De-Signing Fat: Re-Constructing the Global Obesity Epidemic

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ABSTRACT: This paper argues first that claims that we are in the midst of global obesity epidemic are vastly overblown and hardly new since we can find such calls to alarm for over a century at least. Second, we suggest that claims made about the possibility of losing weight are, for most people, simply false. Bluntly stated, there is lots of evidence to suggest that diets don't work for the vast majority of people: even for those who lose weight, their reprieve from fat tends to be short lived with 90% regaining their lost weight. Third, we maintain that claims made that obesity is either itself a disease or is causally and directly linked to harmful and sometimes lethal diseases are also misguided. Finally, we discuss the ways in which the construction of obesity as an epidemic disease has affected various parties, including fat people themselves. In particular, we discuss two approaches that have been made to the general anti-fat attitudes of contemporary western societies: the 'fat and fit' and 'fat and proud' movements.

FAT AND GETTING FATTER?

According to World Health Organization (WHO), the Center for Disease Control and Prevention (CDC), a host of other health related organizations, and countless professionals working in or around health care, we are in the midst of a global obesity epidemic. That is, they claim, we are fat, and getting fatter. According to Heini and Weinstein,[1] the prevalence of overweight and obesity in America increased by 31% between 1976 and 1991 and then increased another 24% between 1994 and 2000.[2] And it's literally killing us. The connection between obesity and Type II Diabetes is perhaps getting the most media attention presently, but there are claims that obesity is related to all sorts of other diseases from heart attacks and strokes to breast cancer. According to a report by the CDC in 1999, an estimated 280,000 deaths/year in the U.S. were due to obesity.[3] Just five years later, a report indicated a dramatic rise in this figure to 400,000 deaths/year that could be attributed to obesity.[4]

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In some ways, Americans have taken these dire warnings to heart. In a recent survey published in *Prevention* magazine, e.g., over 90% of women in particular thought they needed to lose weight. Overall, about 55% of Americans—i.e., approximately 160,000,000 people—are at any time on a diet.[5] This helps explain how Americans spend between $30 and $40 billion/year on the weight-loss industry.[6]

When the experts and general public agree about some particular features of the world, as they do with respect to obesity and its dangers, it becomes extraordinarily difficult to see reality in a different way. That is, the accepted opinion appears to us as both 'natural' and inevitable. Hence, the received opinion has to be de-constructed, which is what we propose to do in this paper. Briefly, we will argue that claims that we are in the midst of global obesity epidemic are vastly overblown and hardly new since we can find such calls to alarm for over a century at least. Second, we suggest that claims made about the possibility of losing weight are, for most people, simply false. Bluntly stated, there is lots of evidence to suggest that diets don't work for the vast majority of people: even for those who lose weight, their reprieve from fat tends to be short lived with 90% regaining their lost weight.[7] Third, we maintain that claims made that obesity is either itself a disease or is causally and directly linked to harmful and sometimes lethal diseases are also misguided. Finally, we discuss the ways in which the construction of obesity as an epidemic disease has affected various parties, including fat people themselves. In particular, we discuss two approaches that have been made to the general anti-fat attitudes of contemporary western societies: the 'fat and fit' and 'fat and proud' movements.

In discussing this last matter especially, we employ a distinction drawn by philosopher Ian Hacking between interactive and indifferent kinds.[8] Indifferent kinds are those objects (or processes) whose behavior is not altered via classification, e.g., microbes, gravity, and so on, and hence not the product of a social construction. As Hacking has said, no one is a social constructionist about gravity when flying at 35,000 feet.[9] Interactive kinds are the opposite: here, behavior is changed by the classification, and is, as such, the product of social construction. In labeling theory, psychology has, in fact, long noted the conformity between the classification one is given and subsequent behavior. So, for example, if one is labeled as smart, schizophrenic, or homosexual, one tends over time to conform to these labels and indeed in some way actually to become that kind. Hacking adds something significant to labeling theory, however, by suggesting that there is not simply a one way interaction between expert classification, those classified and behavior. That is, Hacking thinks that at times people classified in a particular way do not conform to their classification but rather behave in ways contrary it. In some cases, this actually results in the experts changing their classification to accord with the (new) behavior of the classifieds. A classic example of this in the mental health field occurred with respect to the de-medicalization of homosexuality by getting it removed from the Diagnostic and Statistical Manual (DSM) in light of the actions of the gay and lesbian community. Hacking calls this process a "looping effect," and such effects can occur, he claims, either "from above" where it is the experts

providing the main impetus for changes in the classification, or "from below" where it is the people classified who bring about the change. We propose briefly to examine both of these sorts of looping effects. From above, looping has occurred as some within the medical community have argued that obesity is not itself a disease and neither is it causally related to (many of) the diseases with which it is typically correlated. From below, looping has occurred as a result of fat people working to liberate themselves from the associations made of them, and by working to accept and indeed celebrate their bodies.

DIETS, MORE DIETS, AND CALCULATING OBESITY

There is evidence that diets date back at least to Ancient Greece,[10] but things began to change significantly in the nineteenth century when French lawyer and gourmand Jean Anthelme Brillat-Savarin published his influential *The Physiology of Taste* in 1825.[11] Brillat-Savarin struggled with weight his entire adult life but found respite by "a more or less rigid abstinence from everything that is starchy or floury."[12] Thus began the first instance of a low carbohydrate, high protein diet popularized most recently in the Atkins diet. (Indeed, there was a time when dieting was called "banting" after Brillat-Savarin's diet was popularized by a London undertaker by the name of William Banting.) Later in the century, American businessman Horace Fletcher maintained that the cause of obesity was too much protein and too little chewing. (Of course, chewing food excessively became known as "fletchering.") And in 1916, calorie counting had begun, and was advocated by Herbert Hoover who in 1917 was the head of the US Food Administration. By the 1920s, and the flapper era, we get our first indication that dieting was becoming an obsession of adolescent girls. Indeed, Gina Kolata notes that:

> By the first quarter of the [twentieth] century, all the weight loss basics and diet schemes that are familiar today had been discovered and promoted. High protein diets. Behavior modification, in the form of slow eating and excessive chewing. Calorie-counting. Exercise. Metabolic rates. And weight loss entrepreneurs had tried everything from selling reducing belts or thyroid pills to advising that people eat soap or drink vinegar [something popularized by Lord Byron], to instructing the overweight that they must massage off their fat.[13]

Historically, the main nutritional problem people faced was scarcity of food, and being underweight. Hence, dieting was until fairly recently an obsession only of the rich, a point made viscerally in Tom Wolfe's *Bonfire of the Vanities*, his critique of the excesses of the 1980s, when he refers to all the wealthy, excruciatingly thin, women attending Upper West Side parties as "x-rays."[14] The late nineteenth and the twentieth century, however, witnessed a broadening of dieting to include all socio-economic classes. While increased weight and the availability of more food for more people is of course part of the reason for this increase in dieting, part of the reason too has to do with changing perceptions of what constitutes beauty and an ideal weight. Consider, e.g., the changes in the height and weight of Miss America. Since 1922, she has increased in height 2% but decreased in weight by 12%.[15] No wonder, then, that while 90% of American women think they need to lose weight, only 50% of them actually have a Body Mass Index (BMI) above

"normal," and why 90% of formerly obese men and women say that they would rather have a leg amputated or be blind than be fat again.[16]

Besides having models of beauty, particularly female beauty, become thinner over the past century, the health care industry has also reduced the weights for what they consider to be normal, ideal, or acceptable. Interestingly, it was actually the insurance industry that first started constructing charts for norms or ideals of weight. Their hope was that if they could associate overweight and obesity with lower longevity rates, then they could charge those customers more for life insurance, or to screen obese people from their policies completely.[17]

The first insurance industry generated height-weight tables were published between 1897 and 1912: they were sex and age specific tables and contained the "average" weight of policy holders in different categories. For example, a 5'4" woman in her 20s had an average weight of 126 lbs. In her 30s the average was 132, while it was 140 for her 40s, 145 for her 50s, and 144 for her 60s. Mortality was thought not to increase appreciably until one was at least 20% above the average.[18] Health care professionals thought health risks were not significant until weights rose 30% over the average, which applied to relatively few people. In other words, at this time 'overweight'—20–30% above the average—was not thought to be a health problem, only obesity was.

Over time, however, this was to change. The tables themselves were altered quite radically and "average" weights were transformed and lowered. Consider, e.g., the new height-weight tables produced by the Metropolitan Life Insurance Company published in 1942 (for women) and 1943 (for men). "Average" weights were replaced with "ideal" weights, and ideal weight was no longer thought to change with age. People of all ages were now to be assessed in terms of the ideal weight for 20-year-olds.[19] "Ideal" weights were converted to "desirable" weights in the insurance industry 1959 weight-height tables, but what was considered desirable was lighter. For example, under the new standards, a 5'4" woman of any age with a slight build should weigh between 108–116 lbs! As Gaesser puts it: "The obesity epidemic had experienced yet another dramatic surge, which was once again caused mainly by a decrease in what Americans were being told to weigh, rather than an increase in what they actually weighed."[20] Though the BMI, currently favored by the WHO and the National Institutes of Health (NIH), is a bit laxer than the 1959 height weight tables, it is still just another rather arbitrary height-weight table. It is calculated by multiplying weight in pounds by 703, and dividing the result by the square of height in inches. Note once again that no allowance is made for age nor, unlike the 1959 tables, is there any mention of different body frames. And, as is typical of such tables, there is no attempt to measure body fat or, most importantly, fitness levels.

It should also be noted, however, that regardless of how we define normal, ideal, or desirable weight, it is a fact that Americans are getting heavier. In a study conducted by the CDC, for example, data appeared to show that Americans have gained an average of 1.15 pounds per year from 1994 to 2002.[21] Why this should be, particularly in light of all the calls to alarm about increased weight, and what relation it has to increased health risks is, of course, another issue, which we take

up in a moment after discussing how ineffective dieting is, even with all the 'help' provided by the diet industry and Big Pharma.

According to Bray, Bouchard, and James, in *The Handbook of Obesity*, "Dietary therapy remains the cornerstone of [obesity] treatment and the reduction of energy intake continues to be the basis of successful weight reduction programs . . . [yet the results of such therapy] are known to be poor and not long-lasting."[22] One line of thought to explain why people don't successfully lose weight and keep it off is "set point theory," which claims that we have a weight range within which we are unlikely to change via our eating and exercise habits. Some current research suggests that weight is rather a heritable trait, and has to do with hormones rather than behavior.[23] This is both good and bad news for the diet industry and Big Pharma. It is good news for both since what they offer, as we shall see in more detail, does little or nothing to help in weight loss, which has meant, ironically, that customers keep coming back for more 'help' after their unsuccessful attempts to do so. It is bad news for the diet industry because it is based upon the belief that we are able to lose weight by eating less and/or different kinds of food. And it's bad news for Big Pharma because the weight loss drugs they have marketed have nothing to do with genes or hormones. Almost all diet drugs have been amphetamines of one sort or another, such as Fen-Phen, a mixture of fenfluramine and phentermine that Wyeth developed and sold in the 1990s. Of course, we now know that Fen-Phen is linked to primary pulmonary hypertension and valvular heart disease, and Wyeth has paid out at least $16.6 billion in damages.[24] Ironically, Fen-Phen was never even a very effective weight loss drug. Wyeth's own data suggested only a 3% advantage over placebo.[25] Hence, they needed a PR campaign, which related overweight and obesity not only to aesthetics but to health as well. According to bioethicist Carl Elliot,

> Wyeth's "medical education" campaign for Fen-Phen was a model of the genre. It included pay-outs to academic physicians, lavish conferences, and generous grants to professional medical societies. The $54 million set aside by Wyeth to launch the drug included grants to the American Academy of Family Physicians, the American Diabetes Association, and the North American Society for the Study of Obesity, and the American Society of Bariatric Physicians. Wyeth budgeted $700,000 for C. Everett Koop's advocacy group, Shape Up America, $275,000 for a "State of Weight" teleseminar, $179,000 for Dear Doctor" letters, and $50,000 for a Women's Health seminar.[26]

In addition, Wyeth had ten papers written for medical journals promoting obesity treatment through a company they hired that then paid prominent university researchers to attach their name to. Wyeth, of course, kept tight editorial control over the content of the articles. In one case, e.g., they had the following line dropped from a draft of an article: "Individual case reports also suggest a link between dexfenfluramine and primary pulmonary hypertension."[27]

In light of episodes like this it is entirely legitimate to begin to wonder whether obesity is actually a health risk at all.

IS FAT REALLY DEADLY?

While frequently associated in the literature with a number of chronic diseases, obesity itself has been labeled a killer disease, poised to overtake smoking as the world's main preventable cause of illness and death.[28] Health organizations like the CDC, the NIH, and the WHO have suggested that the rise in obesity over the last few decades is causally related to a number of health problems including diabetes, hypertension, and cardiovascular disease. However, the literature that examines the connections between obesity and illness indicates that the relationships are far from clear.

Hypertension has long been associated with overweight and obesity; however, studies have failed to confirm a correlation. The hypotheses that weight *or* body fat are predictive of hypertension have systematically failed to be confirmed empirically.[29] In all but 15% of hypertension cases, body fat appears to have nothing to do with the variation in blood pressure within a given population. And the type of weight that does seem to play a role in hypertension is an excess of lean body tissue, rather than body fat. In spite of the findings which absolve fat of its role in dangerously elevating blood pressure, physicians continue to prescribe weight loss in its treatment. Interestingly, an inevitable outcome of many weight loss programs does present a risk in the etiology of hypertension: yoyo dieting.[30] According to a study conducted by Lee and Paffenbarger,[31] when yo-yo dieters were compared with test subjects who maintained fairly stable body weights, the yo-yo dieters had an 80% higher risk of heart disease, and a 123% higher risk of type 2 diabetes.

While physicians focus their attention on treating hypertension through recommendations which might do more harm than good, they may be ignoring some real causes of the disease. Psychosocial factors such as stress, anxiety and hostility have been identified as predictive factors in hypertension.[32] These psychosocial variables are often described as consequences of modern life in the industrialized world.[33] It is not surprising, then, that across most cultures, rates of hypertension are higher in urban areas than in rural environments.[34] Some research has identified social cohesion—which is often characteristic of rural communities—as a protective factor against hypertension.[35]

Since the 1940s, studies have been conducted to determine the relationship between obesity and atherosclerosis. Findings have consistently vindicated weight and body fat as causes of heart disease.[36] In research conducted at the NIH by Warnes and Roberts in 1984, autopsies performed on morbidly obese women and men indicated they had no greater chance than people of normal weight to suffer from atherosclerosis.[37] These findings were further supported by results obtained McGill et al. in an autopsy study in which 23,000 subjects from 14 countries confirmed that percentage of body fat was not associated with atherosclerosis.[38]

Perhaps the most commonly cited health risk factor associated with overweight and obesity is type 2 diabetes.[39] Several American studies have examined the impact of weight and lifestyle choices on obesity. Surprisingly, results across studies have indicated that although people with diabetes are often obese, symptoms are not controlled by weight loss. In fact, many programs designed to control the

symptoms of diabetes have been successful in curing diabetes without weight loss. Based on the results of these programs, a combination of diet and exercise, not weight loss, have been identified as key factors in the etiology of diabetes.[40]

Epidemiological studies on the prevalence of obesity and diabetes also appear to cast some doubts on the acceptance of overweight and obesity as risk factors for diabetes. An examination of the rates of obesity and diabetes in Asia suggests that the relationship between obesity and diabetes is not a clear linear one. On this continent, the incidence of diabetes has tripled in the last 40 years.[41] And while obesity rates have also increased across Asia, they remain relatively low compared with European, American and Pacific Island trends. The highest rate of diabetes worldwide is found in India where 31.7 million people are affected with the disease.[42] In other words, 12% of the Indian population suffers from diabetes. This is a noteworthy statistic when considering the prevalence of obesity which affects a mere 2% of this population.[43] It appears as though the profile of type 2 diabetes in India varies from other populations. Among a younger age at diagnosis and a higher incidence in males, diabetic Indians also have lower rates of obesity.[44] Some researchers have suggested that the Indian population is genetically predisposed to type 2 diabetes; however, the mode of potential inheritance remains unclear.[45] If we assume the presence of some genetic factor predisposing Indians to type 2 diabetes, our argument is still valid: obesity is not causally related to diabetes. Notwithstanding the suggestion that there may be a genetic marker in the etiology of diabetes among this group, Indians do not have the highest worldwide rate of diabetes because their population is fat.

The relationship between obesity and diabetes remains equally confusing when examining populations suffering from high rates of obesity and comparatively low rates of diabetes. Some of the world's highest levels of obesity are found in populations in the Pacific Island region. In Samoa, 75% of the population is classified as obese, and the rate of type II diabetes is only 9%.[46] In contrast, rates of overweight and obesity in the USA have been reported at 66%[47] while the prevalence of diabetes is around 8%.[48]

Where diabetes and obesity genuinely appear to correlate with one another is in their prevalence in certain living environments. Rates of diabetes and of obesity both tend to be significantly higher in urban areas than in rural areas. In China, the prevalence of diabetes is 5% in the general population but 25% in urban populations.[49] This trend appears to be consistent in many countries, where urbanization is associated with obesity and diabetes. Most explanations for the higher rates of obesity and diabetes in urban populations have suggested that urban lifestyle choices are to blame. Typically, our reliance on motorized vehicles for transportation deprives us of regular opportunities for physical activity. Urban environments are also associated with a highly refined, lipid-saturated diet, which scientists believe is partially responsible for increases in obesity and diabetes.[50]

FAT AND FIT: LOOPING FROM ABOVE

Much of the research on the relationship between weight and illness indicates a much more complex relationship than what we have been led to believe. While

some experts postulate that fat plays a significant role in the etiology of chronic disease, others argue that overweight and obesity are benign consequences of other lifestyle choices that do make people sick. These choices include: the consumption of heavily processed, high saturated-fat foods, and a lack of physical exercise.[51]

In fact, some fitness researchers argue that it is fitness not fatness that is causally related to illness. Fat people can, and sometimes are, fitter than thin people—and consequently healthier. Many research findings indicate that when controlling for fitness, people who are overweight do not have an increased risk of premature death compared with their thin counterparts.[52] Other results suggest that overweight but fit people are healthier than thin fit people. Blair et al.[53] examined the relationship between physical fitness and longevity and found that the overweight-but-fit group outlived the underweight-but-fit group. According to their results, a 5'10" man is twice as likely to die prematurely at 138 lbs as at 175 lbs or more, and a 5'5" middle-aged woman has half the risk of premature death at 146 lbs than at 115 lbs.

The concept of the BMI as a predictor of health is controversial, particularly in light of the "fat but fit" research. Gaesser argues that each person has a natural weight at which his/her body feels healthy—and that height-weight charts are simply not predictive of anything meaningful relating to health status.[54] In fact, they can do potential harm within the context of a weight-obsessed culture, both physically and psychologically. While weight cycling has been associated with many chronic diseases, the psychosocial consequences of a culture obsessed with thinness are many. It is not surprising that within our weight-obsessed culture research has identified a positive correlation between depression and obesity.[55] This association appears to be reciprocal, i.e., the degree to which someone is fat elevates the degree to which he/she is depressed, and vice versa.

Evidence collected on stress and weight suggests that when under stress, half of the population will overeat, and the other half will under eat.[56] In these periods of stress, people who do not overeat tend not to classify themselves as dieters while those who overeat are more likely to fall into the chronic dieter category.[57] These results suggest that dieting and food obsession may lead to overeating and weight gain. As noted above, stress is also implicated in hypertension, urbanization and also interferes with diabetes control.[58] In examining the interrelationships among these variables, it seems increasingly plausible that the energy focused on weight loss might be better spent addressing psychosocial and environmental correlates of illness.

FAT AND PROUD: LOOPING FROM BELOW

In a prescient moment, T. S. Elliott wrote in his "Four Quartets" that "The whole earth is our hospital."[59] When children are now being sent for couples therapy in their early teens[60] and Dr. Phil is absolutely (and dishearteningly) ubiquitous, it's hard to disagree. This has led to a backlash in a number of fields to de-medicalize certain forms of behavior such as, e.g., by transforming clinical depression (back) into human sadness or sorrow.[61] Some within the 'fat liberation' movement think similarly. Fat is not (or is not primarily or typically) a medical issue, they claim.

If it *was*, then surely health care researchers would see from the many studies already conducted, such as the ones we have discussed, that telling patients to lose weight is not helpful since almost all people fail to lose weight and keep it off, and, moreover, yo-yoing is completely *un*healthy.

When we remove the medical camouflage from talk about fat, we start to see that statements made regarding fat are really moral and aesthetic judgments. Morally, fat people are typically associated, by the public at large and by health professionals in particular[62] with at least three deadly sins—sloth, gluttony, and greed. *Part* of the reason for this association stems from the fact that fat is produced by a combination of too much food intake (particularly of the wrong kind) and too little expended energy, and so one might think people are justified in drawing the association mentioned above. But this simple 'equation' misses much of the complexity of individual fat bodies since all sorts of other factors might play a part, such as the hormone leptin or set point theory, mentioned earlier. But this also misses important points. By analogy, think of homosexuality. At its base, homosexuality refers to people who are sexually attracted to people of the same sex. But there is much more to homosexuality than that, and this 'something more' changes according to time and place. So, for example, in America in 1850, homosexuality was thought clearly to be a sin; in 1950, it was considered a psychological ailment; and currently it is considered a sexual orientation in exactly the same way that heterosexuality is.[63] The simple equation, then, is often used as a way to mask the social context of the way in which our society both creates and reacts to fat people, and it is this social context that those working within the 'fat and proud' movement stress. Aesthetically, fat and thin people alike tend to find fat ugly. Consider, for example, a remark made by one traveler who complained that fat people ruined his summer holiday by "polluting" his vista with "disgusting . . . hillocks of flab"[64] Or consider the comments made by documentary filmmaker, Jonathan Ross, responding to complaints about his film, *Fat*, that despite its containing multitudes of shots of fat people stuffing their faces with food, that it was not guilty of being discriminatory against fat people: "I don't think we're being cruel . . . to obese people. They're fat and they're stupid, but in a nice way."[65] Today, fat people are denied any positive characteristics. Indeed, even Santa Claus has not been spared with some now calling for a newer, slimmer model lest we infect our children with a positive image of a fat person. Interestingly, fat is one of the few areas left where jokes are thought to be socially acceptable as indicated by the fact that googling "fat jokes" produces an astronomical 149,000 hits.

Kathleen LeBesco maintains that the source of the problem here is 'fat essentialism.'

> An essentialist position on fat identity can take a biological or sociocultural perspective; the common theme is the idea that the condition of fatness is necessary, could not be otherwise, or is the outcome of some essential (usually failure-related) cause. Whether tracing along a biological path to bad genes or horrible hormones, or along a social path to traumatic childhood experience, proponents of essentialist positions argue that fat identity is the unfortunately inevitable outcome of a causal relationship with some original variable gone awry.[66]

We should note here that many who argue in favor of a 'fat but fit' approach are fat essentialists in LeBesco's sense of the phrase because they argue that most or many fat people can't help being fat. Think again of set point theory or of research done on the hormone leptin. People working within the fat and proud movement are more likely to stress the ways in which the category 'fat' can first be deconstructed and then reconstructed in a more positive way.

The negative connotations of fat in contemporary western society have produced a great deal of abuse against fat people. In her book, *Fat and Proud: The Politics of Size*, Charlotte Cooper relates many stories of fat women who have had to put up with all sorts of abuse covering everything from staring and verbal harassment to physical assault.[67] Faced with these sentiments, many fat people come to feel guilty about their size and inability to do anything about it and to despise their appearance. Ironically, while they find themselves *politically* invisible, so to speak, because they are so marginalized, their bodies seem so unavoidably and publicly visible that they are "desperately trying to hide [themselves] all the time . . . [to avoid] feeling like a circus freak."[68] Sometimes, no matter how lose the clothes and how innocuous one tries to be, the thought of being out in public is too much for many fat people to bear, and they become agoraphobic. As Cooper notes: "We withdraw to places where we feel physically and emotionally safe. . . . In my own experience, it has sometimes felt much easier to stay at home for days, no matter how isolated I become, than to go out and deal with a potentially hostile environment."[69] These emotions help to explain why fat has been linked with all sorts of mental illness. Obese people are 20% more likely to suffer from depression than non-obese people,[70] and that rises to an astronomical 44% increased likelihood of depression for white, college educated individuals who are obese.[71] In addition, obesity is associated with an approximately 25% increase in odds of mood and anxiety disorders.[72] In another study, Schwimmer noted that "Obese children reported scores [on a quality of life survey] that were as bad as cancer patients in each and every domain of life. . . . We were surprised it was that bad."[73]

It is not surprising that given the social climate of fat-hating, many fat people attempt to simply rid themselves of their fat identity by undergoing extensive medical intervention in the form of gastric bypass surgery. While surgery candidates often cite the removal of physical challenges as motivating their choice, many make the decision to go under the knife with the dream of abandoning their fat identity.[74] It is interesting to note that many of these candidates opt for a surgical intervention to address profound psychological distress associated with their weight. Ironically, though many candidates report distrust and a distaste toward physicians, they nevertheless choose a biomedical approach to address their problems. It is commonplace for surgical candidates to report traumatic past interactions with abusive physicians:

> I didn't trust doctors. The doctors I went to before said, 'It's your fault. You could lose the weight if you wanted to.' One actually said, 'You're just stupid.' When I was pregnant with my son and going into labour, my doctor . . . had broken his arm, so another gentleman stepped in. This substitute doctor had never seen me.

> He came in, and I was extremely heavy . . . he took one look at me and said, 'Oh, God, I've got this one?!' . . . and he says, 'Prep her for a c-section—she's never going to have that child the normal way.' . . . I had that child before the doctor came back, and I had him the natural way. And I heard him say when he returned, 'Well, I didn't think she could do it.'[75]

Surely, however, there are better ways of dealing with fat identity than through such drastic surgical interventions.[76] For, even when such very risky surgeries are 'successful' in some sense, they reduce their recipients to a lifelong perverse relationship with food along with lots of nausea and frequent throwing up. But how, then, are fat people to get on with their lives given that ways of trying to shed one's fat identity through diets or surgery are typically unhealthy? According to Cooper, fat people must learn "fat acceptance," which she describes as a slow and ongoing process [that] is different for everyone," but can be

> characterized by a deep and lasting acceptance of our bodies whatever our size. When we feel proud and strong we find ourselves hurt less often, and giving ourselves permission to be fat with no recriminations generally makes us much happier. Feeling good helps us change old patterns: we stop wanting to lose weight, we lose our faith in dieting, and we prefer to treat our bodies with warmth instead of viewing ourselves as objects to be punished.[77]

Given the myriad negative ways in which the media, the health profession and the general public view fat, accepting one's fat is easier said than done. Even prominent fat rights activists have difficulty resisting the lure of thinness. For example, Shelley Bovey, who in 1989 published the influential *Being Fat is Not a Sin*, eventually began dieting again and even changed the title of her book to *The Forbidden Body*. She explains:

> [M]any women are not ready to reclaim the word 'fat'. To stand in a bookshop in front of a strange sales assistant and ask for that title was too much for some. It meant drawing attention to their size and naming it, and using the F-word in the process! What was worse than that was that I, the author, was beginning to find that the title stuck in my throat whenever I was asked what my book was called. Fat activists will not approve of my evasive behaviour and I apologize to them, but being fat is so painful, such a sensitive issue for so many that I believe we must keep that in mind at all times.[78]

Some people, perhaps many, may, then, not be able to become fat accepting in the current climate and at such an early stage of the fat rights movement. This need not be taken as catastrophic news for the movement since incremental change can produce dramatic results over a period of time. In this context, consider, for example, the distance the gay and lesbian community has come in the past 50–60 years with respect to both community and personal perception and acceptance of their sexual orientation. We now have a host of (significantly phrased) 'gay pride' activities sanctioned and indeed publicly supported by governments at many different levels. This would have been unimaginable in the 1940s when homosexuality was considered a mental illness, and people felt they had to hide their sexuality. If homosexuals in that period could magically have become heterosexual, very many of them would have whereas today the vast majority of

gays and lesbians accept their orientation despite the ordeals of having to deal with continuing homophobia and heterosexism in our society.[79]

The question remains, however, how even this incremental change can occur. The answer to this is particularly problematic because, as Judith Butler has argued, we must work within descriptive and defining language constructions that have become oppressive. As she puts it: "discourse becomes oppressive when it requires that the speaking subject, in order to speak, participate in the very terms of that oppression—that is, take for granted the speaking subject's own impossibility or unintelligibility."[80]

Whether it involves activism or not, a central component of the attempt to construct a fat-healthy view is for fat people themselves to band together with others in order to discuss issues of importance to fat people: e.g., discrimination, lack of access (to planes, theatres, jobs, etc.), abuse, etc. Of particular importance is the treatment fat people receive from the medical establishment who, they claim, locate the cause of all their ailments as their size, and always suggest that they need to diet and lose weight. Hence, in its manifesto, Nolose proclaims itself an "organization [that] is dedicated to ending the oppression of fat people" in part by recognizing that "the medical community has yet to fully and conclusively tease out the potential links between health concerns and weight, and that the diet industry capitalizes on this to manufacture massive fat-phobia."[81]

One of the main ways in which to achieve fat acceptance, then, is to de-medicalize it, according to many within the fat acceptance movement. Medicine tends to treat ailments on an individualistic basis, whereas the fat acceptance movement perceives fat as a *social* issue. As Cooper puts it: "Medicalisation ensures that it is the fat on our bodies that is blamed for the problems with which we deal. Fat-hating beliefs insist that it is our bodies which are at fault, that losing weight is a choice we should exercise in order to adapt and fit in."[82] Cooper and others have looked to the disability rights movement for help in understanding both their predicament and how to fight their way out of it: "[D]isabled people offer an important theoretical precedent for challenging this assumption. These debates are rooted in earlier civil rights and feminist struggles to reframe 'the problem' in a social context."[83]

Of course, disability has been defined in different ways. According to the medical or functional view, a disability is the absence or malfunctioning of a system that results in a person having impaired abilities to cope with life.[84] Thus, a malfunctioning visual system results in the disability of blindness. This clearly is not the sort of conception of disability fat activists want since it would look at fat as an impairment or a malfunctioning of the body. Fat activists, rather, need to follow disability activists who have argued for a social constructionist view that regards a disability as the product of the way(s) in which a society deals with people who have certain conditions. Hence, being in a wheelchair is not an impairment in a society where everything is wheelchair accessible.[85] Similarly, then, being fat is not an impairment in a society that refuses to look at fat people as morally weak and aesthetically repulsive, and also makes things accessible for a wide variety of body sizes.

Even granted this definition of disability, we must be careful connecting fat to disability. LeBesco, for example, is critical of the National Association to Advance Fat Acceptance (NAAFA) because in their attempt "to make life in a fat body more bearable"[86] (45), they turn fat people into "survivors"—and even refer to them as such. Indeed, LeBesco thinks that it's rather wrongheaded to treat all fat people as sharing something essential in common—something typical of fat essentialist positions which, she thinks, fat people must eschew. We must rather, she argues, treat fat people as unique individuals who should be otherwise celebrating their beauty and their bodies.

We make no attempt to resolve this debate within the fat rights movement. Our goal here was rather merely to outline in broad strokes various ways in which fat people have attempted to become accepting and indeed to celebrate their identity as fat people, whatever the causes of that fatness turns out to be or what ways (various) people adopt to come to that acceptance.

CONCLUSION

In closing, we would like to refer to an experiment conducted by Ancel Keys at the University of Minnesota in the 1940s, which involved putting healthy and normal weight people on a diet.[87] Mimicking the diets of overweight and obese people, the subjects ate about half of what they normally ate, and were put on an exercise routine walking about 23 miles a week over three months. They lost about 25% of their body weight, but gained that weight back within three months of the end of their diet. Moreover, they became absolutely obsessed with food, and would eat huge amounts of it and still not feel satiated. Many became psychologically troubled suffering from depression, mood swings, and irritability. Many even lost interest in sex, finding it took too much energy. Perhaps this was because their metabolisms slowed to 40% of what it was before the diet, and their body temperatures dropped and their heart rates slowed.[88]

The Ancel Keys study serves as a cautionary note to the promotion of weight loss, as often prescribed by the diet industry and by health care practitioners. As we mentioned earlier in this paper, a focus on lifestyle (including diet and exercise) will more appropriately address most health concerns that are currently related to fat. Not only does a thin-obsessed culture inevitably lead to a population of dieters, disguising weight loss as a way to treat chronic illness is misleading. Fat is simply not the culprit in the etiology of chronic disease. Nonetheless, the pharmacological and diet industries ensure the public is manipulated into consuming their weight-loss products for fear they will become (or remain) either ill or ugly. While individual lives become consumed with thoughts of food and diets, Big Pharma seems only too happy to keep its purse strings open.

Earlier in this paper, we briefly described some of the psychological variables associated with fat and dieting which are surely influenced by a culture that values thinness. At the level of the individual, stress, depression and low self-image are all associated with the experience of being fat in a thin-obsessed culture. These psychological issues almost seem like small potatoes when comparing the social and cultural ramifications of a culture consumed with dieting.

Our obsession with thin bodies often has negative effects on our relationships with food—both personally and communally. Social rituals involving food are abandoned in favor of portion-controlled, calorie-counted meals that are often eaten alone.

In our concerns about obesity and in all of our discussions about health and weight loss, we should not lose sight of the fact that eating food is one of the great things about living our lives. Its shared preparation and consumption is part of what makes our lives joyous. Hence, eating is a part of most festivals and intimately connected to most of the major events of our lives such as marriages and funerals. It is conceivable that the ritualization of communal meals might prevent the formation of unhealthy relationships with food. We have witnessed this protective phenomenon with alcohol consumption as a ritual among the Jewish American population.[89] Alcohol is introduced to young members of the Jewish community within a ceremonial religious context and its underage use is also strongly discouraged by the community. Researchers have suggested that by ritualizing alcohol consumption, by providing meaning associated with its consumption, this population is protected from developing issues of abuse of alcohol. By abandoning cultural traditions relating to food choices and patterns of consumption, as we have done in the western world, we have essentially changed meanings associated with eating. The abandonment of traditional diets in many third world populations has seen associated rises in obesity.[90] The most widely cited explanation for these types of trends focuses on unrefined foods being replaced with highly processed, refined alternatives. This explanation, while undeniably plausible, may only partly explain reported rises in obesity. Perhaps the modification of or abandonment of traditional rituals associated with meals contributes to these increases in obesity by reducing meaning associated with mealtime rituals, and changing relationships with food.

One of the problems with the current concerns about obesity is that it has a tendency to lose focus on this and to develop an unhealthy and unhappy relationship with food, where, e.g., we sneak food so that no one will see us, or feel guilty for every bit of carbohydrate or chocolate that we eat. Surely, we don't want to become the obsessive compulsive whose entire unhappy and unfulfilled life is shaped by exactly how much—or more accurately, how little—goes in our mouths. This strikes us as the equivalent of medieval monks flagellating themselves to atone for their sins. Eating is not a sin, and the more we accept that, the more we are likely to accept our bodies regardless of their size.

Endnotes

1. Heini and Weinsier, "Divergent Trends in Obesity and Fat Intake Patterns," 254–64.

2. Flegel et al., "Prevalence and Trends in Obesity Among US Adults," 1723–7; Johnson, "Obesity: Epidemic or Myth?" 25–29.

3. Allison et al., "Annual Deaths Attributable to Obesity in the United States," 1530–8.

4. Mokdad et al. "Actual Causes of Death in the United States," 1238–45. The use of language is important in the discussion about weight, just as it in others; e.g., in discussions about sex and gender. The medical community uses the terms "overweight" and

"obesity." People working within the fat rights movement argue that these biomedical terms are inappropriate (and insulting) because fat people suffer from no disease qua their weight itself. In this paper, we use the terms overweight and obesity only when we are discussing the views and research of those working firmly within the biomedical model. Otherwise, we use the term 'fat' and its cognates.

5. Gaesser, *Big Fat Lies*, 28, 29.

6. Ibid., xx.

7. Ibid., xxi; also see Kolata, *Rethinking Thin*.

8. Hacking, *The Social Construction of What?*; Hacking, *Rewriting the Soul*; Hacking, "The Looping Effects of Human Kinds," 351–94; and Hacking, "Making Up People," 222–36.

9. Hacking, *The Social Construction of What?*

10. See Kolata, *Rethinking Thin*.

11. Brillat-Savarin, *The Physiology of Taste*.

12. Kolata, *Rethinking Thin*, 37.

13. Ibid., 56.

14. Tom Wolfe, *Bonfire of the Vanities*.

15. Kolata, *Rethinking Thin*, 65

16. Ibid., 66, 69.

17. Ibid., 39.

18. Ibid., 39–40.

19. Ibid., 42.

20. Ibid., 47.

21. Ogden, Fryar, Carroll, and Flegal, "Mean Body Weight, Height, and Body Mass Index," 347.

22. Cited in Taubes, "The Great Diet Delusion."

23. See Kolata, *Rethinking Thin*.

24. C. Elliot, "Pharma Goes to the Laundry," 18–23.

25. Brown, "The Poison Pill."

26. Elliot, "Pharma Goes to the Laundry," 20.

27. Ibid.

28. Narkiewicz, "Obesity and Hypertension," 264–7.

29. See, e.g., Gaesser, *Big Fat Lies*.

30. Guagnano, "Risk Factors for Hypertension in Obese Women," 356–60.

31. Lee and Paffenbarger, "Change in Body Weight and Longevity," 2045–9.

32. See Light et al., "High Stress Responsivity," *Hypertension*, 1458–64; Krantz and McCeney, "Effects of Psychological and Social Factors on Organic Disease," 341–69; and Deter et al., "Salt Sensitivity, Anxiety, and Irritability," 17–26.

33. Schumaker, *The Age of Insanity*.

34. Gupta, "Trends in Hypertension Epidemiology in India," 73–8; Erdine and Aran, "Current States of Hypertension Control Around the World," 731–8.

35. See, e.g., Cubbin, et al., "Neighborhood Deprivation and Cardiovascular Disease Risk Factors," 228–37.

36. See, e.g., Patel, Eggen and Strong, "The Heart in Massive Obesity," 1087–91.

37. Cited in Gaesser, *Big Fat Lies*.

38. Cited in ibid.

39. Zimmet, et al., "The Prevalence of Diabetes," 45–51; Yoon et al., "Epidemic Obesity," 1681–8.

40. Gaesser, *Big Fat Lies*.

41. Yoon et al., "Epidemic Obesity."

42. S. Wild et al., "Global Prevalence of Diabetes," 1047–53.

43. Yoon et al., "Epidemic Obesity."

44. West, "Diabetes in the Tropics," 249–59

45. Viswanathan, "High Prevalence of Type 2 (non-insulin-dependent) Diabetes," 907–10.

46. Zimmet, "The Prevalence of Diabetes," 45–51.

47. Wang and Beydoun, "The Obesity Epidemic in the United States," 6–28.

48. American Diabetes Association, "Total prevalence of Diabetes and Pre-Diabetes."

49. Zimmet, et al. "The Prevalence of Diabetes;" Yoon et al., "Epidemic Obesity."

50. Wild, et al., "Global Prevalence of Diabetes"; Brody, "The Global Epidemic of Childhood Obesity," 1–7.

51. Gaesser, *Big Fat Lies*; Zimmet et al., "The Prevalance of Diabetes."

52. Gaeseer *Big Fat Lies*; Blair et al., "Physical Fitness and All-Cause Mortality," 2395–401.

53. Blair et al., "Physical Fitness and All-Cause Mortality."

54. Gaesser, *Big Fat Lies*.

55. Markowitz et al., "Understanding the Relationship Between Obesity and Depression," 1–20.

56. Willenbring, et al., "Stress Induced Eating and Food Preferences in Humans," 855–68.

57. Heatherton et al., "Effects of Distress on Eating," 801–3; Polivy, "Psychological Consequences of Food Restriction," 589–92; and Tanofsky-Kraff, "Impact of Interpersonal and Ego-Related Stress on Restrained Eaters," 411–8.

58. Gupta, "Trends in Hypertension Epidemiology in India," 73–8.

59. T. S. Eliot, *Four Quartets*.

60. See, e.g., McLaren, "Growing Up on Therapy."

61. See, e.g., Horwitz and Wakefield, *The Loss of Sadness*; and Stewart, "Hacking the Blues," 219–37.

62. Wooly, "Psychological and Social Aspects of Obesity."

63. There are, of course, exceptions to these generalizations. Hence, we could still find people and institutions today who think homosexuality is a sin or a medical disease, or both.

64. Cited in Cooper, *Fat and Proud*, 21.

65. Cited in ibid., 25.

66. LeBesco, *Revolting Bodies*, 14.

67. Cooper, *Fat and Proud*, 25–35.

68. Ibid., 41.

69. Ibid., 38.

70. Minerd, "Obesity Linked to Depression, or Vice Versa."

71. Simon, "Association Between Obesity and Psychiatric Disorders," 824–30.

72. Ibid.

73. Cited in Lawson, "The Obesity-Depression Link."

74. Meana and Ricciardi, *Obesity Surgery: Stories of Altered Lives*.

75. Ibid., 18.

76. We make no claim that gastric bypass surgery is always inappropriate, any more than even ardent supporters of natural childbirth would argue that all C-sections are unwarranted. We claim only that a large number of such surgeries are ill considered and typically the result of a fat-hating society rather than purely physical and medical reasons.

77. Cooper, *Fat and Proud*, 44

78. Bovey, *Being Fat is Not a Sin/The Forbidden Body* (London: Pandora, 1989/1994), 257–8 **WHICH BOOK ARE THE PAGES REFERENCED FROM?**.

79. In saying this, we are of course not saying that one's sexual orientation is a matter of choice. Our example means simply to draw analogies between acceptance of one's fat and acceptance of one's sexual orientation.

80. Cited in LeBesco, *Revolting Bodies*, 3

81. Nolose, "The Nolose Manifesta."

82. Cooper, *Fat and Proud*, 121.

83. Ibid.

84. Glover, *Choosing Children*, 6.

85. Ibid., 7

86. LeBesco, *Revolting Bodies*, 45.

87. Cited in Kolata, *Rethinking Thin*.

88. Kolata, *Rethinking Thin*, 107–10.

89. Yeung and Greenwald, "Jewish Americans and Mental Health," 292–7.

90. Monteiro et al., "Obesity and Inequities in Health in the Developing World," 1181–6.

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