust in his otherwise properly sensitized soul. But the sight of a fat woman – make than an 'obese' – better yet a 'morbidly [sic.] obese' woman going into Wal-Mart... ah, that is something else again.

For Campos and Katie LeBesco, Associate Professor of Communication Arts at Marymount Manhattan College and author of Revolting Bodies: The Struggle to Redefine Fat Identity (2004), (Smith 2004), much like eugenics movements of the early 20th century, discussions about the health risks of obesity potentially rationalize and justify social inequality by pointing to the biological inferiority of poor and minority groups.

Similarly, Tesh (1988:45-46) has argued more generally that lifestyle arguments validate upper-middle class habits and preferences and reinforce social hierarchy:

In some circles, it is chic not to smoke, to jog around the streets, to exercise in gyms, to eat low-cholesterol foods. Doing these things, or claiming to do them ("We hardly ever eat meat any more"; "I've started running again"), testifies to membership in the affluent classes. Such behavior means you are economically successful, or expect to be, or at least are very much like people who are. It has come to demonstrate a willingness to work to improve yourself and an eagerness to move up socially. Moreover, whether or not all this activity prolongs and wards off disease, it usually gives people a sense of wellbeing. Thus, like the personal behavior theory in the nineteenth century, the lifestyle theory stands for self-reliance and at the same time it makes you feel good.

In that people can – or think they can – tell if someone exercises and "eats healthy" by the size of their body, weight potentially becomes a particularly powerful legitimation for social inequality.

While dictates to be thin concern men and women, there is evidence that women are affected more than men by social pressures to be thin. Our interview respondents were more likely to discuss women's weight than men's. Women, who are more often than men judged on their appearance, are more likely to be invested in their looks than men (Feingold and Mazzella 1998; Pliner, Chaiken, and Flett 1990), are more likely to be unhappy with their appearance (Cash 2000), and to develop anorexia or bulimia (American Psychiatric Association 1994). Women and girls are much more likely than males to try to lose weight by a range of methods, including restricting food intake, taking weight-loss pills, vomiting, taking laxatives, and undergoing weight-loss surgery (Blanck, Khan, and Serdula 2001; Connor-Green 1988; Krowchuk, Kreiter, Woods, Sinal, and DuRant 1998; Zizza, Herring, Stevens, and Carey 2003). If, as HAES researchers argue, discussions about the medical importance of weight loss reinforce cultural dictates to be thin – an empirical question not warrants further research – then women can be expected to bear the brunt of this pressure.

Such concerns are dismissed by anti-obesity crusaders as grounded class prejudice. Crister (2003:121), quoting Richard MacKenzie, "a physician who treats overweight and obese girls at Children's Hospital in downtown L.A," writes:

"No one wants to overemphasize the problems of being fat to these girls, for fear of creating body image problems that might lead to anorexia and bulimia." Speaking anecdotally, [MacKenzie] adds: "The problem with that is this: For every one affluent white anorexic you create by 'overemphasizing' obesity, you foster ten obese poor girls by downplaying the severity of the issue.' Judith Stern, a professor of nutrition and

internal medicine at the University of California at Davis, is more blunt about this issue.

"The number of kids with eating disorders is positively dwarfed by the numbers with

obesity. It sidesteps the whole class issue. We've got to stop that and get on with the real

problem." 121

According to Crister (2003:123), anorexia has received a disproportionate amount of media

attention, as compared to obesity, because most anorexics are from the upper-middle class and

the media is biased towards problems that concern this social group. Similarly, without referring

to class, James Hill points out that: "If you just simply look at the number of people affected, you

have a huge number with obesity and a very tiny number with anorexia and bulimia."

While eating disorders and body image problems have been identified as a concern for

primarily white middle class women, recent studies have suggested that they may be more

prevalent than thought among poor or minority women (Williamson 1998). Moreover, poor and

minority women may be targeted by a focus on slimness in other ways, including as mothers

who are held responsible for their children's obesity.

CREDIBILITY STRUGGLES

Given lack of unanimity about how to *interpret* the evidence, assessments of scientific

credibility tend to focus on *claimants*, and not just on *claims* (Epstein 1996: 333). This section

discusses how interview respondents establish their own credibility, while undermining that of

their opponents. All appealed to academic prestige to establish the credibility of their claims and

those making similar claims; the anti-obesity camp also frequently questioned the academic

standing of their most visible opponents to undermine them. Fat acceptance activists evoked

their personal experiences with weight-loss techniques and fat prejudice as an alternative form of

expertise. Interestingly, both sides also appealed to their own love for individual fat people to

establish their credibility and sound intentions. The fat acceptance camp invoked conflict of

interest, pointing to the fact that many anti-obesity researchers receive research funds from

pharmaceutical companies, run weight-loss clinics, and advise weight-loss companies; while the

anti-obesity researchers pointed to the *physical bodies* of their opponents as evidence of a

different sort of conflict of interest, in which denying the health risks of obesity is read as

"making excuses" for personal fatness.

To shore up support for the position that obesity is an important health risk factor, obesity

crusaders typically referred to both the numbers of articles establishing this and the prestige of

the research. According to VanItallie: "So many studies have shown this relationship that it

makes no sense to question it." One researcher[5] said of HAES researcher Paul Ernsberger, who

is a neuroscientist and Professor of Nutrition and studies genetic obesity and the role of nutrition

(and specifically yo-yo dieting) in cardiovascular disease:

> He took this position that obesity was not bad for you. You know that runs counter to a
>
> thousand articles in the literature that have been well done. Where does somebody like
>
> that get off saying something like that, unless he refutes each of these articles?... We're
>
> talking about four national health surveys, done on thousands of people. We're talking
>
> about the Nurses Health Study, the Health Professionals Study, any number of
>
> epidemiological studies, a fair number of clinical studies done in Europe. I mean, are
>
> these people all deluded or what's the problem?

When asked about the fat acceptance position that obesity research intensifies the stigma fat

people experience, this same researcher responded:

> Well you know, when you listen to what people say, you have to think about what their
>
> qualifications are for saying it. I think the Vatican came out with some kind of statement

that said all opinions are not equal, and if your opinion is rendered by somebody who has no qualifications to render the opinion, it shouldn't be given much attention.

Fat acceptance activists were acutely aware that their lack of advanced degrees translated into a lack of credibility, which is why the HAES movement – composed with people with such academic credentials – has been so important in strengthening their position. In response to a question about how the fat acceptance movement is different from the Health at Every Size movement, Lynn McAffee responded:

> I think they [HAES researchers] have credibility and we [fat acceptance activists] don't. I think that's really it in a word… People would say to me all the time when I come up with these studies, "you don't know what that means, you're not a doctor." Well, I don't have to be a damn doctor to know what a 98% failure rate is.

Fat acceptance activists invoked their personal experiences with weight as an alternative source of expertise. For instance, several spoke about how draconian weight-loss diets lead to weight *gain* over time, as after each diet was over they regained back all the weight lost plus additional weight until they had, in the words of 44-year old administrative assistant member of NAAFA, "I doubled my weight through dieting in a little over twenty years." She explains:

> I wasn't always fat even though I thought I was. My height and weight sort of maxed out at 5'2" and 125 lbs, and at that weight I had people telling me I was fat, and my friends were my height [and] around 100 lbs, and then I had friends quite a bit taller than me who weighed 115 and 120 [pounds], and this wasn't too long after the Twiggy thing, and when I first started reading women's magazines the rule in all these magazines was you should be 100 lbs for 5 feet and 5 pounds for every inch over that, so I should have

weighed 110, and I weighed 125… And I still believe that had I never dieted, I'd still be

pretty close to that 125.

When presented with these arguments during interviews, obesity researchers typically dismissed them as anecdotal. Like others, Hill responded: "Well you really don't have the control condition there, you really don't know what would have happened to their weight if they hadn't dieted do you?"

Both camps also evoked personal *love* and *concern* for fat people to establish their credibility. Walter Willett reasoned that if you love someone, you don't want them to be obese and you don't feed them food that is highly caloric and low in nutritional value:

I think if you really care about somebody you would rather that they not be badly

overweight or obese because they're much less likely to be around for the long run…. If

we really loved [our friends or relatives] we wouldn't feed them [all kinds of things that

are terrible for them]. Unfortunately, people sabotage other people's efforts to control

weight, out of a misplaced or even unreal concern [for them].

Likewise, during an interview, Kelly Brownell asked what the interviewer would do if her aunt or grandmother was morbidly obese and diabetic and said that, if it was his loved one, he would advise weight loss surgery. In this case, his apparent concern for someone so close to him was intended to demonstrate his credibility.

Fat acceptance activists are familiar with these claims and adamantly reject them, arguing that alleged concern for health functions merely as, in the words of Marilyn Wann, "a big old smoke screen…for people being able to take out their fat hatred." Fat acceptance activists and HAES asserted their own concern and love of fat people, fat acceptance activists often referring to "my people" to talk about fat people. For instance, Wann said in an interview: "[At a meeting

on obesity and women's health,] I sat next to [a weight loss surgeon] just to feel like what it felt like to sit next to people, someone who butchers my people, to put it in melodramatic terms." Evoking love or concern to establish credibility is probably more common in medical compared to other scientific debates. Future research should investigate how claims about love and care are used in debates over other medical issues.

Fat acceptance activists often pointed to diet industry funding as a means of discrediting anti-obesity researchers. Claims about the economic motivations of obesity researchers serve as an important means for activists to discredit the work of mainstream scientists who advance anti-obesity positions. For example, official NAAFA policy statements argue that "most obesity researchers experience a profound economic conflict of interest." They point to the increased revenue that accrues to researchers, the commercial weight loss industry, and physicians with each redefinition or renewed concern about the effects of obesity. NAAFA states that "most leading obesity researchers are either consultants to diet or pharmaceutical companies, conduct research for these companies, presenting [*sic*] their results at conferences sponsored by these companies, or sometimes all three." The organization "condemns those obesity researchers who use their position as public health policymakers to further their own economic interest."

Concerns about the economic drive behind mainstream alarm about obesity are also echoed among individual activists. Fat acceptance activists and HAES researchers tend to be openly critical of obesity researchers in talking among themselves and commonly refer to these researchers as the "obesity mafia." The term "mafia" expresses internal cohesion, danger, and crime, but perhaps most significantly implies the extent to which researchers illegitimately profit from the exploitation of anti-obesity health rhetoric.

During interviews, anti-obesity crusaders generally admitted that obesity research is influenced by funding sources. According to one researcher,[6] "industry can… probably identify people that they feel like they can get a positive result from" and "if you're out there taking money from industry… you better worry because you walk a very fine line doing it." Another researcher[7] said more generally: "Well, it may not be overt, but I think that there's a tendency to expect that the investigators will come up with a favorable report."

However, they denied that this disproves the general conclusions about the health risks of excess weight, in part because most of the major studies about prevalence or cost of obesity have been funded by the U.S. government. Brownell acknowledged that pharmaceutical companies do sometimes fund studies of the health and economic cost of obesity because "they want to sell their drugs, and…one of the barriers they face is that the physicians weren't dealing obesity as a disease." However, he argued that the benefits of having the pharmaceutical companies fund these studies outweigh the costs.

> Big managed care organizations do not pay for the treatment of obesity, when it could have very valuable benefits for people. For instance, somebody with really bad diabetes can get treatment of their diabetes covered but not the treatment of the health problem that's causing the diabetes – the obesity – and so that's an area of outright discrimination…. And here's this massive problem, it's getting basically ignored by the government. And [now] the drug companies are putting all that money in. Great. We need those studies.

Another researcher[8] also pointed to the value of industry funding of research: "At the moment the funding situation is such that… it'd be very difficult to function without some financial support." In other words, while the fat acceptance activists and HAES researchers see obesity

researchers as driven by the interests of the weight loss industry, anti-obesity crusaders see the weight loss industry as providing additional resources for work they independently consider important.

Hill explained why he thinks fat acceptance activists have a naïve understanding of how industry funding influences science:

> The people that really want to say that researchers [who] are funded by industry are tools of industry, [don't] understand the realities of science, in that we want to do the very best science we can and, oftentimes, there are situations where our interests and industry interests [overlap]. There are other times when they don't, and that's where you are always walking this fine line. I've turned down a lot of industry studies because it wasn't consistent with what I felt like I wanted to do, but I've accepted others because it was consistent.

To resolve the tension between the need for industry funds and the risks involved, researchers generally agreed on the importance of taking measures to safeguard against bias, including by disclosing sources of funding, stipulating in grants that the work will be published regardless of the findings, and insisting that the funding source will have no input into the publications.

Moreover, as Hill pointed out, though government grants provide the "more non-biased way to get funding," "people are potentially biased by all sorts of funding," including NIH funding:

> Your whole goal in NIH research is to get that grant funded, and there's a whole bias toward showing that your hypothesis works…. You [also] tend to focus on the things that you think NIH is interested in, so if they have an RFA [Request For Applications] out for this particular area, you focus your work toward that area.

In other words, as funding agencies like the NIH make more money available for obesity research, more researchers are likely to study it. For Hill, a researcher's integrity was the best safeguard against bias: "For most of us, our reputation is the most valuable thing we have."

Some fat acceptance activists point to exploitation of fat people by money-hungry diet clinics, doctors, or weight-loss surgeons. Kelly Brownell acknowledges that there are abuses but contends that most doctors and academic researchers have integrity:

> I've heard of some surgeons that just [operate on] lots and lots of people…. There was some case of some doctor in Florida that was flying his private plane from coast to coast just writing hundreds of prescriptions [for Phen-Fen]. Those people ought to be in jail. But I would say… that's the minority of people. [Obesity research and treatment are] not glamorous [or] highly regarded by the field. It's only been a short time that there's even been journals [on obesity]…. The government didn't fund it very well, so you couldn't get a lot of grant money. So, it's kind of hard to argue that people are in it just to make money or to rip off overweight people.

While the fat acceptance/HAES camp suggested that obesity researchers could not be trusted because of their financial interests, the anti-obesity camp suggested that fat acceptance and HAES were just excuses for bad health behavior. In interviews, obesity researchers suggested that the fact that most fat acceptance activists are very fat women discredited them as simply making excuses for their weight. Michael Fumento writes that the claim that one can be five to fifty pounds over current weight guidelines is of little or no consequence as long as one is physically fit, "gives self-deceiving obese people something to hide behind, because they can (and do) assure themselves that while, yes, they burst through the ceiling of the height-weight charts long ago, the 'feel like' or 'just know' they're in damned good condition." Likewise,

when asked about the risk that public recommendations that people try to lose weight by dieting lead to yo-yo dieting, one researcher (1) responded: "I'm worried about the opposite message, that people use [the risk of dieting becoming yo-yo dieting] as an excuse not to deal with obesity."

This attitude appears to be widespread. Glen Gaesser said in an interview that his book editor only agreed to publish *Big Fat Lies* when she saw that he was tall and thin because she reasoned that, if he had been fat, the book "would have been viewed as almost a rationalization for being fat, [as if he had] a personal axe to grind." Michael Fumento (1997:119), in a section entitled "The 'Fatlash' Books" worries that Gaesser's weight status does indeed give his book authority:

> Gaesser's book came out just before another fat acceptance book, Richard Klein's *Eat Fat,* and half a year before yet another, Laura Fraser's *Losing It.*   But it has potential to do much more damage because the Klein and Fraser books come across as written by fat people trying to justify their conditions rather than change them…. But Gaesser is thin!

On the other hand, researchers – even those with impeccable academic credentials – who fall in the overweight or obese categories can expect to be discredited because of their weight. For instance, when asked about research findings showing that one can avoid health risk by being "fit and fat, an obesity crusader (1) evoked the author's personal health history to undermine his findings: "[Steve Blair] is fat, and he's been exercising a lot, but he can't lose weight. But he's had a bypass himself, and he's had a myocardial infarction…. He might have been better off with weight loss as well as fitness."

That a fat person is incapable of speaking *objectively* about weight seems to be readily accepted, while the idea that a thin person would be biased in a different but equally strong

direction seems less intuitive. In this case, thinness functions as the "unmarked category," much as whiteness or maleness are considered unmarked categories for race and gender, respectively. In all of these cases, the biases of the dominant group are ignored.

A PARADIGM SHIFT?

Despite seemingly having *less* institutional power than the anti-obesity crusaders, the fat acceptance and HAES advocates seem to have had a surprisingly *great* amount of influence over mainstream medical practices and scientific expertise regarding weight and health. In this section, we argue that political traditions of anti-discrimination provide an opportunity for fat acceptance, in that activists can "bridge" (Snow and Benford 1988) the issue of fat discrimination onto discrimination based on race, gender, sexual preference, or physical ability. Fat acceptance activists have also been able to exploit structural opportunities for influence. For instance, Lynn McAffee has participated in countless NIH and FDA meetings. Her presence there was made possible largely by the AIDS movement (see Epstein 1996), which legitimated the value of the personal experiences of patient groups in such meetings.

The influence of the fat acceptance movement is more evident in the increased recognition of problems related to size discrimination. NAAFA was founded in 1969 on a size discrimination platform and this issue has always been at the heart of fat acceptance activism. Yet while, according to Ernsberger, NAAFA used to be "considered part of the lunatic fringe" for discussing the stigma associated with obesity, "now everyone talks about fat discrimination." We saw this in the interviews with obesity crusaders above. Indeed, "discrimination" is included as one of the "hazards of obesity" in most current reviews and consensus statements. For instance, the "Healthy People 2010" report described the "Health Impact of Overweight and Obesity" in the following terms:

Overweight and obesity substantially raise the risk of illness form high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances, and problems breathing, and certain types of cancers. Obese individuals also may suffer from social stigmatization, discrimination, and lowered self-esteem.

Ironically, Ernsberger writes that the group that has embraced the concept the most is weight-loss surgeons, who "argue that societal discrimination is one of the main justifications for surgery." For instance, the end of a section entitled, "Rationale For The Surgical Treatment Of Morbid Obesity," on the website of the American Society for Bariatric Surgery states:

There are widespread negative attitudes that the morbidly obese adult is weak-willed, ugly, awkward, self-indulgent and immoral. This intense prejudice cuts across age, sex, religion, race, and socioeconomic status. Numerous studies have documented the stigmatization of obese persons in most areas of social functioning. This can promote psychological distress and increase the risk of developing a psychological disorder.

Debby Burgard, co-author of *Great Shape: The First Fitness Guide for Large Women* (Lyons and Burgard 1988), licensed psychologist, and active NAAFA member, wrote that she agreed "that even the most rabid obesity fundamentalist seems to bend over backwards to acknowledge discrimination, and this has been a useful card to play in curbing the worst interventions with kids." For instance, she has influenced medical authorities by helping to shift the focus of the "Childhood Obesity Task Force" to a health-based, rather than weight-based, approach.

The influence of the HAES movement is also evident in several authoritative health publications. For instance, the Weight Realities Division of the Society for Nutritional

Education produced an October 2002 report entitled "Guidelines for Childhood Obesity Prevention Programs: Promoting Healthy Weight in Children" adopted an explicit HAES approach. According to Burgard, "many HAES folks were instrumental in getting that written and published." Indeed, several health professionals and researchers associated with the fat acceptance and HAES movements are listed among the "committee of nutrition experts" that developed the guidelines. This report stresses the importance of setting "goals for health, not weight, as appropriate for growing children," and says that it is "unrealistic" to expect all children to be at an *ideal weight range.* Instead, this report defines "healthy weight" as "the natural weight the body adopts, given a healthy diet and meaningful level of physical activity," which it later specifies to be one hour of physical activity each day. It stresses the importance of fostering self-esteem, body satisfaction, and positive body image in all children.

Pat Lyons is a regular participant on the HAES listserv. A registered nurse with a masters in psychology, she is the co-author of *Great Shape* (Lyons and Burgard 1988). Lyons wrote on the HAES listserve that the HAES movement now has "enormous numbers of allies in public health." As an example of this, she described "a wonderful booklet done by the California Rural Indian Health Board with photos of healthy happy Indian kids of many tribes, and of all sizes, including very big kids, enjoying an outdoor camp." Lyons was pleased by the "positive, doable messages and activities" in the booklet and particularly a caption that read "Love Your Body," next to a photo of a "smiling round cheek girl of 17." The booklet, wrote Lyons "was full of HAES content." Moreover, she wrote: "That would not have happened without us, and I've worked with Indian tribes for 20 years before it did! But it did…and I agree…that there is a momentum of real folks that is shifting in our direction…. The obesity mafia has just gone too far." Since children are seen as morally innocent, it is not surprising that they are less likely to be

blamed than adults for their weight and more likely to elicit concern about whether weight-loss advice could negatively influence self esteem or worsen stigmatization. However, arguments about the problem of size discrimination, including in health care, have resonated for adults as well.

This seems to have been further facilitated by the fact, in the wake of AIDS activism, the United States has seen a marked upsurge of groups that "construct identities in relation to particular disease categories and assert political and scientific claims on the basis of these new identities" (Epstein 1996:347). These disease categories include most notably breast cancer but also chronic fatigue, multiple chemical sensitivity, and Alzheimer's (Epstein 1996:348). These groups criticize the quality of their care, the ethics of clinical research, and advocate for more investment in both research and treatment of their particular illnesses. ACT-UP lobbying related to AIDS, in particular, has opened up avenues for fat acceptance activists *as patient representatives* to claim authority to intervene in medical debates that directly concern them. Lynn McAffee, for instance, has had a seat at the table at FDA and NIH meetings. She said in an interview that she thinks that she often has an impact in obesity conferences even when she says nothing, because her "physical presence as a very fat woman there changes the dynamic a little bit."

This influence is evident in several official health documents. For instance, an article published by the National Task Force on the Prevention and Treatment of Obesity (2002; henceforth NTFPTO 2002) and two pamphlets published by the NIH (NIH Publication No. 03-5335 and NIH Publication No. 00-4352), on which McAfee played an important advisory role, promote a HAES approach. NTFPTO 2002, entitled "Medical Care for Obese Patients: Advice for Health Care Professionals," discusses how "health problems experienced by persons who are

obese are worsened by lack of access to care because of their obesity" and how "patient concerns about being disparaged by physicians and/or medical staff because of their weight" may "decrease patients' willingness to seek medical care" (NTFPTO 2002:82-83). While the article *does* assert that obesity constitutes an "independent health risk", the stated purpose of the article is "to provide guidance on ways to optimize the medical care of these patients, independent of recommendations for weight loss treatment" (NTFPTO 2002:83).

Evidence for Lynn McAffee's influence is provided not only by her own testimony during an in-depth interview but also in a footnote to National Task Force on the Prevention and Treatment of Obesity (2002), where she is thanked for her "thoughtful comments." The Council on Size and Weight Discrimination, on which McAffee is an active member, as well as NAAFA and several HAES publications are listed at the end of the two NIH pamphlets, providing further testimony to the influence of fat acceptance and HAES movements on these publications.

Many of the recommendations made to health care professionals in this article were also stressed in an NIH pamphlet (Publication No. 03-5335) targeted at health care professionals. These included adapting the office for obese patients by providing sturdy, armless chairs; sturdy, wide examination tables, "preferably bolted to floor to prevent tipping;" extra-large examination gowns; split lavatory seat and specimen collector with handle; large adult blood pressure cuffs and thigh cuffs; extra-long phlebotomy needles and tourniquets; and large vaginal speculae (NTFPTO 2002:83). Doctors are also informed of the importance of providing weight scales with capacity for patients over 350 pounds and weighing patients privately and only when necessary.

Readers of both the article and NIH pamphlet are told to be careful about "word choice," and that "patients may respond extremely negatively to the use of the term obesity, but be more

amenable to discussion of their difficulties with weight or being overweight" (NTFPTO 2002:84). This reflects some understanding of fat acceptance arguments about how the medical language of "obesity" can be stigmatizing, but does not go so far as to reject that pathologization or medicalization of fatness. Yet by blurring the lines between different weight categories, it undermines the scientific basis for claims about weight and health. The lines are further blurred by the fact that many of the issues discussed only concern people who would be categorized as morbidly obese according to current deadlines. Neither publication completely rejects the goal of weight loss, but both also urge doctors to encourage lifestyle changes independent of weight-loss and the importance of avoiding further weight gain. The NIH pamphlet urges medical professionals to discuss even minimal weight loss – as little as 5 to 10 percent of body weight – as a treatment for weight-related medical conditions but also advises them, as does the NTFPTO (2002) publication to encourage physical activity to improve cardiovascular health and to "promote self-acceptance and encourage patients to lead a full and happy life."

McAffee's influence on an NIH pamphlet on physical activity for "very large" individuals is also evident. With photos of several NAAFA members, visibly weighing about 250-400 pounds, engaged in a variety of physical activity, the pamphlet's message "if you are a very large person, you can still be physically active" is clearly targeted to even the heaviest. The pamphlet highlights the health and personal benefits of exercise, from protection against diabetes to boosting one's mood. It advises readers to start their exercise routine slowly, set realistic goals, track progress (of fitness, not weight), fit activity into daily life, get support, and have fun. It explains the advantages and disadvantages of different kinds of exercise and provides practical tips, like standing up straight and relaxing one's shoulders when walking. Sounding like a

HAES advocate, it informs the reader that "healthy, fit bodies come in all sizes. Whatever your size or shape, start exercising now and keep moving for a healthier life!"

Lynn McAffee has played an important personal role in many these developments. She inspires great respect and admiration among the fat acceptance and Health At Every Size movement for her courageous health activism and also seems to enjoy credibility and respect from obesity experts. In an interview with the first author, she said that she sees herself as mediating between the extremes of fat acceptance and the "obesity mafia." While she thinks that obesity experts often exaggerate the risks of obesity, she also believes that the fat acceptance movement downplays them. In her activist work, she tries to promote HAES goals among health officials and professionals, such as improving preventive care for fat individuals through respectful care, equipment that fits, and by encouraging patients to increase physical activity and improve diet as ends in themselves.

Some HAES practitioners say that these messages are influencing practicing physicians. Burgard wrote that, due in part to the effect of HAES workshops provided to medical professionals, "I now have many patients who tell me their docs no longer harass them about their weight but instead pay attention to whether they are getting out and about." Burgard further pointed to the greater "interest in movement for large people."

In that feminist research has raised concern about women's "obsession with body weight" and the prevalence of eating disorders, especially among young, white, middle class women, this also provides an opening for critiques about weight-focused health recommendations. A few listserve participants pointed to the importance of linking obesity and eating disorders in prevention efforts and argued that the HAES movement can take some credit for this. Burgard argued that HAES can take partial credit for new understandings that one can not "white-

knuckle" through a diet and then "go back to eating normally," but that dietary and activity changes must be permanent. Likewise, the dangers of yo-yo dieting have become more generally accepted. As Ernsberger puts it: "outside of the expert NIH panels, most clinicians and lay people alike [now] accept that it is unhealthy to lose and regain large amounts of weight," known as weight cycling or the yo-yo syndrome.

The FDA is one of the institutional arenas where the AIDS movement has made the most inroads in terms of consumer representation (Epstein 1996). The fat acceptance movement has made use of these avenues, as well as public concern about dangerous consumer products, to push for regulation of the most egregious weight-loss claims and products. For instance, the Food and Drug Administration (FDA) postponed the approval of specific kind of weight-loss surgery due largely to McAffee's intervention. Several fat acceptance activists were also "involved in getting the Federal Trade Commission (FTC) to ban the worst of the weight-loss gimmicks/ads," according to Burgard.[9] But HAES advocates point to local successes as well, such as, in the words of Burgard, "the time I prevented my desperate hospital from embarking on an Optifast®-type program to make money; or [when I squashed] a workplace weight loss contest called the 'Lard-Off' at the university where I was working."

We have seen how genetic arguments about obesity play an important cultural role in discussion of body weight because they seem to counter common understandings of weight as under personal control and therefore an indicator of morality. Ernsberger pointed to the increased influence of theories of body weight "set point" (a personal weight range to which one's body tends to naturally revert), genetics, and hormones, as an area of HAES influence. In his words, "These ideas represent progress over the old paradigm that body weight is a personal choice reflecting only one's own will." Ernsberger's own work has contributed to this field, but

there are also many other factors supporting the growing popularity of genetics as a scientific model (see Rothman 1998).

CONCLUSION

This paper provides a detailed analysis of current debates over body weight and health. Strikingly, we found that what appear to be strictly arguments over scientific method and empirical facts are actually heated struggles over framing. We identified three competing weight frames including: 1) fat as "body diversity," 2) obesity as a "risky behavior"; and 3) obesity as disease; and demonstrated the different moral assumptions and political implications of each. This paper thus suggests that scientific debates, far from being devoid of morality or free from politics, provide a site for struggles over morality. These struggles, in turn, have important implications for social inequality.

We demonstrated how framing obesity as "risky behavior" potentially serves to legitimate social inequality and health disparities. For if obesity is read as visible proof of bad food choices and refusal to exercise, then the poor and minority groups – who have higher rates of obesity – are personally responsible for their poor health. Personal responsibility and self-discipline is thus highlighted while poverty, lack of health insurance, and violence are relegated to the background. Moreover, if fat people are labeled as "demon users" (of fast food or junk food) in a moral crusade against obesity (Kersh and Morone 2002), policy action against obesity would be expected to deepen social divides along class, racial, and ethnic lines.

While it is commonly understood that a disease frame removes blame from those categorized as ill, the obesity case presents a challenge to such received wisdom. Treating obesity as a disease is increasingly common, largely as a tactic to cover weight-loss treatment under health insurances and to make it tax deductible. Yet, we found no evidence that such

framing lessens blame of fat individuals. For, unlike cancer, for instance, which is treated through surgical operations, chemotherapy, or radiation, or AIDS which is now treated with drug therapy; "treatment" for obesity requires that an individual reform their "lifestyle" of diet and physical activity.[10] Thus responsibility and blame remain with the individual.

This suggests that the social effect of treating a condition as a disease will vary depending on available treatments for the particular condition. The fact that the treatment for alcoholism also requires lifestyle change – abstinence – may explain why alcoholics who do not reform continue to be blamed for their behavior. Despite some similarities, obesity differs from alcoholism in that abstinence from food is not an option and it is unclear to lay people and experts alike what "eating healthy" actually means in practice (low fat? Low carb? Vegetarianism? Portion size?). Instead, a thin body is read simultaneously as evidence of healthy eating and as the reward for healthy eating. Those who fail to lose weight, despite dieting, are blamed for this failure. In addition, by being labeled as diseased, their stigma is reinforced.

Those who believe that a genetic model of obesity holds the key to removing blame and stigma associated with the condition should reflect on how the eugenics movement of the early 20th century attempted to eliminate undesirable characteristics – especially those considered evidence of ill-health or immorality – from the population by limiting the fertility of the poor. As is discussed above, some scholars have likened the "war on obesity" to the eugenics movement of this period because they perceive obesity as a bodily trait associated with poverty that is increasingly coming under attack by the authorities.

The fact that the "body diversity" frame has not resonated more in the contemporary United States, where traditions of anti-discrimination and multiculturalism are particularly

strong, is surprising and reveals the power of medical expertise in framing contests. For, unlike arguments about racial diversity, gender diversity, or diversity based on sexual orientation; arguments about body diversity run up against protests that fat bodies are evidence of pathology not healthy diversity. Epidemiology pointing to the health risks associated with "overweight," "obesity," and "morbid obesity" are used to argue that promoting "body diversity," "size acceptance," or "fat acceptance" is medically dangerous because it obscures the health risks associated with weighing "too much." This claim thus moves the debate out of the political realm into a medical one. As a consequence, fat activists find themselves in the uncomfortable position of having to debate medical science as a prerequisite for speaking about civil rights. This explains why the Health at Every Size researchers have played an increasingly important role for the fat acceptance movement and sensitizes us to how medical expertise can be used to stymie political protest.

At a time when scientific knowledge and health are both increasingly sacred, scientific arguments about health are symbolically powerful. Future work should examine other instances in which such knowledge is used to counter justice claims. For example, certain groups of deaf people have opposed medical interventions for deafness on the basis that they erode "deaf culture" (Rutherford 1988; Smith and Campbell 1997; Berbrier 1998). One might expect, as with obesity, medical arguments about the pathology of deafness to challenge claims to a deaf community with "deaf rights." But in this case, seeing deafness as pathological does not seem to foreclose the possibility of deaf rights because, we would argue, disability is generally not blamed on the individual. Thus, "deaf acceptance" is unlikely to be understood as a sign that one is not willing to work to become healthy, as "fat acceptance" is readily seen as an excuse for one's weight.

Identity groups based on disease categories like breast cancer, chronic fatigue, multiple chemical sensitivity, and Alzheimer's are similar to fat acceptance activists in that they assert political and scientific claims based on these new identities (Epstein 1996:347-348). They differ from fat acceptance activists, however, in that they embrace their status as ill. As such, their demands for a higher quality of care, improved ethics of clinical research, and more investment in research and treatment of their illness are consistent with a medical framing of their condition. While challenging particular expertise, they strengthen rather than undermine medical expertise and authority. They ask for better treatment not that their condition be considered a healthy form of diversity. A group that refused medical treatment and instead affirmed "pride" in their illness status would probably run up against resistance from medical professionals. However, in that the illnesses listed above are not considered self-inflicted, a, say "chronic fatigue acceptance association" would not – anymore than a deaf acceptance association – be seen as a morally compromised attempt to get away with bad behavior. Indeed, many chronic illnesses including diabetes are recognized as a protected disability under the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.).[11]

The group anti-obesity crusaders compare most often to the obese are smokers. A "smoking acceptance association" would certainly be considered morally suspect for many of the same reasons that fat acceptance is. Argument that one should tolerate diversity in regards to smoking choice would certainly encounter powerful protests about the health consequences of smoking. Smoking status is different from weight status, however, in that smoking is not a permanent physical characteristic. Policies to ban smoking in public restaurants, for instance, do not ban smokers. They only require the smoker not to smoke in the restaurant; (s)he can step outside to smoke and return to her/his meal. In contrast, a fat person cannot shed her/his

"excess" fat to enjoy a meal without enduring comments about how (s)he should not be eating so much or such high-caloric food. While smoking is known to be hard to quit, it is much easier to hide than body fat. Moreover, while smoking has become increasingly stigmatized of late and is increasingly associated with lower socio-economic status, the stigma associated with fatness is arguably much worse.

In addition to facing resistance by the medical community, fat acceptance claims have been limited by their own constituency, which is overwhelmingly white, female, middle-class, and in the highest weight categories (see also Sobal 1999). Because of this membership base, the fat acceptance movement has focused on issues of concern to the very heaviest, such as public accommodations and medical equipment for people weighing over 350 pounds. The class, race, and ethnic dimensions of this issue are not of central concern to this movement. The lack of a social movement organized around moderate obesity or overweight is a topic that deserves further research. One might expect dieting groups to curtail political identity by focusing on individual solutions and by promising weight loss as a way to exit the category of overweight or obese. Clearly, there are many barriers to activism that poor and minority groups face.

In light of the fact that the fat acceptance movement has been so small, the successes of the Health at Every Size movement in the medical arena are even more noteworthy. We discussed how this movement has made inroads into the medical establishment by exploiting societal concerns about discrimination, particularly against children, and by piggy-backing on the inroads made by the AIDS movement in consumer representation. In that it challenges the equation of larger body sizes with pathology, the HAES movement has the potential to lessen the stigmatization associated with larger bodies. However, in that this paradigm also works within a

lifestyle model, it is unlikely to lead to a radical challenge of the moral assumptions about health

that run so deep in U.S. culture and politics.

SOURCES CITED

Alvarez-Leite, Jacqueline I. 2004. "Nutrient Deficiencies Secondary to Bariatric Surgery." *Current Opinion in Clinical Nutrition and Metabolic Care* 7(5):569-75.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders* (4th edition). Washington D.C: Author.

Armstrong, David. 1995. "The Rise of Surveillance Medicine." *Sociology of Health and Illness* 17:393-404.

Baier, Leslie J. and Robert L. Hanson. 2004. "Genetic Studies of the Etiology of Type 2 Diabetes in Pima Indians: Hunting for Pieces to a Complicated Puzzle." *Diabetes* 53(5):1181.

Berbrier, Mitch. 1998. " "Being Deaf Has Very Little to Do With One's Ears": Boundary-Work in the Deaf Culture Movement." *Perspectives on Social Problems* 10:79-100.

Blair, Steven N. and Tim S. Church. 2004. "The Fitness, Obesity, and Health Equation: Is Physical Activity the Common Denominator?" *JAMA* 292:1232-34.

Blanck, Heidi M., Laura K. Khan, and Mary K. Serdula. 2001. "Use of Nonprescription Weight Loss Products." *JAMA* 286:930-935.

Brown, Peter J. and Vicki K. Bentley-Condit. 1998. "Culture, Evolution, and Obesity." Pp. p. 149 paraphrase: higher weights inversely correlated with social class in heterogeneous and affluent societies like the United States in *Handbook of Obesity*, eds. George Bray, Claude Bouchard, and W. P. T. James. New York: Marcel Dekker.

Campos, Paul. 2004. *The Obesity Myth*. New York : Gotham Books.

Cash, Thomas F. 2000. "Body Image." Pp. 436-39 in *The Encyclopedia of Psychology*, ed. Alan E. Kazdin. Washington, D.C.: American Psychological Association and Oxford University Press.

Connor-Green Patricia A. 1988. "Gender Differences in Body Weight Perception and Weight-Loss Strategies of College Students." *Women Health* 14(2):27-42.

Conrad, Peter and Joseph W. Schneider. 1992. *Deviance and Medicalization: From Badness to Sickness*. Philadelphia, PA: Temple University Press.

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18:209-32.

Crawford, Robert. 1980. "Healthism and the Medicalization of Everyday Life." *International*

Journal of Health Services 10:365-88.

Crister, Greg. 2003. *Fat Land: How Americans Became the Fattest People in the World*. Boston/New York: Houghton Mifflin.

Crossley, Nick. 2004. "Fat Is a Sociological Issue: Obesity Rates in Late Modern, 'Body-Conscious' Societies." *Social Theory and Health* 2:222-53.

Epstein, Steven. 1996. *Impure Science: AIDS*. Berkeley: University of California Press.

Ernsberger, Paul and Paul Haskew. 1987. *Rethinking Obesity: An Alternative View of Its Health Implications* . New York: Human Sciences Press.

Feingold, Alan and Ronald Mazzella. 1998. "Gender Differences in Body Image Are Increasing." *Psychological Science* 9(3):190–195.

Flegal, Katherine M., Margaret D. Carroll, Cynthia L. Ogden, and Clifford L. Johnson. 2002. "Prevalence and Trends in Obesity Among US Adults, 1999-2000." *JAMA* 288(14):1723-27.

Fumento, Michael. 1997. *The Fat of the Land: Our Health Crisis and How Overweight Americans Can Help Themselves*. Penguin Books .

Gaesser, Glenn A. 2002 [1996]. *Big Fat Lies: The Truth About Your Weight and Your Health*. New York: Fawcett Columbine.

Gamson, Joshua. 1998. *Freaks Talk Back: Tabloid Talk Shows and Sexual Nonconformity*. Chicago: Chicago University Press.

Gamson, William. 1992. *Talking Politics*. Cambridge: Cambridge University Press.

Garner, David and Susan Wooley. 1991. "Confronting the Failure of Behavioral and Dietary Treatments for Obesity." *Clinical Psychology Review* :729-80.

Goffman, Erving. 1963. *Stigma: Notes on the Management of a Spoiled Identity*. New York: Prentice-Hall.

_____. 1974. *Frame Analysis: An Essay on the Organization of Experience*. NY: Harper Colophon.

Goodrich, G. K. and J. P. Foreyt. 1991. "Why Treatments for Obesity Don't Last." *Journal of the American Dietetic Association* 91:1243-47.

Gusfield, Joseph R. 1981. *The Culture of Public Problems: Drinking-Driving and the Symbolic Order*. Chicago: University of Chicago Press.

Heinich, Nathalie. 1991. "Pour Introduire La Cadre-Analyse." *Critique* 535:936-53.

Hilgarten, Stephen and Charles L. Bosk. 1988. "The Rise and Fall of Social Problems: A Public

Arenas Model." *American Journal of Sociology* 94(1):53-78.

Illich, Ivan. 1976. *Medical Nemesis: The Expropriation of Health*. New York: Pantheon.

Irwin, Alan. 1985. *Risk and the Control of Technology: Public Policies for Road Traffic Safety in Britain and the United States*. Manchester: Manchester University Press.

Katzmarzyk, PT, TS Church, I Janssen, R Ross, and SN Blair. 2005. *Diabetes Care* 28(2):391-7.

Kersh, Rogan and James Morone. 2002. "How the Personal Becomes Political: Prohibitions, Public Health, and Obesity." *Studies in American Political Development* 16(Fall):162-75.

Kirkland, Anna. 2003. "Representations of Fatness and Personhood: Pro-Fat Advocacy and the Limits and Uses of Law." *Representations* 82(Spring):24-51.

Kolata, Gina. 30 Sep 2004. "Health and Money Issues Arise Over Who Pays for Weight Loss." *The New York Times*, A (1), p. 1.

Kramer, F. M., R. W. Jeffery, J. L. Forster, and M. K. Snell . 1989. " Long-Term Follow-Up of Behavioral Treatment for Obesity: Patterns of Weight Regain Among Men and Women." *International Journal of Obesity* (13):123-36.

Krowchuk, Daniel P., Shelley R. Kreiter, Charles R. Woods, Sarah H. Sinal, and Robert H. DuRant. 1998. "Problem Dieting Behaviors Among Young Adolescents." *Archives of Pediatrics & Adolescent Medicine* 152(9):884-88.

Lasalandra, Michael. 1 Jan 1998. "Doctors Say Losing Weight Is Emphasized Too Heavily." *The Boston Herald*, p. 20.

Luker, Kristin. 1984. *Abortion and the Politics of Motherhood*. Berkeley, Los Angeles, London: University of California Press.

Lyons, Pat and Debby Burgard. 1988. *Great Shape: The First Fitness Guide for Large Women*. New York: Morrow.

Merton, Robert K. 1987. "Three Fragments From a Sociologist's Notebooks: Establishing the Phenomenon, Specified Ignorance, and Strategic Research Materials." *Annual Review of Sociology* 13:1-28.

Merton, Robert K. 1987. "Three Fragments From a Sociologist's Notebooks: Establishing the Phenomenon, Specified Ignorance, and Strategic Research Materials." *Annual Review of Sociology* 13:1-28.

Miller, Wayne C. 1999. "How Effective Are Traditional Dietary and Exercise Interventions for Weight Loss?" *Medicine and Science in Sports and Exercise* 31(8):1129-34.

National Task Force on the Prevention and Treatment of Obesity. 2002. "Medical Care for Obese

Patients: Advice for Health Care Professionals." *American Family Physician* 65(1).

Nestle, Marion. 2002. *Food Politics: How the Food Industry Influences Nutrition and Health*. Berkeley: University of California Press.

Nettleton, Sarah and Robin Bunton. 1995. "Sociological Critiques of Health Promotion." *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, Eds. Robin Bunton, Sarah Nettleton, and Roger Burrows. London: Routledge.

Orbach, Susie. 1978. *Fat Is a Feminist Issue*. Berkeley Books.

Parsons, Talcott. 1951. *The Social System*. New York: Free Press.

Pliner, Patricia, Shelley Chaiken, and Gordon L. Flett. 1990. "Gender Differences in Concern With Body Weight and Physical Appearance Over the Life Span." *Personality and Social Psychology Bulletin* 16:263-73.

Riska, Elianna. 2003. "Gendering the Medicalization Thesis." *Advances in Gender Research* 7:61-89.

Robison, Jon and Karen Carrier. 2004. *The Spirit and Science of Holistic Health: More Than Broccoli, Jogging, And Bottle Water More Than Yoga, Herbs, and Meditation*. Authorhouse.

Rothman, Barbara K. 1998. *Genetic Maps and Human Imaginations: The Limits of Science in Understanding Who We Are*. W.W. Norton & Co.

Rutherford, Susan. 1988. "The Culture of American Deaf People." *Sign Language Studies* 59:129-47.

Schlosser, Eric. 2001. *Fast Food Nation: The Dark Side of the All-American Meal*. Boston and New York: Houghton Mifflin Company.

Serdula, Mary K., ME Collins, DF Williamson, RF Anda, E Pamuk, and TE Byers. 1993. "Weight Control Practices of U.S. Adolescents and Adults." *Annals of Internal Medicine* 119(7 Pt 2):667-71.

Smith, Dinitia. 1 May 2004. "Demonizing Fat in the War on Weight." *The New York Times*, B (1), p. 7.

Smith, Murray E. G. and Pamela Campbell. 1997. "Discourses on Deafness: Social Policy and the Communicative Habilitation of the Deaf." *Canadian Journal of Sociology* 22:437-56.

Snow, David and Robert D. Benford. 1988. "Ideology, Frame Resonance and Participant Mobilization." *International Social Movement Research* 1:197-217.

Sobal, Jeffery. 1995. "The Medicalization and Demedicalization of Obesity." Pp. 67-90 in *Eating Agendas*, eds. Donna Maurer and Jeffery Sobal. New York: Walter de Gruyter, Inc.

_____. 1999. "The Size Acceptance Movement and the Construction of Body Weight." Pp. 231-49 in *Weighty Issues: Fatness and Thinness As Social Problems*, eds. Jeffery Sobal and Donna Maurer. New York: Aldine de Gruyter.

Solovay, Sondra. 2000. *Tipping the Scales of Justice*. Amherst, NY: Prometheus Books.

Sontag, Susan. 1990. *Illness As Methaphor and AIDS and Its Metaphors*. New York: Anchor Books.

Stearns, Peter N. 1997. *Fat History: Bodies and Beauty in the Modern West*. New York and London: New York University Press.

Stunkard, A. J. and M. McLaren-Hume. 1959. "The Results of Treatment for Obesity." *Archives of Internal Medicine* 103:79-85.

Tarrow, Sidney. 1992. "Mentalities, Political Cultures, and Collective Action Frames: Constructing Meanings Through Action." Pp. 174-202 in *Frontiers in Social Movement Theory*, Aldon D. Morris, Carol M. Mueller, and eds. New Haven and London: Yale University Press.

Tesh, Sylvia N. 1988. *Hidden Arguments: Political Ideology and Disease Prevention Policy*. New Brunswick, NJ: Rutgers University Press.

Wang, C. 1992. "Cultural Meaning and Disability: Injury Prevention Campaigns and the Production of Stigma." *Social Science and Medicine* 35:1092-102.

Wann, Marilyn. 1999. *FAT! SO?: Because You Don't Have to Apologize for Your Size*. Berkeley, CA: Ten Speed Press.

Weber, Max. 1949. *The Methodology of the Social Sciences*. New York: Free Press.

Williamson, Lisa. 1998. "Eating Disorders and the Cultural Forces Behind the Drive for Thinness: Are African American Women Really Protected?" *Social Work in Health Care* 28(1):61-73.

Zizza, Claire A., Amy H. Herring, June Stevens, and Timothy S. Carey. 2003. "Bariatric Surgeries in North Carolina, 1990 to 2001: a Gender Comparison." *Obesity Research* 11(12):1519-25.

Zola, Irving K. 1972. "Medicine as an Institution of Social Control." *Sociological Review* 20:487-504.

FIGURE 1: Articles on Obesity in Medical Research and Mass Media
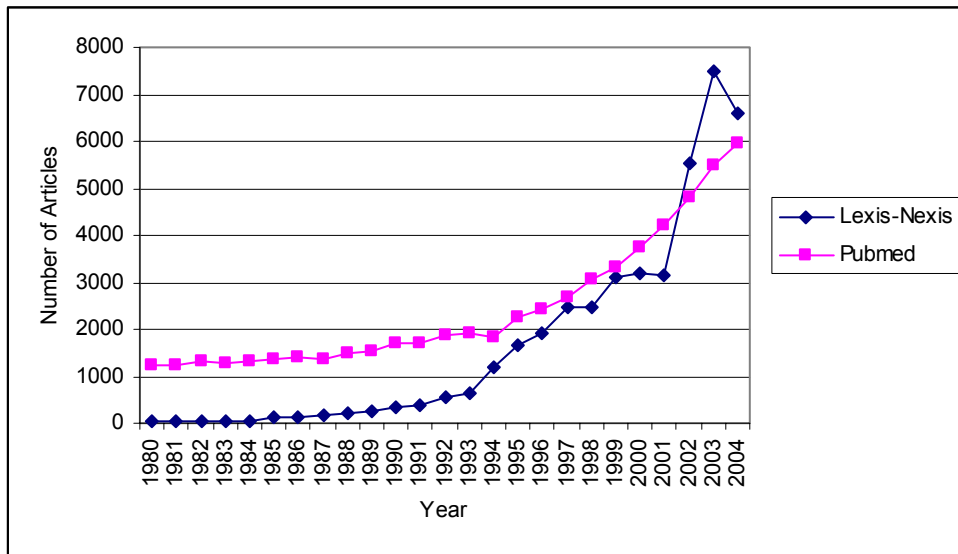
NOTES

[1] While Goffman's (1974) concept of "frame" provided the inspiration for social movement framing analysis, the way social movement theorist use the term is quite different from what Goffman intended (see Heinich 1991).

[2] Three of the respondents did not give their consent to be quoted by name. They are identified by number in this manuscript.

[3] But one could imagine that if people were seen as having been negligent in guarding against germs, e.g., by knowingly exposing themselves to germs or by not taking precautions like hand-washing known to reduce susceptibility to germs, they might receive less social latitude for their illness.

[4] Conrad (1999, cited in Riska 2003:65) has also likened the genetic paradigm to the old germ-theory model for other reasons, including that they are both based on reductionist medical thinking and that both are based on the following three interrelated assumptions: 1) the doctrine of a specific etiology; 2) a focus on causes internal to the body; and 3) the metaphor of the body as machine. Tesh also discusses environmental theories, which tend to put the spotlight on industrial production practices, occupational hazards, or air and water pollution as major causes of disease, thus shifting social responsibility and economic cost for reducing disease to large industries. However, she points out that in certain instances like with smoking and eating, environmental theories put the burden on individuals to control their exposure to certain environmental factors and, as a result, continue to blame them for their ill health (Tesh 1988:55-56).

[5] After reviewing the full interview transcript, this researcher expressed the desire not to be identified with this comment.

[6] After reviewing the full interview transcript, this researcher expressed the desire not to be identified with this comment.

[7] After reviewing the full interview transcript, this researcher expressed the desire not to be identified with this comment.

[8] After reviewing the full interview transcript, this researcher expressed the desire not to be identified with this comment.

[9] By contrast, according to HAES researcher Francie Berg, HAES and eating disorder researchers have had less success influencing the Health People Reports, despite having sent several group and organizational letters requesting, for instance, that eating disorders be considered a health risk for Healthy People 2010.

[10] Weight-loss drugs are intended for use in combination with a weight-loss diet and exercise. Even weight-loss surgery aims to reduce the amount of food consumed by surgically modifying the stomach so that eating over a tiny amount creates severe gastro-intestinal upset, although the operation also reduces hunger in some patients.

[11] *Branham v. Snow,* 392 F.3d 896 (7th Cir. 2004) (concluding that a trier of fact rationally could determine that diabetes and the associated treatment regimen substantially limit the major life activity of eating and is therefore covered under ADA). Some have argued that obesity should be a protected disability, but so far this argument has not been widely acknowledged. For thoughtful discussions of how U.S. law could potentially be used to fight size discrimination, see Solovay (2000) and Kirkland (2003).