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http://commons.emich.edu/honors/149

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In the current popular of America, fat is seen as a very bad thing. Having excess weight is not only a perceived health risk, but is also socially unacceptable. Three major areas relating to fat— medical research, body image and self-esteem, and social justice—are explored in order to explain the current perceptions of excess weight, the impact these perceptions have and what could be done to change them. The overarching goal of this project is to make readers more aware of the conflicting research there is about fat, to show how unnecessary this negative view of excess weight is and how devastating it is to those who are fat.

Degree Type
Open Access Senior Honors Thesis

Department
Women's and Gender Studies

Keywords
Obesity, Body weight, Body image, Obesity Social aspects

Running Head: FAT IS FINE

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August 28, 2008

Abstract

In the current popular of America, fat is seen as a very bad thing. Having excess weight is not only a perceived health risk, but is also socially unacceptable. Three major areas relating to fat—medical research, body image and self-esteem, and social justice—are explored in order to explain the current perceptions of excess weight, the impact these perceptions have and what could be done to change them. The overarching goal of this project is to make readers more aware of the conflicting research there is about fat, to show how unnecessary this negative view of excess weight is and how devastating it is to those who are fat.

"The cure for this disease [of obesity] is simply to recognize that it doesn't exist."

~Paul Campos, *The Obesity Myth,* p. 135

To the vast majority of Americans, this opening sentence may seem like a joke. For many years in the United States, as well as around the world, common knowledge has told us that obesity is not only unhealthy for us, but also potentially deadly. Over the past two decades or so the focus on obesity has intensified due to medical research, the diet industry, and the public's steadfast obsession with obtaining Western culture's ideal of a thin body (Campos 2004; Kolata 2007). This spotlight on obesity has become so intense that there is a public battle being fought known as the "war on fat". On one side of this war are the diet industry, popular culture standards and a number of academics, with the justification that fat needs to be controlled in order to save the health of the public. On the other, as one might expect, is fat. But fat is not the only victim of these so-called do-gooders. It is the feelings, emotions, self-esteem, body image and, sometimes, the physical bodies of those who are fat that end up being the casualties of this war.

If one digs deeper than popular culture hype, alarmist journalism and exaggerated statistical findings, it is not hard to see that many of the arguments given against fat are flawed. So flawed in fact, that the opening statement given is not that far off from what one might conclude when doing one's own research about fat. The objective of this project is to show how harmful these popular beliefs are to those who are fat. Through three different avenues- medical research, self-esteem and body image, and social justice- I will show how the popular view of fat

became so distorted, the consequences of this distortion and possible solutions to lessen the pain inflicted on fat people due to this view.

<u>Definitions</u>

Considering that there are a number of terms related to weight that are often used interchangeably, it is important to clarify their meanings in order to make my arguments understood. Most people are familiar with the "body mass index," or BMI, which is calculated by dividing weight in kilograms by height in meters squared. The resulting number falls into one of five categories: underweight, normal, overweight, obese and morbidly obese. While this may seem pretty straightforward, there is actually a lot of ambiguity as to what the categories say about health. The information the BMI was based on came from information collected by insurance companies, which largely consisted of data on affluent white men who could afford insurance (Wann, 1998). Furthermore, from the heights and weights reported, there was no evidence to show any kind of correlation between weight and health (Wann, 1998). Research since the conception of the BMI has continued to show that there is little or no correlation between higher weight and mortality or health problems, and, in many cases, the inverse relationship of higher weight being associated with better health was present (Wann, 1998).

What this means is that the idea that there is an "ideal weight" and that one can be above that "ideal" is a social construct (Evans, 2003), utilized in the same way constructs of race and gender are utilized—to discriminate against those who fall into categories of "otherness", which in this case are overweight and obesity. When using the terms "underweight," "normal," "overweight," "obesity" and "morbid obesity," my intent is for them to be seen as the social constructs that they are, and not a kind of medical diagnosis. The term "fat," on the other hand, is not a social construct in the same sense as the BMI categories as it was not created as a social

classifier.   It is an adjective as well as a noun that does not carry any kind of empirical health

risk (Evans, 2003). Fat, by itself, does not cause any specific health problems and it is necessary

for normal body functions and protects against injury and illness (Wann, 1998). It has, however,

gained negative connotations within our culture, related to both health and social stigmas. I will

be using the term "fat" without those negative implications, but as a descriptor or noun.

<u>Medical Research</u>

The first step in understanding that the "disease" of obesity doesn't exist is to understand

how it came to be seen as a disease (Oliver, 2006). The definition of "disease" in *Stedman's*

Medical Dictionary, as stated in Oliver (2006) is, "an interruption, cessation, or disorder of the

body function, system, or organ"(p. 612). Given this definition, body fat would have to be

pathological in order for obesity to be considered a disease, and there is no evidence that shows

how or even if adipose tissue (fat cells) is harmful to the body (Oliver, 2006). As J. Eric Oliver

explains in a 2006 edition of *Perspectives in Biology and Medicine*:

> For some extremely heavy people, their body fat may disrupt their ability to function,
>
> particularly their ability to exercise, or may create joint problems like osteoarthritis, but
>
> for the vast majority of technically obese people (those with a BMI between 30 and 35),
>
> there is no clear evidence that their fatness is a disorder. The average American has only
>
> gained between eight and twelve pounds over the past 20 years. The most recent
>
> estimates calculate that excess body weight is responsible for only 26,000 deaths a year
>
> in the United States, a number lower than that which comes from "weighing too little".
>
> Most epidemiological studies that find an association between obesity and various
>
> morbidities do not take into account factors such as diet, exercise, or family history;
>
> indeed, body fat on some parts of the body, such as the thighs, may be beneficial. Even

Stedman's Medical Dictionary does not call obesity a disease, it is simply "excess

subcutaneous fat in proportion to lean body mass" (p. 612, *references omitted)*

In order for obesity to be conceptualized as a disease, it has to be presented in the medical

community and elsewhere as something that is out of the individual's control, like a virus that

spreads (Oliver, 2006). William Dietz, who put this presentation of obesity forth in

1998, believed that obesity was something that happened to people due to their environment and

not because of individual choice (Oliver, 2006). In order to get his message across, he created

PowerPoint slides with maps of the United States, one for each year from 1985 to 1999, in which

each state was colored according to the percentage of obesity in that state (Oliver, 2006). The

colors range from light blue (less than 10% obesity rate) to red, which represented an obesity rate

of more than 20% (Oliver, 2006). Over the course of those 14 years, the states got darker and

three red states popped up in 1997; there were a total of 20 red states in 1999 (Oliver, 2006).

Between these powerful visuals and the fact that they were made available publicly, the idea that

obesity is a disease spread quite rapidly (Oliver, 2006).

The interesting thing about the notion of obesity as a disease is that it was not preceded

by any kind of discovery or new information regarding weight (Oliver, 2006). Studies from the

past century have repeated the same information in a variety of different forms that ultimately

leads to there being little or no correlation between being overweight and having particular

health problems (Campos, 2004; Kolata, 2007). The tendency preceding the development of

Dietz's visual aids was for the medical profession to label conditions as diseases that do not fall

under the definition of a disease (Oliver, 2006). Conditions such as hypertension and high

cholesterol, which are correlated with stroke and heart disease, respectively, have been labeled

diseases in themselves, when, in fact, they are symptoms of actual pathologies that have a

number of different symptoms, not just the ones that are emphasized today (Oliver, 2006).

On top of this tendency, the medical and dietary communities both have a lot to gain from categorizing obesity as a disease. Many of the diet drugs that are on the market today are accompanied by some relatively or severely harmful side effects that cannot be justified if there is not a medical reason for taking these drugs (Oliver, 2006). The same thing can be said of doctors who perform bariatric surgery. This type of surgery, which lessens the body's ability to take in and absorb food, is not only the only general non-cosmetic surgery that is advertised for, but also the only surgery that targets a healthy organ; the sole purpose of the surgery is to make the stomach and small intestine absorb fewer nutrients (Oliver, 2006). The success of the surgery is actually measured by how well the absorption capabilities of these organs are impeded, or, to look at it another way, make them as dysfunctional as possible. As Oliver (2006) articulates:

> The Orwellian logic behind this process is telling: in order to "cure" the imaginary "disease" of obesity, doctors will surgically alter a healthy organ and make it permanently sick to the point where it actually meets the technical definition of a disease. They are ostensibly treating an imaginary disease by creating a real one. (p. 624)

Bariatric surgeries generally do not cause significant long-term weight loss (Oliver, 2006). Furthermore, the rate of accompanying complications that lead to serious health problems is about 30% (Oliver, 2006; Kolata, 2007). On top of this, about a thousand Americans that undergo the surgery each year will die from complications during surgery, and it is possible that many more will die from compilations that occur after the surgery (Oliver, 2006). Almost all of the patients that undergo the surgery and survive have chronic side effects like body odor, bad breath, chronic vomiting, diarrhea and infections (Oliver, 2006). These are staggering negative side effects for a surgical procedure that does not typically cause significant long-term weight

loss considering the lack of clear evidence that being overweight or obese poses serious health risks.

What most people tend to fall back on when the topic of obesity comes up is the medical research that has shown that being fat is bad for your health. As I have mentioned, this is far from what epidemiological studies show, and I would like to explore how and why medical research is skewed to affirm and reaffirm the belief that excess body fat is bad. There are two things I would like to point out about credible research. One is that within scientific research, there are always ways to improve any given study because there are always limitations when conducting research, which means that studies do not produce "facts"; they give support either for or against a certain hypothesis. This is why studies that have been performed over and over and come up with the same results are seen as credible. Along with this comes the separation of correlation, when two things have a statistically significant relationship, and causation, which is when one event causes another. When it comes to obesity research, these two basic principles are largely ignored and there is an abundance of examples that illustrate this, some of which I will go over (Campos, 2004). On the other side of the coin are the credible epidemiological studies that give evidence saying that weight is not a major factor in health and sometimes that it is healthier to be in a higher weight category. There is also evidence that when fat people try to lose weight, it does more harm than good (Campos, 2004).

Because the field of obesity research is so large, I am going to focus on the claim that excess fat causes premature death and the research that contradicts this claim to show the contrast of the research in one particular area. The few articles that are cited the most showing that there is a correlation between increased weight and increased mortality all have significant problems with their procedures and results (Campos, 2004). They can be, and largely are,

misread by the public (Campos, 2004; Herndon, 2002). The first of these studies is "Body

Weight and Mortality Among Women" published in the *New England Journal of Medicine* in

1995; this study is more commonly known as "the nurses study" and it followed 115,195 nurses

over the course of 16 years (Campos, 2004). The sample was comprised of about 98% middle-

aged, middle-class, white women and only 4.5% (a total of 4,726) died over the course of the

study (Campos, 2004). A significant thing to point out that was not discussed in the findings is

that a 4.5% death rate in that group size is a pretty low mortality rate (Campos, 2004). The most

serious health risk in the data was smoking, with the death rate of smokers several times higher

than non-smoking participants, and thin women were twice as likely to smoke as fat women

(Campos, 2004). When looking at all of the data, the mortality rates of the obese BMI range were

the same as those in the ideal range, and women who fell in the overweight range actually had

the lowest mortality rate of all the weight groups in the study (Campos, 2004).

The way the researchers were able to manipulate the data to make it look like higher

weight was correlated with higher mortality was to remove smoking as a factor; then the data

showed a small increase in mortality rate among heavier participants (Campos, 2004). The

researchers focused on cardiovascular disease, where the largest increase in mortality related to

weight showed, and then played up percentage differences, not the actual number of deaths, in

order to make the difference seem a lot larger (Campos, 2004). The total number of deaths

related to cardiovascular disease in the study was 184 (less than .15% of the total participants),

so when the authors said that mild obesity increased the chance of cardiovascular disease by

60%, they were looking at a minuscule portion of the data (Campos, 2004). When there is an

increase of 60% of almost nothing, the result is still almost nothing (Campos, 2004).

Two other articles both come from the *Journal of the American Medical Association*

(*JAMA*). One from 1993, titled "Actual Causes of Death in the United States" (Herndon, 2002),

and the other from 1999, title "Annual Deaths Attributable to Obesity in the United States"

(Campos, 2004). The striking thing about both these articles, besides the similarity of their titles,

is that they both produced the figure of 300,000 deaths, which is a widely quoted number relating

to obesity in mortality rates. The 1993 article attributed those 300,000 deaths to poor eating

habits and sedentary lifestyles; weight was not mentioned at all (Herndon, 2002). When this

number was cited in other works, that rather crucial bit of information was left out; weight was

attached to the 300,000 figure and all the public heard in the end was that excess weight caused

300,000 deaths per year (Herndon, 2002). The 1999 article did actually attribute 300,000 deaths

to obesity, but this is not what their data showed; their data showed a U-shaped curve in which

the ideal and obese weight ranges had approximately the same risk of premature death and those

in the overweight range had the lowest risk of premature death (Campos, 2004). Other studies

have consistently failed to show any correlation between increased BMI and increased mortality

in people over the age of 65; and, if we consider that 78% of deaths occur in people 65 or older,

that leaves about 500,000 deaths that could be attributed to other causes (Campos, 2004). To say

that 60% (300,000) of these deaths are attributed only to weight, when there are a plethora of

other causes such as suicide, homicide, accidents, drug use, tobacco, alcohol, infections, cancer,

etc., makes no sense at all (Campos, 2004).

A widely cited article from 2003, which also appeared in *JAMA,* called "Years of Life Lost

Due to Obesity," once again picks out the most staggering contrasts within the data and plays

them up instead of looking at them within the context of the entire dataset (Campos, 2004). The

authors did actually state that there was a negative correlation between increasing weight and

mortality rate among African-Americans, and that the only weight range in which mortality was

significantly elevated was in the underweight range (Campos, 2004). Among the white test

subjects, the changes in mortality rates were negligible until the BMI range of the mid-30s (the

obese range starts at 30) and this even had a strong correlation to gaining the weight at a very

young age (Campos, 2004). If one were to look at the data without the commentary of the

authors, these two findings seem like they would be positive, but the authors did not focus on

these results (Campos, 2004). They instead focused on the finding that a 20-year-old white male

with a BMI of over 45 (about 130 to 140 pounds above the ideal range) would lose an average of

13 years compared to someone of the same demographic categories that is in the ideal weight

range (Campos, 2004).

　　While there is this array of misinterpreted data within research related to obesity, there is

quite a bit of credible research that supports the lack of correlation between excess weight and

health problems. Since the 1980s, it has been found that life expectancy in relation to the BMI is

a consistent U-shape, with the overweight range at the lowest point and the obese and ideal

ranges higher and about the same (Campos, 2004). A study that followed 1.8 million people over

10 years in Norway found this general result with the lowest life expectancy in the underweight

range (Campos, 2004). What is more striking is that those who are in the lower part of the ideal

range (a BMI of 18 to 20) have a shorter life expectancy than those with a BMI in the 34 to 36

range, who are considered extremely obese (Campos, 2004). Another project, undertaken by

those at the National Center for Health Statistics and Cornell University, consisted of analyzing

data from dozens of previous studies with a total of 600,000 subjects and follow-ups for up to 30

years (Campos, 2004). These results, once again, resemble a U-shaped curve, but the striking

pattern found was that the lowest mortality rates were among a very wide range of weights for

both men and women (Campos, 2004). The trend that these comprehensive studies show is that

it is healthier to be 50 to 80 pounds "overweight" than to be 5 pounds "underweight" (Campos, 2004).

From what I have described so far, the exaggeration and manipulation of the data in the studies that show excess weight as a problem is relatively clear. It is also very important to mention that these studies, and many others similar to them, assume that because there is a correlation between increased weight and any kind of health problem that the weight is a contributing factor of that problem (Campos, 2004). This muddling of correlation and causation is bad methodology.

On top of this the public hardly ever hears the critics of those questionable studies; the debate about the implications of weight is almost completely academic (Kolata, 2007). This is due to the way that obesity research is funded (Campos, 2004). Many boards of health consist almost exclusively of doctors who own weight-loss clinics (Campos, 2004). This gives these boards incentive to fund researchers who will confirm that excess weight is a bad thing because it keeps their businesses going (Campos, 2004). The studies that are produced from this financially motivated cycle are similar to the ones mentioned above that skew their findings. Obesity researcher Suzanne Wooley calls these results "P.S. messages" where the data produces a result that does not show a negative correlation between excess weight and health but in the closing statements the authors reaffirm the idea that obesity is bad and that people should weigh less (Campos, 2004). These closing statements are "P.S. messages" to their funders that are basically saying 'we gave you the message you wanted, please fund us again' (Campos, 2004). This may sound rather critical, but this type of thinking is present in the consumer and social world of the overweight and obese, as well.

Because there are so many health problems perceived to be associated with excess

weight, I would like to address a few more major health issues, besides mortality rate, in relation to obesity. Heart disease is often associated with obesity, but the actual correlation is between heart disease and people who have tried to lose weight (Campos, 2004). Obese people who go on low-calorie diets have much higher congestive heart failure rates than fat people who never dieted (Campos, 2004). There is actually an interesting historical example of this. In World War II, the hospitalizations due to hypertension increased 50% after a siege had been lifted off Leningrad, because those who had starved during the siege began to gain back weight (Campos, 2004). The medical profession still recommends that overweight hypertensive people should try to lose weight (Campos, 2004). Another problem with the idea that there is a link between increased weight and heart disease is that obesity continues to increase as deaths from heart disease continue to decrease (Campos, 2004). If there was any kind of causal link there, they should both be going in the same direction. There is also not sufficient evidence that the increase in type two diabetes is correlated with increasing obesity rates (Campos, 2004). There are two main reasons that type two diabetes seems to be skyrocketing. The first is that, for a long time, type two diabetes was largely under diagnosed (only about a third of diabetics were aware of their condition) and now that people are more aware of it, they are able to be part of the statistic (Campos, 2004). The definition of "diabetes" has also changed from a fasting blood sugar of 140 to 126, causing millions of Americans to become diabetic overnight (Campos, 2004). Another major health problem, cancer, is also popularly known to be correlated with increased weight, but this is largely due to miscommunication (Campos, 2004). In 2003, the American Cancer Society announced that one third of cancer deaths are related to inactivity and diet (Campos, 2004). Just as with the previously mentioned *JAMA* study, weight got attached to this statistic and that was all the public heard. The medical literature actually shows about 40 medical studies

that found lower mortality from cancer with increased body weight (Campos, 2004).

Now that I have addressed the medical research connecting obesity with health problems, the idea that fat people can and should become thin needs to be examined. I have shown above that there is no substantial evidence that being thinner makes you healthier, there is evidence that being fat can decrease your risk of certain health problems, and there is evidence that trying to lose weight can impede fat peoples' health. The importance of eating healthy and exercising was present in a number of articles I discussed and in those instances bad eating habits and lack of exercise were automatically associated with the excess weight by the public, even though this was not what the data was showing. There is a public belief that eating right and exercising lead to losing weight, and, if done consistently, permanent weight loss. This is far from the truth (Campos, 2004; Kolata, 2007; Wann, 1998).

There have been a number of studies conducted that look at what happens to one's body when one tries to lose or gain a significant amount of weight. A study done in World War II had 36 military men who were of normal weight and psychologically sound eat a diet of half as many calories as they would normally and walked 22 miles a week; a similar kind of regimen that overweight and obese people would partake in if they were trying to lose weight (Kolata, 2007). These men became obsessed with food and their metabolic systems changed dramatically (Kolata, 2007). Their metabolisms dropped up to 60%, their body temperatures dropped and their heart rates slowed; their bodies were clinging to all of the food they were given. They also obsessed about food—talked about it endlessly, dreamt about it, and some started to collect cooking utensils (Kolata, 2007). Their interests in other activities besides eating, including sex, all took a back seat to the fixation on food (Kolata, 2007). When the men were allowed to start eating normally again they would eat much more than necessary, some to the point where they

would become ill, and others would feel hungry even after eating a large meal (Kolata, 2007). In essence, these men were starving, and this is the same thing that happens to fat people when they try to lose weight (Kolata, 2007).

In the 1950s Jules Hirsch, a scientist at Rockefeller University in New York, discovered this 'starving' result during a study that initially focused on what happened to fat cells when fat people lost weight (Kolata, 2007). At the beginning of the study, in which a number of obese people lived at the University Hospital and were fed a strict diet in order to lose weight, Hirsch took four weeks of baseline readings with the participants on a "maintenance" diet before changing their food intake to make them lose weight (Kolata, 2007). What Hirsh found was that as the participants lost more and more weight their metabolic functions changed—their metabolism slowed up to 25%—and they became obsessed with food, just like the military men (Kolata, 2007). These results make sense if we put them in a context of human history in relationship to food. Until very recently in the span of human existence food was not always readily available (Campos, 2004). Our bodies had to adapt to periods of famine, making the ability to conserve energy imperative to survival (Campos, 2004). Now that food is cheap and abundant, we no longer have to worry about starvation and our bodies are able to gain more weight as a result (Campos, 2004).

This same principle is why people who lose weight and gain it again repeatedly (also known as "yoyo dieting") tend to gain back a few more pounds than they lost (Campos, 2004). Because the body went through a perceived period of famine, it holds onto a few extra pounds as a way of preparing for the next bout of starvation; therefore, when people attempt to lose weight, it ends up making them fatter (Campos, 2004). Diet foods, which have less fat or artificial fat (for flavoring), contribute to this slow weight gain as well (Campos, 2004). This happens

because low-fat foods tend to have more calories, and because fake fat is not nearly as satiating as real fat, we end up eating more of the food with the artificial ingredients in order to satisfy ourselves and therefore we consume more calories (Campos, 2004). In the generation before diet food, people consumed 20% more fat but 10% less calories than we consume today (Campos, 2004). Once again, this does not mean that excess weight is a bad thing, but it does mean that we spend extra money for diet food (diet food is often cheaper to make and has a higher profit margin because it has "special qualities") that really has no positive impact on our health at all (Campos, 2004).

This does not mean that our bodies do not know how to regulate how much weight they gain; in fact, our bodies do this quite well. University of Vermont researcher Ethan Sims embarked on a study in the 1970s to see if people were able to gain weight at will (Kolata, 2007). He used university students who had never been fat and had no family history of obesity as subjects and found that it was almost impossible for them to gain much weight (Kolata, 2007). Sims thought that maybe they were able to get too much physical activity to burn off the extra calories, so he decided to use prisoners, who did not have the freedom to move around, as his test subjects (Kolata, 2007). Even with their limited mobility it was very difficult for them to gain weight; it took four to six months and up to 10,000 calories a day in order for the men to increase their weight by 20 to 25% (Kolata, 2007). Not only did the prisoners gain less weight than they should have by calculation of food intake, but their metabolisms increased by 50% and they needed two thirds more calories per day to maintain their increased weight compared to when they were at their normal body weight (Kolata, 2007). Besides metabolism, energy is also expended in our daily lives through non-exercise activity thermogenesis, or NEAT, which happens during things like fidgeting, fine muscle contractions and holding posture (Campos,

2004). In a study in which people were overfed by 1000 calories a day, their change in NEAT varied from nothing to almost 700 calories per day, which is about the same amount of calories expended by a runner during a 10K race (Campos, 2004). This research supports the theory of "set point", which is that the body has a range of 10 to 30 pounds within which each individual's body fine-tunes itself (Campos, 2004; Kolata, 2007).

The final area of medical research shows that weight cannot be controlled at will is genetics (Kolata, 2007). Since the Civil War, Americans have gotten an average of 3 inches taller, because we have the nutrients and protection against disease that lets our genetics reach their full potential (Kolata, 2007). The same thing is true of weight; we continue to get fatter, on average, because our bodies are relishing in a healthy environment (Kolata, 2007). In the 1980s, Mickey Stunkard, an obesity researcher from the University of Pennsylvania, gained access to adoption registries in Iceland and Denmark and through mailed surveys found a very substantial link between biology and weight (Kolata, 2007). The weight of the adopted child had nothing to do with their adoptive parents; 80% of the children who had (obese) biological parents became obese, whereas less than 14% of those who had thin biological parents became obese (Kolata, 2007). Stunkard conducted another study examining the weight of twins who had been raised separately and together (Kolata, 2007). There was virtually no weight difference between the identical twins whether they had been raised separately or together; fraternal twins had more variation, but this is to be expected, as they only share some genes, just like any siblings (Kolata, 2007). The researchers concluded that about 70% of variation in weight can be attributed to biology, which is a stronger link to biology than any other genetic-related tendency, like heart disease, breast cancer or mental illness (Kolata, 2007).

Considering the prevalence of popular beliefs against excess fat, one would expect to find

more credible research supporting these beliefs and little, if any, research to support the contrary. As this review of obesity research has shown, this is far from the case. Not only are the studies that fuel fat prejudice able to be broken down and discredited, the substantial amount of oppositional research is rarely heard by the public. Besides the fact that obesity is discredited as a disease by technical definition, there is a lot of research that rejects supposed health risks associated with obesity. On top of this, research has shown that our bodies are working to the best of their abilities in relation to their environment as they have for thousands of years. In the next two sections, I am going to take my opening statement and explain why "simple acknowledgment", as the opening quote says, would not do much to help the people that have been wrongfully burdened by the claim that fat is bad.

Body Image and Self-Esteem

While good physical health is generally near the top of people's lists of things that make life enjoyable, there are other factors that play just as important a role in one's well-being. In 1946, the World Health Organization defined health as, "A state of complete physical, psychological and social well-being" (Davies; 2007, p. 448). Body image and self-esteem make up and influence all three of those three states. Because these are so intertwined with a person's overall health, it is imperative to look at how culture affects the body image and self-esteem of fat people (Grogan, 2006). It is equally important to examine the underlying factors that have culminated in today's very public hatred of fat. There is nothing "simple" about the implications of the perceived disease of obesity.

As a point of reference, I think it is important to review some recent research examining body image and self-esteem. Body image is the way we see ourselves in relation to how we believe our body should look compared to the rest of our culture (Lowery et al 2005). In the

Journal of College Student Development, Lowery et al.(2005) state that, "Body image is constructed from self-observation, the reactions of others, and the complicated interaction of attitudes, emotions, memories, fantasy and experiences, both conscious and unconscious" (p. 612). Self-esteem, on the other hand is how much we like and respect ourselves (Lowery et al., 2005). In examining the effects of cultural standards of physical appearance on body image and self-esteem, women are generally more affected than men, though this is changing as men become more objectified by the media (Goldenberg, Arndt, Hart and Brown, 2005; Lowery et al. 2005; Joan and Lennon 2003). In addition to the greater effect of culture on women's body image and self-esteem, the body image of women plays a much greater role in their self-esteem than it does for men (Grogan, 2006; Lowery, 2005). This is due in part to the fact that women are more likely to be evaluated on physical attractiveness than their skills or abilities (Jung and Lennon, 2003). Concern about weight is one area in particular that has a profound effect on women's body image and self-esteem, as Goldenberg et al. (2005) addresses in the discussion of results of their study examining the relationship between BMI and mortality salience, weight and appearance are routinely primed to be thought about in our culture. Because it is primed so often, it is bound to have influence on the factors that make up body image.

In order to put things into some kind of perspective on a global scale, it must be pointed out that in the majority of cultures outside of the United States, being "fat" is the standard of beauty (Campos, 2004). In many countries, the standard of beauty is often over 200 pounds, a radical difference from our "thinner is _____" (better, sexier, more attractive, healthier etc.) mentality (Campos, 2004). The same can be said for our country before food became abundant and cheap; if you were fat, it showed that you had the wealth to keep yourself fed; therefore, it was desired (Campos, 2004). Even women who wore corsets to have skinny waists, this was in

line with the hourglass figure, which included thick hips for childbearing. This mentality

supports the medical research I have already presented that shows that, if given access to the best

nutrition and health care, as the wealthy people were around the time of the industrial revolution,

the body would be both taller and heavier. How then, did the idea that being thin is healthy

become so popular, and what is the impact on body image and self-esteem? The answers to these

questions are a combination of environmental and social factors.

As the wealth of America started to spread out more and it became more middle-class,

more and more people started to live longer and became larger. Along with this came a higher

number of ailments like heart disease and diabetes, so people were inclined to thinking that these

health problems are associated with being larger, when it actually had to do with length of life

(Campos 2004). While this was a rather gradual process in the United States, we have more

striking examples when looking at the westernization of isolated populations (Campos 2004).

Parts of Micronesia have an adult population with an obesity rate of over 80% where, prior to

westernization, starvation was constant and their life expectancy was less than 40 years (Campos

2004). Now that they have continual access to food and medication, they are living long enough

to get ailments like heart disease and diabetes (Campos 2004; Czerniawski, 2007). Our culture is

quick to point out that these obese people have increasing health problems, but if their bodies

had not been given the opportunity to flourish, their life expectancy would still be 30 years less

than it is today (Campos 2004). Modern conveniences of western culture, such as cars and better

public transportation, as well as a shift from hard labor to less physically demanding jobs, has led

to a much more sedentary lifestyle than in the past. It is this lack of exercise that is a major

contributing factor to health problems, not excess weight (Campos 2004; Kolata, 2007). The life

expectancy in this country continues to rise, just as the increase in excess weight continues to

rise (Campos 2004).

As I said earlier, insurance companies have played a major role in determining how we conceptualize a healthy weight. Starting in the mid-1800s, insurance companies began focusing on weight as a way to predict the risk associated with insuring different people (Czerniawski, 2007). They were trying to use body size as a visible physical indicator of someone's health, and originally they were more concerned about people who were too thin, as opposed to being fat, because thinness was indicative of a number of diseases, including tuberculosis (Czerniawski, 2007). Because there was so much variation between different examiners and whether or not a person should be granted insurance, the companies needed a way to eliminate as much of the guesswork as possible, which resulted in height and weight charts (Czerniawski, 2007). The major problem with these charts is that the information used to form them was based only on data on previous policyholders (Czerniawski, 2007). They would have had better health care and nutrition than the general population, because they had the excess money to have life insurance (Czerniawski, 2007). During the first third of the 1900s, the average weight of a man covered by the insurance companies decreased (Czerniawski, 2007). This is because fear of diseases like tuberculosis had diminished and the focus was being put on other ailments like heart disease and diabetes, so thinner people started to be accepted for insurance, while heavier people were still excluded, bringing down the average weight (Czerniawski, 2007). One of the insurance companies found a three to five pound decrease of their women policyholders during the 1920s, which is they attributed to the popularity of being thin illustrated by actresses and other role models (Czerniawski, 2007).

The insurance charts were eventually adopted by the medical community (though initially resisted) and the most common one today is the BMI (Czerniawski, 2007). In 1998, the bottom

end of both the 'overweight' and 'obese' BMI categories were lowered by the government (Czerniawski, 2007). This caused a lot of people to be in "risk of poor health" overnight, which was done deliberately by the government to try to get people to pay more attention to their "health" (Czerniawski, 2007). This is particularly disturbing considering the research showing the U-shaped pattern of mortality rates in relationship to weight and the research supporting that weight loss can cause more problems than benefits. On a social level, this move creates more social pressure on the individual to conform to stricter standards than before, which can cause even more damage to body image and self-esteem. If a person is trying to fit into a mold that is too small for them already, making the mold smaller does not promote more determination; rather, it promotes more frustration.

Around the turn of the 20th century, the public depiction of women in the United States started to change; particularly when the Gibson Girl appeared on the cover of life magazine in 1901 (Kolata, 2004). Charles Dana Gibson created drawings of a tall, thin, young, alluring girl that within the decade had swept the country's imagination and became the archetype of American beauty (Kolata, 2004). She appeared in many different settings performing different activities with grace and captivating her audience (Kolata, 2004). Girls all over the country started mimicking her style and boys wanted to be her companion (Kolata, 2004). While the concept that a set of drawings could captivate the entire nation may sound rather incredible, what is even more incredible is that she was not real (Kolata, 2004). People wanted to know who Gibson's model was and he admitted that she had come from his imagination; she was a mesh of many women, what he thought to be the ideal woman (Kolata, 2004).

The Gibson Girl was followed by the flappers of the 1920s (Kolata, 2004). Like the Gibson Girl, flappers became the ideal and, like the Gibson girl, they were not real (Kolata,

2004). As Gina Kolata writes in her book *Rethinking Thin: The New Science of Weight Loss*,

> By the 1920s, they no longer wanted to be Gibson girls. Now they wanted to look like the rail-thin flappers they saw in drawings by artist John Held, Jr. Like the images of the Gibson Girl, these were *drawings*- and not even drawings of real women. They were drawings of a man's fantasy of woman. But they set the standards for what a woman's body should look like.

The biggest difference between the Gibson Girl and flappers was that flappers were geared more toward promoting fashion accessories and the Gibson Girl was more about looks and allure. The trend of a continually shrinking ideal body has continued. From 1922 to 1999, Miss America has gone up 2% in height and down 12% in weight (Kolata, 2004). Men were not exempt from this change in standards; before the turn of the century there had been a number of fat gentleman's clubs were man could boast about their weight and how much they could consume at one time (Kolata, 2004). While they had not been completely socially accepted as a group, they had carved out a niche for themselves, especially in the upper class; this was completely shattered once the standard started to become thinner and thinner (Kolata, 2004).

Kolata (2004) attributes these drastic changes to three inventions—the bathroom scale, the full-length mirror, and photography. If we extrapolate the use of these items into today's culture, their profound effects can still be seen. Those are the three major ways that we use to criticize ourselves; people use these items as tools to obsess about the way they look (Kolata, 2004). While many of us associate being weighed with the medical profession and our health, doctors did not regularly use scales until *after* the height and weight charts were created by insurance companies (Czerniawski, 2007; Kolata, 2004). The availability of photography during the early part of the century made it possible for people to view themselves as other people saw

them, giving them a new angle from which to criticize themselves (Kolata, 2004). Photographs were also used for the first time in magazines and newspapers, which could show real models, actors and actresses (Kolata, 2004). By this point, the new thin ideal had already taken over, so the actual real-life representations that people had access to were trying to mimic the Gibson Girl or flappers that preceded them (Kolata, 2004).

On top of promoting thin people as an ideal, the media today is constantly criticizing the shape and size of bodies, much more so than even ten years ago (Seligson, 2008). It is hard to go a day without hearing about how a certain celebrity has gained weight, or that another has lost weight and looks "amazing", even if one is not looking for this type of information. It is present everywhere from TV commercials to the grocery store checkout line to online pop-up ads. With the way that advertising has changed since the beginning of the 1900's—to play into the emotional vulnerability of its market (Featherstone, 1982)—it is no surprise that businesses in today's culture use weight in order to get attention. Journalism has also taken up weight, obesity in particular, as a topic that causes a moral panic among its readers (Campos, 2004). The results of this have been very negative for the fat community, because there is a certain amount of credibility that is associated with journalism and much of what is reported is not a balanced view of the conflicting research (Campos, 2004). This assumed credibility gives a confounding stance to the public view that excess weight is bad; if information is received from a credible established source, then that information is much less likely to be questioned.

Both journalism and the mass media have helped in standardizing the idea that thin people are both normal and ideal. When giving examples of fat people, such as an article that is talking about the rise of obesity, the person the article is examining is going to be an extreme example of a fat person in order to make the issue more vivid (Campos, 2004). The result of this

is that when people think of an overweight or obese person, they automatically jump to this

conceptualization of an extremely large person who has "lost control" and needs help to be

"saved from their fat". In actuality, fat people make up a much broader range of weights than this

extremely stigmatized extreme (just as thinner people do not all have the same weight, but a

range). A further consequence of this over exposure of extremely fat people and promoting

extreme thinness as the ideal is that society as a whole is not exposed to the entire range of sizes

that actually comprise it. This leads us to believe that these two extremes (extreme skinniness

and extreme fatness) are normal when they are not. The impact of this on body image and self-

esteem is that we (fat or thin) do not have the opportunity to think of fat people as attractive

because the public does not see them and the few that are seen are so steeped in negativity that

any positive correlations to that body type are all but impossible. Granted, there have been some

body positive ad campaigns in the very recent past, but they are a drop in the bucket compared to

the prevalence of 'thin is ideal' and 'fat people are disgusting and unhealthy' messages in the

mass media.

One example from contemporary culture that plays into the media's preoccupation with

ideal bodies is the phenomenon of bodysnarking. Bodysnarking is the almost constant and very

public criticism of other people's, particularly women's, bodies. Between the media's increased

focus on picking apart unflattering photos of celebrities (usually taken without permission by

paparazzi), and the common practice of teens and young adults taking pictures and uploading

them online, nitpicking at the way other people look is a common practice (Seligson, 2008). The

websites that these photos are uploaded to are designed to be able to leave comments on the

pictures, giving anyone freedom to criticize as they see fit, or even blog about those photos in

their online journals (Seligson, 2008). The potential negative impact of this practice on young

people is profound; it makes the projected ideal even more damaging because it is no longer a general criticism of people who are not "ideal", but makes it personal by the young people becoming the specific targets of the ridicule. Young people who have problems with body image and self-esteem have an even harder time trying to be okay with themselves when they are a direct target of the scrutiny; they do not have the mindset to deal with that kind of pressure, and they should not have to.

As I have mentioned, socioeconomic level is a very important factor when it comes to understanding weight ideology. When food was hard to attain, thinness was associated with being poor; now that food and healthcare is readily available it is associated with the rich and elite because it is the harder physical form to achieve (Campos, 2004). In Dietz's PowerPoint slides that contributed to conceptualizing obesity as a disease, the first states to reach his 'epidemic' level were Mississippi, Alabama, and West Virginia, due to the fact that these states are largely rural and poor (Evans, 2006). Because it takes so much time and effort for people to stay thin—denying themselves food and exercising more than necessary to make up for lower metabolism—it becomes a full-time job (Campos, 2004). People with a lot of money are the only ones that can afford to make this kind of commitment; poor people have to work longer hours and have less income to spend its on non-necessities, like a gym membership, diet pills or a personal chef (Campos, 2004). There is also the issue of availability of healthy food; poor people, such as those in inner cities, do often not have access to fresh food. Processed food is cheaper than fresh fruits and vegetables as well, meaning that processed food is going to be picked over fresh if it stretches the budget farther. This discrepancy could account for some of the associations between excess weight and poor health—lack of a balanced diet.

Race, while having its own set of cultural problems and prejudices, is also a factor when

talking about weight prejudice (Campos, 2004). As one might imagine, because racial and ethnic minorities tend to have lower socioeconomic levels, they also tend to be more overweight and obese (Campos, 2004). The interesting thing about non-white minorities in relation to weight is that they tend to have a much better body image than whites do (Campos, 2004). A study done at the University of Arizona found that while only 10% of white teenage girls were happy with their bodies, about 70% of ethnic minorities were happy with their bodies, even while minority women weigh more than white women (Campos, 2004). This could have some major positive implications considering that studies have yet to find any correlation between health problems and overweight or obesity in black women (Campos, 2004). Instead of looking at the better body image of minority girls versus white girls as a positive thing, obesity researchers recommend that those results, "Should be used in the development of culturally sensitive Public Health intervention programs to help reduce the high rates of obesity within the black community and encourage black youth to achieve a healthy and reasonable body size" (Campos, 2004, p. 89). They are basically saying that minority girls need to be "sensitized" to the "fact" that they have better body image than they should, and that they should try to lose weight (Campos, 2004).

Besides just having the resources (in general, being affluent and white) to accomplish having a thin body, there is virtuousness tied to having a thin body (Campos, 2004). Much like a number of religions that promote moderation and discipline, there is a notion that if you are thin you are presumed to have discipline and self-control; this makes you a better person than those who do not (Evans, 2003; Campos, 2004). Herein lies the moral panic that causes so many people to be fat phobic in the Western world—we have taken strong values of our culture and projected them onto our body size (Evans, 2003; Campos, 2004). Similar things have happened in the past such as with rock and roll during the mid-20th century. The mainstream culture at the

time felt threatened by the new music and the 'loss of morals' it promoted—they thought it was going to corrupt and ruin their children (Campos, 2004). It may not seem like the rise of a musical genre is similar to weight gain, but it is. Both of these things have the power of contamination (Campos, 2004). Just as those in the 50s and 60s were afraid of rock and roll facilitating onto their lives (a perceived threat), people are now afraid of fat, which is also a perceived threat. Rich white people are not likely to become poor or nonwhite, but they could become fat and this creates tremendous fear (Campos, 2004).

As far as the social consequences of being fat, that fear is quite warranted. Fat people encounter a multitude of harms, from insults to job and housing discrimination (Campos, 2004; Wann, 1998). Without going into specifics about the different types of discrimination (this will be discuss this in the next section), it is rather amazing that fat people do not have worse problems than they do regarding body image and self-esteem (Campos, 2004). Fat people are told that it is their fault that they are fat and the prevalence of this belief has made life miserable for many fat people (Campos, 2004; Kolata, 2007; Wann, 1998). What could be more damaging to someone's self-esteem than being told, not only are they not good enough (by being fat), but that they are also a continual failure because they fail to become thin? This may sound rather cruel, but this is not only in public opinion towards fat people; it is has also become the rationale of many public organizations. People are being told that they should lose weight in order to avoid being discriminated against (Campos, 2004). Considering the evidence available, including studies cited earlier, which show the way people's genetics work with the environment to give them the best ('best' meaning suited for survival) body possible, and that losing weight often causes health problems, it is like telling a black person to become white in order to gain the privileges of a white person.

The absurdity of this circular logic is summed up rather nicely in the way diets are marketed and the actual outcome of the diets themselves. If one sits through an hour of television on virtually any TV station, they are bound to come across some kind of advertisement for weight loss. Two of the major themes that you see in almost every commercial is that losing weight will make one look and feel better about oneself. Some go further and talk about the (largely false) negative health implications of being fat and some even go as far to recognize that it is a lifelong commitment (though this is rather rare, most weight loss commercials focus on getting thin *now*). Considering that this is a $50 billion per year industry, one would expect there to be some kind of proven success in a number of the methods advertised. The truth is that 95 to 98% of diets fail (Campos, 2004; Kolata, 2007; Wann, 1998). These failures are not attributed to the companies and their products; their failure is blamed on the dieters (Campos, 2004). There is no other market within our capitalist society that blames the failure of its products solely on the consumer. If this were any other product—say a car, a frying pan, or a clock—and the car does not run, the frying pan will not cook things, and the clock does not tell time, consumers would not buy that product or want their money back when it does not work; they would not tolerate the failure of the product, much less be blamed for its malfunction. This failure of diet products is not for lack of 'proper' use the product. People try incredibly hard to try and get diets to work-why else would they be willing to invest so much money if they were not putting forth the effort? I have also discussed how much genetics and bodies designed to survive starvation impact attempted weight loss (or gain); our bodies do everything they can to maintain a steady weight so attempting to stay on some kind of 'weight loss' regimen is being fought by the body itself. The diet industry is selling products that go against our bodies' designs; it should not be a surprise that they do not work, yet people continue to pay for products that never worked in the first

place.

In regard to body image and self-esteem, it is clear that the cards are stacked rather heavily against those who do not have a body type that is close to the social ideal. Because these issues are wrapped up in so many societal influences, such as race, socioeconomic status, and the media, it can be difficult to see where the prejudices spring from. I have done my best to point out the basics of the impact of size discrimination on body image and self-esteem and how it is harmful to fat people emotionally. While I have touched on a number of issues, is important to note that there are multitudes of personal stories that reflect the problems I have pointed out and also run much deeper personally for many people than the scope of this paper can cover. From here, I am now going to take a look at the more public implications of size discrimination, and how damaging it is to fat people on a social level, outside of body image and self-esteem, to live in a world where their bodies are labeled as unsatisfactory.

<u>Social Justice</u>

The social realm is another place that obesity has taken hold and sorting out its consequences are, once again, not "simple". There is an incredible amount of discrimination against fat people in a variety of social arenas. Thus far, I have explored medical research surrounding of the relationship between fat and health and looked at the effects of fat hatred on the body image and self-esteem of fat people. In this final section, there are two areas of social interaction that I would like to focus on. The first is to highlight the sheer scale and threat to the well-being of fat people by having excess weight being seen as both unhealthy and undesirable. The second is to explore some of the reasons the hatred of fat has become such a big problem and to suggest some possible changes in order to reduce or negate its profound negative impact.

As one might expect, the overabundance and widely publicized (though not necessarily credible) research linking fat to health problems has an impact on the way doctors view and treat fat patients. Doctors tend to focus solely on weight as the source for health problems, instead of looking for direct causes (Kolata, 2007; Wann, 1998). I have come across these examples of discrimination hundreds of times through online forums and personal conversations, as well as in the academic literature. People have been told they cannot be helped unless they lose weight first (Kolata, 2007; Wann, 1998). One woman was told by her doctor that she was trying to commit suicide by gaining weight and that she had two options—to be checked into a mental institution or have her jaw wired shut so she could not eat (Kolata, 2007). The same person was also told, on another doctor visit due to a fall that resulted in a swollen knee, that the reason she fell was because she was so fat and that they could not do anything for her unless she lost weight (Kolata, 2007). Other symptoms that have been brushed off because of weight include sharp heel pain (actually plantar fasciitis), nasal congestion (a sinus infection) and shooting lights in the field of vision (a brain tumor) (Wann, 1998). These examples are just a small glimpse at the negative way fat people are treated by doctors.

There are studies that report that many doctors find fat people disgusting and some even refused to treat them (Kolata, 2007). Two stories that I have come across exemplify the medical field's prejudice against fat people. The first, relayed in Marilyn Wann's *Fat!So?* (1998), is of a woman who went to the doctor because of a cough and while initially the doctor focused on weight (and the patient explained that was not why she was there), the doctor ordered x-rays of the women's chest. On the second visit the doctor was ready with a handful of weight loss pamphlets and a speech about how bad fat is—she had all but forgotten about the x-rays; there was an abnormality and she had to be tested for cancer. On the third trip back the doctor was

ready with more pamphlets and she was exasperated when the patient said she was not there to

lose weight,

>'Well, I just don't even know why you bother to come here if you're not going to listen to
>
>what I say' [the doctor] said. 'I came to find out if I have a lung cancer' I said through
>
>clenched teeth. 'Oh,' she said. You could tell she had forgotten. I did not have lung
>
>cancer. (p. 43)

The second story is relayed in Kolata (2007):

>A fat man […] happened to be hospitalized when a man in the next bed to him began
>
>having a massive heart attack. Doctors rushed in and put paddles on the fat man's chest,
>
>jolting him with an electric shock to restart his heart, while the man whose heart had
>
>stopped was ignored. 'They assume that if someone was having a heart attack, it had to
>
>be the fat one,' [the storyteller] said. 'So they failed to save the man who was having a
>
>heart attack'. (p. 69)

These stories may sound shocking, but they are common stories posted on any fat

positive forum. The blame placed on fat has serious negative consequences for the actual health

and well-being of fat people. Because of the high likelihood that this type of discrimination will

happen when visiting the doctor, many fat people try to avoid going to the doctor at all costs

(Kolata, 2007; Wann, 1998). This fact in and of itself could account for many of the correlations

that are found between excess weight and poor health; if one avoids going to the doctor then they

are much less likely to get help for a medical problem until it is severe and harder to treat

(Campos, 2004; Kolata, 2007; Wann, 1998). Even if a fat person wants to go to the doctor, it

would be much less likely that they could afford to go as fatness correlates with lower income

levels (Campos, 2004), which means that they are less likely to be able to afford insurance as

premiums for fat people are much higher than for thin people (Wann, 1998). Doctors rarely take

into account the physical activity or diet of the people they are treating (fat or thin) and this has

serious ramifications for everyone (Jutel, 2001). Studies have shown that people who fall into the

categories of overweight and obese and exercise regularly have better overall health than thin

people who do not (Jutel, 2001; Kolata, 2007). If a doctor discounts eating habits and exercise

and looks at body weight as the determining factor of health, they will not only more likely to

prescribed a diet to a heavier person (which do not work and can be dangerous), but they also be

less likely to prescribe healthy eating habits and exercise to a thin person, because the doctor

presumes that is what they are already doing (Jutel, 2001).

There is overt discrimination against fat people in the areas of housing, education, and

employment. Landlords are less likely to rent to fat applicants than they are thin applicants

(Wann, 1998). Studies have also found that fat people are less likely to be admitted to elite

colleges (Kolata, 2007). Employment, which is very much interconnected with housing and

education, shows quite a bit of discrimination in regard to weight. Fat people are less likely to be

hired, make less money than their thin counterparts and are less likely to be promoted (Kolata,

2007). A survey taken by fat men and women members of the National Association to Advance

Fat Acceptance (NAA FA) showed that over 40% of men and 60% of women had not been hired

for a job due to their weight; over 30% said they had been denied a promotion because of their

weight (Kolata, 2007). One of the respondents commented that the management of his company

had told him that he would not be promoted until he lost weight; the union he belonged to took

the company's side (Kolata, 2007).

These examples of discrimination in medicine, housing, education and employment are

small parts of the entire cycle that help perpetuate the fear and loathing towards excess weight.

While it may not be the easiest thing to do, many fat activists are working from a grassroots or individual level to try and make improvements to the institutionalized hatred of fat people. On Marilyn Wann's website, www.fatso.com, there is much talk about how to stand up to and explain fat positiveness to people in positions of authority. One example is, when going to the doctor's office, refuse to be weighed (Wann, 1998), and explain to the doctor and/or nurse the exact reason for the visit and that weight loss is not an option so it does not need to be discussed.

It also is the responsibility of the medical community (whose opinions, as we have seen, have a huge impact on social thought) need to be more forthright with the opposing evidence to commonly held beliefs about excess weight; they have largely failed to do this even when given the opportunity. The 1999 *JAMA* study examined earlier that attributed 300,000 deaths to excess weight and its questionable methodology had caught the attention of other researchers who are trying to answer the question of how many deaths are related to excess weight (Kolata, 2007). These researchers did their own study trying to correct for all of the issues they saw with the already published study. They used a representative sample of the population, which the first study did not and the height and weight data was recorded by a researcher, not reported by the participant, as much of the former study's data had been (Kolata, 2007). The result was a much lower number of deaths associated with excess weight, with a U-shaped pattern of mortality rates with the overweight range being the lowest point.

A firestorm of critical attention from the obesity research community followed its publication (Kolata, 2007, Oliver, 2006). Obesity researchers who did not agree with their findings criticized everything from their methods to their personal credentials; Harvard even held a seminar to refute the findings and invited the press to be there (Kolata, 2007, Oliver, 2007). This type of response is virtually unheard of in research; studies are critiqued through more

research, reviews or possibly at conferences, but not in what was essentially a press conference

(Kolata, 2007). Along with this conference, the Disease Control (CDC) gave its own response.

Oliver (2006) recalls,

> The CDC issued a set of "talking points" to state health agencies claiming that "despite
>
> the recent controversy in the media about how many deaths are related to obesity in the
>
> United States, the simple fact remains: obesity can be deadly". Scandalously, the CDC
>
> presentation went on to assert that "obesity causes about 2/3 of diabetes, 2/3 of heart
>
> disease, 20 percent of cancer in women, and 15 percent of cancer in men," when, in fact,
>
> there is absolutely no clinical evidence to make such a causal claim. In the name of
>
> sustaining its own political agenda, the nation's leading health agency was issuing
>
> statements about health that were patently false. (p. 621 *references omitted)*

This type of sweeping statement made with no evidence is deplorable; the public deserves better

than that. Statisticians outside of obesity research were impressed with the newer findings as the

well thought out research methods the study utilized. This included presenting multiple

statistical analyses that controlled for different factors, such as smoking or prior illness, in order

to see the impact of these different variables had on the entire sample (Kolata, 2007). Overall,

their findings ended up being explained away or ignored by people that did not want to hear

them (Kolata, 2007).

From the perspective of social justice, it should be a *good* thing that fewer deaths are

attributed to obesity, not a bad thing (Kolata, 2007). It seems incredibly counterintuitive in a

field that is supposed to be enhancing the health and well-being of people with excess weight to

be outraged at findings that say excess weight is not as unhealthy as previously thought and even

go as far to make drastic false statements. How then, is there such disassociation in the field of

obesity research that positive findings are ignored in order to perpetuate negative ones? Campos

(2004) presents the theory that the reason for the disassociation is that the concept that fat is bad

is what the whole discipline is based on; therefore, any alternative interpretation does not make

sense. For many obesity researchers (as well as the public), excess weight not being bad for you

is quite literally an 'unthinkable thought' (Campos, 2004). To an extent this reasoning makes

sense; if the entire reason one is working in a certain area is one particular principle, the idea that

this basic principle is flawed will hardly be well received (Campos, 2004). This of course, does

not make it acceptable. Our culture has already gone through the process of trying to correct past

indiscretions towards other minority groups; the way those people were being treated through

science and culture was not right and steps have been taken to try and rectify these wrongdoings.

Correcting these past indiscretions is what fat activists are now trying to promote through

education and awareness and it is just as hard to do on a social level as it is in the medical

research community.

      This society makes it extremely difficult to live a fulfilling and happy life as a fat person.

Fat people are the only minority towards which people still feel comfortable openly discussing

and criticizing their perceived 'problem' of excess weight in the sense that people think it is the

fat person's fault for being that way (Campos, 2004). Even those who believe excess weight is

due to environment and not personal choice, like William Diets who created the PowerPoint

slides, still propose that being thinner is better. In the NAA FA survey previously mentioned,

90% of the respondents said that their friends or relatives ridicule them or make nasty comments

about their weight and three quarters said they had been laughed at or derided by coworkers. One

of the respondents wrote, "While attending a lecture in college, a professor stopped speaking in

the middle of a sentence and said, 'when are you going to lose weight? You are really fat.'

There were over a hundred people in the class" (Kolata, 2007, p. 69). This kind of treatment towards anyone is reprehensible; people (for the most part) police themselves and others against this kind of behavior toward any other minority, but fat people are still the exception.

As I have said, the ridicule of overweight is, for the most part, tied in with the idea that people have the ability to control how much they weigh. Regardless of what research says about weight, as far as social acceptance is concerned, this idea that people can control their weight at will does not make sense. Campos (2004) illustrates,

> If […] nearly two out of every three adults Americans weigh too much, while living in a culture which weighing "too much" brings with it severe social condemnation, poverty, job discrimination, poor self image, and a host of other well-documented disadvantages, why would anyone believe that a significant proportion of those people could actually managed to acquire and maintain more socially acceptable bodies? (p. 124)

If losing weight were really that easy to do, people would do it; there would not be an issue surrounding it, because it would just happen. There would be no reason to talk about it, much less have research, reports and national organizations dedicated to it.

There is a multitude of ways that people are reminded daily of how much they weigh or, more importantly, how much society thinks we should weigh. From advertising to TV shows to the diet food lining the shelves in supermarkets, people are told that they need to pay attention to their size. On top of the ingrained awareness of weight, getting or maintaining a thin body is seen as a common goal that people feel comfortable talking openly about. Once I started being aware of this concept and started paying attention to how many times weight comes up in daily conversation, I was amazed. People in our culture have a preoccupation with weight that is so embedded that it has become part of how we value ourselves (Campos, 2004). This connects to

what I discussed earlier about thinness being associated with virtue, but this is a subtler practice that has engulfed almost our entire culture. People put so much value into what they look like and how much they weigh that they end up not enjoying the two things that are most important for physical health—diet and exercise.

People get many conflicting messages about food (Campos, 2004); for example, there are as many varieties of low-fat and diet ice cream as there are super-premium ice creams. One focuses on 'health' and the other on 'indulgence' as though they are mutually exclusive. This type of contradicting food variety increases the awareness of the perceived link between food and body size. There is also the issue of trying to pay attention to the body's cues about food. Restaurants provide huge portions and advertisements entice consumers to eat certain foods, regardless of whether or not they are actually hungry. Because of these types of environmental cues, people have lost their instincts about food (Campos, 2004). Our culture has also attached intense emotion to food; connotations of things such as "home cooking" generally elicit good feelings, but for the most part, people associate food with guilt. Many diet programs, particularly in the past, claimed that there were certain foods that should be "off limits" because they were "bad". While this message is not promoted in quite the same way today, the sentiment is still present. More often than not when I have had conversations about food, someone mentions that they feel "guilty" for eating a certain kind of food or for eating too much. It is as if people are constantly feeling bad about what they are eating either while they are eating it or after they finish. In terms of life fulfillment, this makes no sense. I argue that food, because it is so intrinsic to people's daily lives, should be something that is focused on much less; it should be a small part of daily focus, not something that is obsessed over. Eating healthy food is important, and is something people should strive for, but it also makes sense to enjoy the overall experience

with food. One of my favorite things to say when talking about a healthy diet is, 'have desert, but eat a salad, too'. There needs to be balance in the food people consume as well as the time spent focusing on food; the way it is obsessed about now leaves no room for enjoyment.

Exercise is the other major factor for being physically healthy, but its function is now distorted and is seen as negative. For many adults in our culture, exercise is seen as a means to lose weight (Campos, 2004). While it is possible that exercise may cause some weight loss, it often does not (Campos, 2004). Because of the association between exercise and weight loss, many people only see exercise as a tool to lose weight and not something that needs to be done to be healthy in and of itself. The result of this is that when people do not get the weight loss they want when they exercise, they stop because the exercise is seen as 'not working'. This is actually the worst thing someone could do; studies have shown that an active heavier person has a longer life expectancy than a sedentary thin person, showing that exercise is more important than weight in terms of health and longevity (Campos, 2004). Exercise also has the association of being a type of punishment (Lowery et al., 2005), perhaps because it is associated with dieting or because there are many other 'easier' and 'more fun' options in our culture today. Once again, the result is that people do not do it as much as they should, which decreases their health. Along with the association that exercise equals weight loss and exercise being seen as punishment, there is a prevailing image of what someone who exercises should look like (Grogan, 2006). Because exercise is associated with thin, muscular people, those who do not have that body type can be discouraged from exercising, because they feel they do not have the 'right kind' of body (Grogan, 2006). This is another paradoxical situation that is brought about by the associations of weight loss in our culture; people think that they have to exercise to be thin, but that they also have to be thin to fit the social standards of the exercise community. Even

if the idea that exercise equals weight loss were true, many fat people are discouraged from being involved because they do not 'look the part' (Grogan, 2006).

The 'moral panic' discussed earlier relating to body size and the virtue this culture associates with it is also present in the social justice part of the issue. Our consumer culture has many problems that it has to deal with, much of which is related to the consumption—war, global warming, dwindling natural resources, etc.—and these worries are waylaid in part by obsessing about weight (Campos, 2004). These big issues are things that people do not have direct control over and as a result fat has become a scapegoat to rectify the culture's problems. Campos (2004) illustrates,

> [People] may drive environmentally insane SUVs that dump untold tons of hydrocarbons into the atmosphere; [people] may consume a vastly disproportionate share of the world's diminishing natural resources; [people] may support a foreign policy that consists of throwing America's military weight around without regard to objections from our allies— but at least [they] don't eat that extra cookie when it's offered to [them]. (p. 235)

Because people feel as though they do not have control over these big things, they are exercising their control where they have it- over their diets (Campos, 2004). Once again, because there is a perceived correlation between food consumption and body size, there ends up being animosity towards fat people.

All of these social issues relating to fat are in large part perpetuated by the majority of the institutions in our culture. For example, journalism is seen as a credible source of information, and the fact that much, if not all, of the journalism on obesity is negative has damaging consequences for the way people think about it. I think it is reasonable to question institutions on their misrepresentations of obesity in regards to social responsibility and the people they affect.

People also need to be more skeptical of the information that they hear in relation to weight and health. I have pointed out a number of flaws in the argument against fat and they are not hard to comprehend; people just do not know to look for them. If more people were aware that what they are being told about fatness is not the truth, they might take a harder look at the information they are given, and learn the truth for themselves. This, in turn would have an impact on the institutions that produce the information. If people refused to put up with (or pay for) the messages given out by the diet industry, then those companies would alter their practices to reflect what the consumers want. If more people realized that health can be attained at a range of sizes and wanted help with obtaining health and satisfaction within these parameters, the diet companies could shift their practices to help promote them. This would not be an easy process for the companies, but it can happen. Institutions are designed to perpetuate themselves; they change to meet the demands of those that support them. It is the people's responsibility to make this happen. What I have just proposed may sound naïve on my part, but in actuality it is that type of process that happened in other minority movements, just in different ways. I have no doubt that this type of change would take years or decades, but it is possible.

As discussed in relation to a number of different points, money plays a large part in perpetuating the view that excess weight is dangerous. The weight loss industry alone makes 50 billion dollars annually on products that do not work for 95 to 98% of the people they are sold to (Campos, 2004; Kolata, 2007; Wann, 1998). Granted, they are businesses, but as I just proposed, they could be using their money in more constructive ways. Individual people could be spending their money on things like necessities or helping out others. Wann proposes several suggestions in *Fat!So?* (1998) for large scale philanthropy that would be possible with the money given to the diet industry are: increase Medicade services by 20%, provide three times more federal

funding for both the Environmental Protection Agency and federally funded day care for working parents, provide nine times as many free school lunches for disadvantaged children, etc. These examples speak directly to the idea that people focus on their diet as a way to ignore bigger problems- they could use the money they spend on dieting for things that are really important. Even if people do not spend that money on humanitarian endeavors, they could use it for something they get enjoyment out of, thus improving their quality of life instead of frustrating themselves trying to achieve a body that is impossible for most to attain and possibly putting their health in jeopardy in the process.

The fact that pharmaceutical companies and bariatric surgeons promote their products and procedures despite the drastic health risks associated with both is something that the public should be outraged about and be resistant to. The risks of bariatric surgery I discussed earlier are not well known, but the risks of pharmaceuticals are very well known, and yet diet pharmaceuticals continue to be a strong component in the diet industry (Campos, 2004). Drugs like phen-fen and Redux were taken off the market due to links with heart valve damage; they had not been given proper testing before they were released for widespread sale—the Food and Drug Administration found this out after million of prescriptions had been filed (Kolata, 2007). This is a vicious cycle—people are willing to put their pocketbooks (and in some instances their lives) on the line in order to try and reap the social benefits of a thin body. This mentality has to stop; too many people are paying too much (in money, emotions, physical health and social well being) for an unattainable illusion.

In response to all of the negative connotations, discrimination, and expenses (monetarily, physically, emotionally and socially) that fat people have to deal with, a fat acceptance movement has been created. Two major organizations, the NAAFA, and Health at Every Size

(HAES) promote understanding and acceptance of fat people and the issues around weight and health. There are also, as I have mentioned, fat positive websites, such as fatso.com, that are an outlet for people who deal with fat discrimination. Forums on websites like this give people the opportunity to create a fat-positive community; a place where they can share their stories and find support and advice. There is also a growing academic realm, called fat studies, that is trying to make the issues around weight open to more than one interpretation—that fat is bad. While these are all wonderful resources, fat people have yet to create a fat culture (Wann, 1998). Compared to other minority groups—for instance the LGBT community—established positive cultural norms are nearly nonexistent. Fat people do not have 'fat pride parades' or 'size acceptance community centers' for people to go to in order to find acceptance. As the community grows, these types of resources will eventually emerge, but there is still much work to be done in order to make a change in the way the general population perceives fatness.

The social side of the impact of negative connotations of excess weight has been shown to be rather intricate. People have to deal with discrimination in a multitude of areas that have an impact on everything from education to fitness. While the reasoning behind some of this negativity can be understood due to cultural influences, it does not excuse it. People, as well as institutions, have a social responsibility to others that is seriously lacking when it comes to understanding excess weight. While there are a number of organizations that already exist to try and change this, the fight to promote fat equality is still very much in its infancy. Just like any other minority group, fat people have to educate themselves and others about the flaws in popular culture beliefs in order to make life better for people of all sizes. It may be a long and slow process, but it is at least underway.

Conclusion

Through research and life experience in the fat community, I have shown that there is evidence that obesity is not the problem the public believes it to be in relation to health. However, this popular belief has profound implications emotionally and socially for fat people. The medical research that the public learns about is virtually one-sided: excess fat is bad for one's health. The reality is that there is quite a bit of evidence showing that fat is not inherently bad and that it is possible to live healthily at a much wider range of weights than the ones we are told are "ideal". Genetics and the body's self-regulation also play a large part in the size of people's bodies and help explain why people are becoming larger.

In regards to body image and self-esteem, the unrealistic ideal and the negativity towards fatness has created a lot of stress and emotional hardships for fat people, because they are told that they can and should have smaller bodies. Self-esteem and body image problems have plagued people—particularly women and increasingly more men—for a long time and society's negative attitude toward larger bodies exacerbates the issue. Various implements, namely bathroom scales, full-length mirrors and photography, as well as social standards of acceptable body type getting thinner, have helped keep this issue at the forefront of our social consciousness. These, combined with the social issues related to class and race, continue to make fat people have a difficult time accepting and enjoying their bodies.

Finally, the social realm is also highly negatively impacted by fat prejudice, as fat people have to deal with discrimination in many social areas. Unfair treatment in healthcare, employment, wages, housing, and social settings are all results of the negative attitude towards fat. Our country also uses fat as a distraction from public issues people should actually be worried about. This prejudice also prevents people from focusing on the actually important factors that determine health—eating a balanced diet and exercising. The diet industry has also

capitalized on the obsession with weight and convinces people to pay for attempted weight loss instead of using their money for things that could improve their quality of life. In an attempt to curb the negative effects of fat hatred, fat acceptance advocates have created a supportive community where people can learn to accept their bodies. This movement has yet to create a solidified culture, but it is gaining momentum and helping thousands to learn to like themselves. If I were to edit the opening statement to reflect the actual implications of obesity it would be, "The remedy for the false concept of obesity is to educate oneself and be aware of the ramifications obesity has on people of all shapes and sizes".

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