

## Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity

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**Abstract** Despite recent and growing media attention surrounding obesity in the United States, the so-called obesity epidemic remains a highly contested scientific and social fact. This article examines the contemporary obesity debate through systematic examination of the claims and claimants involved in the controversy. We argue that four primary groups—antiobesity researchers, antiobesity activists, fat acceptance researchers, and fat acceptance activists—are at the forefront of this controversy and that these groups are fundamentally engaged in framing contests over the nature and consequences of excess body weight. While members of the fat acceptance groups

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All quotations in this article are from interviews with the first author unless otherwise noted. Interviews were conducted in person or by telephone between 2001 and 2005 in various U.S. cities.

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embrace a body diversity frame, presenting fatness as a natural and largely inevitable form of diversity, members of the antiobesity camp frame higher weights as risky behavior akin to smoking, implying that body weight is under personal control and that people have a moral and medical responsibility to manage their weight. Both groups sometimes frame obesity as an illness, which limits blame by suggesting that weight is biologically or genetically determined but simultaneously stigmatizes fat bodies as diseased. While the antiobesity camp frames obesity as an epidemic to increase public attention, fat acceptance activists argue that concern over obesity is distracting attention from a host of more important health issues for fat Americans. We examine the strategies claimants use to establish their own credibility or discredit their opponents, and explain how the fat acceptance movement has exploited structural opportunities and cultural resources created by AIDS activism and feminism to wield some influence over U.S. public health approaches. We conclude that notions of morality play a central role in the controversy over obesity, as in many medical disputes, and illustrate how medical arguments about body weight can be used to stymie rights claims and justify morality-based fears.

In the 1980s, when AIDS was ravaging communities of gay men, the latter formed social movements and interest groups to raise the public profile of this epidemic. The AIDS Coalition to Unleash Power (ACT-UP) and other groups demanded more money for research, wider availability of drugs, and greater public awareness (Epstein 1996). Gay men condemned government inaction as evidence of homophobia and used scare tactics to shock the government and country into action. In contrast, in the early 2000s, despite a 2001 surgeon general's report having declared that "overweight and obesity have reached nationwide epidemic proportions" (U.S. Department of Health and Human Services 2001: v) and the World Health Organization (WHO) calling obesity "a global epidemic" (WHO/FAO Report 2002: 3), fat activists have called for *less* public awareness and intervention regarding obesity. Fat activism, which has reclaimed the word *fat*, much like the civil rights movement reappropriated the word *black* and the gay movement reclaimed *queer*, has not rallied behind calls to stamp out the obesity epidemic, of which fat activists are arguably the greatest victims. Rather, the fat acceptance movement<sup>1</sup> has countered such claims by saying that one can be healthy at any size and that claims about obesity being a health risk are simply overblown.

Why has the fat acceptance movement refused to enlist in the war on obesity? This article considers this question by examining the role that moral concerns play in shaping debates over scientific and medical evi-

1. *Fat activism* and *fat acceptance activism* are used interchangeably within the movement and in this article. Another commonly used synonym is *size acceptance activism*.

dence. We suggest that in the case of obesity, debates over the nature of the condition have largely hinged upon underlying moral assumptions about fat individuals and their behaviors. To date, *medical* arguments about the health risks of obesity have been effectively used to stymie *political* arguments about rights for fat individuals, although there is some indication that this situation is beginning to change.

The intersection of medicine and morality is a long-standing interest in social science. Some observers of medicalization have argued that, compared to treating a behavior as sinful or criminal, medicalizing behavior fundamentally “diminishes or *removes blame* from the individual for deviant actions” (Conrad and Schneider 1992: 246, emphasis in original). In contrast, others have argued that the language of medicine merely extends moral judgment in a new guise (Zola 1972; Illich 1976), and more recent health surveillance scholarship has demonstrated how concerns about health risk can offer a thinly veiled language through which to extend judgments of responsibility, blame, and morality (Armstrong 1995; Crawford 1980; Lupton 1995; Nettleton and Bunton 1995). Obesity provides a “strategic research site” (Merton 1987) for studying how moral concerns shape debates over scientific evidence because fatness has been considered both evidence of medical pathology and moral turpitude in the United States since the turn of the twentieth century (Stearns 1997). Furthermore, given that higher weights are inversely correlated with social class in heterogeneous and affluent societies such as the United States (Brown and Bentley-Condit 1998: 149) and that African American and Mexican American women are especially likely to be categorized as obese (Flegal et al. 2002), blaming fat people for their weight may serve to justify and reinforce social inequalities.

However, whether medicalization in fact removes blame or extends moral judgment may depend on how illness is framed by various social actors. Popular lifestyle theories—which attribute illness to personal lifestyle—may be more likely to imply individual blame for illness, for instance, than, say, germ theories (Tesh 1988; see also Sontag 1990). Although previous work suggests that the way illness is framed has important social consequences and despite the growing public prominence of obesity as a public policy issue (see Kersh and Morone 2002), there has not to date been a systematic examination of obesity frames.

Understanding competing obesity frames is substantively important not only because of the increasing prioritization of obesity as a health policy issue, but also because, in the case of body weight, medical frames compete with political rights frames. Since 1969, when the National Association

to Aid Fat Americans (NAAFA, later renamed the National Association for the Advancement of Fat Acceptance)—a “human rights organization dedicated to improving the quality of life for fat people”—was founded, the fat acceptance movement has argued that fatness is a form of body diversity that should be tolerated and respected, much like diversity based on race, ethnicity, or sexual preference. But they have met a different kind of opposition than other identity movements: medical arguments about health risk. By shedding light on how arguments about health risks are used to counter fat rights arguments, the obesity case can help contribute to our understanding of why certain rights claims but not others are successful in the contemporary United States. Such an examination can also clarify why distinct identity movements respond differently to medical issues facing their constituencies.

In what follows, we review the literature on framing and credibility struggles, which provides the theoretical framework for the analyses that follow. After briefly reviewing our data and methods, we introduce the main claimants discussed in the article: antiobesity activists, antiobesity researchers, fat acceptance activists, and fat acceptance researchers. This provides the background for the subsequent discussion of how these different groups frame weight, especially in regard to health and morality, and the disparate impact of these discussions on people based on their gender, social class, race, and ethnicity. We discuss in a subsequent section the ways in which interview respondents establish their own credibility and discredit opponents. Surprisingly, considering their small numbers, we found that fat acceptance arguments are actually having some influence on authoritative approaches to weight. We investigate how fat acceptance activists and researchers exploit available opportunities for social change, including political traditions of antidiscrimination and institutionalized avenues for patient influence in medical expert bodies. In the conclusion, we compare fat identity to other group identities, contrast obesity to other medical and health policy issues, and suggest lines of future inquiry.

### Competing Frames and Credibility Struggles

Work on social problem construction has identified two levels at which competition among social problems occurs (Hilgarten and Bosk 1988: 58). First, for each topic, there is competition between different ways of framing the same situation. For example, in the area of road-traffic safety, claims about reckless drivers compete with claims about unsafe vehicles

(Irwin 1985, quoted in Hilgarten and Bosk 1988: 58). In U.S. abortion debates, pro-choice contingencies frame abortion as about women's right to freely choose if and when they would reproduce, whereas pro-lifers frame abortion as murder of unborn babies (Luker 1984; see also Gamson 1992; Snow and Benford 1988; Tarrow 1992).<sup>2</sup> Different frames imply not only different ways to understand social problems but also different courses of action. Previous work has established the power of antidiscrimination and rights frames in the contemporary United States as a basis for claims making (Epp 1998; Saguy 2003) and has investigated why certain rights claims are more successful than others (Phillips and Grattet 2000; Jenness and Grattet 2001). For instance, having the support of an organized social group has been shown to be important in promoting hate crime legislation for particular groups (Phillips and Grattet 2000). This work has not considered, however, how medical arguments about health risk may be used to stymie rights claims or when this is likely to happen.

The obesity case provides a window into precisely such a phenomenon. In the case of body weight, framing fatness as a sign of body diversity suggests that diversity training, greater social tolerance, and less discrimination on the basis of size are needed. In contrast, framing fatness as a preventable health risk or an illness in and of itself suggests that less tolerance and more public vigilance is needed. Although the body diversity frame draws on U.S. traditions of antidiscrimination and civil rights, the health risk frame draws on well-established patterns of public health interventions against behaviors such as smoking.

When there is ambiguity or the empirical reality is complex, competing frames are plausible, and which frame prevails depends largely on rhetorical skill and the credibility of the claimants. Resituating debates over body size in a medical, rather than political, arena is likely to make medical expertise and authority critical for credibility. Work on "credibility struggles" (Epstein 1996) further leads us to expect that participants will use a variety of strategies to establish their own credibility and discredit their opponents. A careful examination of the obesity case can shed further light on the variety of types of claims that are used in credibility struggles.

The second level at which competition among social problems occurs is contests among diverse social problems for public attention (Hilgar-

2. Although Goffman's (1974) concept of "frame" provided the inspiration for social movement framing analysis, the way social movement theorists use the term is quite different from what Goffman intended (see Heinrich 1991).

ten and Bosk 1988: 58). For instance, claims about the so-called obesity epidemic may be countered by arguments that weight obsession—not obesity—is the real problem. Because the competition for scarce public attention is fierce, in the early stages of social problem formation, there is a tendency for those promoting particular social problems to exaggerate their urgency, leading to a dominance of alarmist claims. Such claims often result in equally alarmist counterclaims, seeking to challenge the original positions. This dynamic suggests that, in such cases, it may be prudent to counsel patience in policy making until a more balanced perspective emerges. Yet, when a condition is perceived as an epidemic with rapidly growing social costs, as is the case with obesity, delays may be seen as extremely problematic or downright risky. In this case, factors that suppress or discourage attention to more moderate frames can be particularly costly.

When competing frames represent opposing dualities—such as alarmist claims about the dire consequences of even a little extra weight versus arguments that body weight, no matter how high, is never a health problem—it may be difficult to capture a more nuanced view of the situation. If the truth lies in the middle, the policy challenge will require finding a more integrative perspective. And the tensions produced by credibility struggles are not simply a natural part of the Hegelian dialectic of knowledge, but may actually undermine the creation of a synthesis that combines the insights from the two competing perspectives.<sup>3</sup>

### Claimants

There is currently disagreement in the United States over many questions related to weight and health, including if or why higher weights have adverse health consequences, what an ideal weight is or whether a universal ideal weight even exists, why people gain weight, why some weigh more than others, and whether weight loss improves health. Despite the complexity of the scientific issues, we identify two camps that have dominated public discussions of obesity in the media and have framed these issues in simpler and competing terms: *antiobesity* and *fat acceptance*. Each of these camps, in turn, includes a research and activist component, so that we can speak of four groups: antiobesity activists, antiobe-

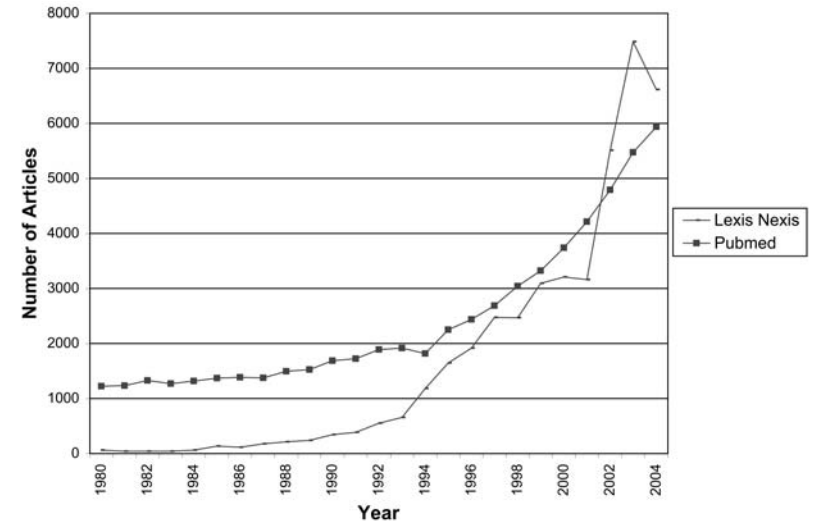
3. In other policy arenas, this has been characterized as the differences between hawks, doves, and owls (Allison, Carnesale, and Nye 1985; Reuter 1992). We are grateful to Mark Schlesinger for this point.

sity researchers, fat acceptance activists, and fat acceptance researchers. In reality, many activists and researchers fall somewhere between these “ideal types” (Weber 1949: 89) at least some of the time. Still, conceptualizing actors as belonging to one of these four groups helps demarcate some of the major disagreements in contemporary debates over weight and health.<sup>4</sup> Below, we describe each of these groups, beginning with antiobesity researchers and then activists, since antiobesity activism has grown out of research. We then present fat acceptance activists followed by fat acceptance research since, in the case of fat acceptance, the research agenda followed in the wake of activism.

*Antiobesity researchers* are researchers who study obesity and argue, in their work and often in public forums, that obesity is an urgent health crisis. We intentionally use the term *antiobesity*—rather than simply *obesity*—research to signal the moral and political valence of their work, that they not only study body weight and health but are also committed to the principle that obesity is an important health problem that needs to be fought. Among antiobesity researchers are scientists trained in a variety of academic backgrounds, including epidemiology, psychology, nutrition, and neuroscience and involved in diverse kinds of research (from statistical analysis to rat experiments) and clinical practice (mainly weight-loss clinics although one—Kelly Brownell—also treats eating disorders). They argue that overweight and obesity have dire consequences for health and that increasing population weights represent an alarming trend. They advocate for a range of public responses, including increased public investment in obesity research, public policy initiatives, and personal responsibility for maintaining healthy body weight.

The view that obesity is a serious health problem dominates studies of obesity. As shown in figure 1, medical research on obesity has ballooned since 1995 and has preceded a subsequent increase in mass media reporting on obesity. Mass media reports on obesity draw heavily on antiobesity research and interviews with antiobesity researchers. Antiobesity researchers also dominate obesity expert panels at the National Institutes of Health (NIH), Federal Drug Administration (FDA), and WHO. A few, like Marion Nestle, author of *Food Politics* (2002), or Kelly Brownell, author of *Food Fight* (Brownell and Horgen 2003), have published

4. A drawback of this way of presenting the debate is that many more moderate perspectives are difficult to reconcile with this schema. Among these are an increasing number of what could be called “obesity skeptics,” including scientists, social scientists, journalists, or others who are skeptical about the extreme claims regarding obesity but do not assert that obesity is not a problem at all.



**Figure 1** Articles about Obesity in Medical Research (PubMed) and the Mass Media (Lexis Nexis), 1980–2004.

books destined for a wider public. Based on nonsystematic observation and according to many of the interview respondents, most antiobesity researchers (especially if they are women) are themselves thin and closely monitor their weight, although a few fluctuate in weight and struggle with weight-loss diets.

Antiobesity researchers are supported by and participate in several antiobesity organizations that advocate for more federal funding for obesity research and higher prioritization of obesity as a health crisis, such as the North American Association for the Study of Obesity (NAASO, founded in 1982), the International Association for the Study of Obesity (IASO, founded in 1986), the American Obesity Association (founded in 1995), and the International Obesity Task Force (founded in 1996 and joined IASO in 1997). Since the 1970s, there has been a medical specialty of “bariatric medicine” (Sobal 1995), specializing in weight loss and represented by associations such as the American Society of Bariatric Physicians and the American Society for Bariatric Surgeons. These organizations have a professional interest in raising public concern over obesity. Specialty journals dedicated to obesity include the *International Journal of Obesity*, IASO’s official journal founded in 1976, and *Obesity Reviews*, founded by IASO in 2000.

We define *antiobesity activists* as people committed to the antiobesity movement who do not do primary research, but who are involved in fighting obesity in other ways. Antiobesity activism draws on antiobesity research to publicly argue that obesity has become an alarming health threat that demands public intervention, research funding, and private action. Well-known works by antiobesity activists in recent years have included Eric Schlosser's (2001) *Fast Food Nation*, Michael Fumento's (1997) *The Fat of the Land*, and Greg Critser's (2003) *Fat Land*. Other antiobesity activists includes Morgan Spurlock, author of the documentary "Super-Size Me," and George Washington law professor John Banzaf III, who has brought lawsuits against fast-food restaurants for contributing to obesity and has threatened to sue doctors who do not warn their overweight or obese patients of the health risks associated with overweight and obesity.

In opposition to antiobesity activism, fat acceptance activism has long rejected the term *obese* because its participants claim that this term pathologizes heavier weights and that weight should be a political rather than medical issue. NAAFA, which describes itself as "a non-profit human rights organization dedicated to improving the quality of life for fat people," is the only nationwide fat acceptance organization. NAAFA speaks out against discrimination based on body size in such areas as airline policies that require people who cannot fit into one airplane seat to purchase two at full price, the weight-loss industry, offensive advertising, and negative media representation. NAAFA works to gain legal protection for fat people by educating lawmakers and serving as a national legal clearinghouse for attorneys challenging size discrimination. NAAFA also provides emotional support to fat people by offering workshops and support groups during the annual national convention and local chapter meetings designed to foster self-empowerment. The NAAFA annual national convention and state chapter meetings also allow fat women and their (mostly thin) male admirers (known as fat admirers or FAs) to meet and socialize. Indeed, most NAAFA members are not activists at all but come to socialize and meet romantic partners (see Goode 2002; Saguy 2002). FAs have played an integral role in fat acceptance. For instance, the founder of NAAFA and several past chairs were FAs.

Other fat acceptance organizations include the International Size Acceptance Association (ISAA), an outgrowth of NAAFA, which has chapters in several U.S. states, Canada, France (via the affiliate Allégro Fortissimo), the United Kingdom, Norway, and Russia; NOLOSE (National Organization of Lesbians of Size); and the feminist-oriented Largesse. The Council

on Size and Weight Discrimination acts as a consumer advocate for larger people, especially in the areas of medical treatment, job discrimination, and media images. In the 1970s, the Fat Underground (FU) denounced fat prejudice from a radical feminist perspective and in 1988, a member of the NAAFA Research Committee and the National Organization for Women (NOW) jointly founded the Body Image Task Force (BITF) (Cooper 1998: 133, 151) to promote "consciousness raising on the issues of 'looksism' and 'fatphobia' and their connection to other forms of prejudice, especially sexism" (BITF 2003).

The number of people involved in the size acceptance movement is relatively small and includes few minorities or very low or very high socioeconomic status participants, even though obesity in the country at large is associated with low socioeconomic status (Sobal 1999). NAAFA had no more than two to three thousand paid members in 2001, according to a member of the NAAFA board. Based on participant observation at the 2001 Annual Convention and interviews with NAAFA members, female NAAFA members (as opposed to male FAs) tend to weigh between 250 and 600 pounds. This membership base shapes the association's key concerns, including making seatbelt extenders mandatory in cars, finding solutions for people too big to fit in one airline seat, or making available magnetic resonance imaging (MRI) machines that accommodate someone over 350 pounds.

Unlike other identity movements, the fat acceptance movement has run into resistance from medical researchers who argue that what they claim to be a largely immutable aspect of identity (fatness) is actually a preventable health risk (obesity). This has forced the fat acceptance movement into scientific debates over obesity. Leading fat acceptance activist Lynn McAfee, who is director of medical advocacy for the Council on Size and Weight Discrimination and takes part in obesity conferences and government panels on obesity, explains why she became involved in debates over medical activism:

I'm not actually particularly that interested in [health] and God I hate science . . . but I recognized very early on that if we are ever to succeed, we have to get a foothold in the medical world and make them understand. And that's what I've tried to do because, when it comes down to it, the last argument is, "oh but it's so unhealthy for you. . . ." People get to discriminate against us because they're just trying to help us with our health.

Because medical claims about health risk have been used to undermine political claims about fat rights, the work of fat acceptance researchers—

who challenge scientific claims that body weight is under personal control and that obesity causes ill health—has taken on an important political role for the fat acceptance movement.

The term *fat acceptance researcher* refers to researchers who challenge conventional wisdom that overweight and obesity cause ill health. Some researchers embracing this perspective also refer to their approach as the Health at Every Size (HAES) paradigm. Fat acceptance researchers include neurobiologists, exercise physiologists, nutritionists, social workers, and others. Recently, Paul Campos, a lawyer, wrote a widely selling fat acceptance book that has been discussed a great deal by the mainstream media and includes an extensive review of the medical research on obesity as a health risk (Campos 2004). Because much influential fat acceptance research involves secondary rather than primary analysis and because, unlike antiobesity activism, fat activism is not primarily focused on medical research, we define *fat acceptance researcher* more broadly than *antiobesity researcher* to include researchers who do secondary obesity research. As with the antiobesity activists and researchers, fat acceptance researchers see themselves as having a mission to spread an alternative message about weight and health, not only through scientific publications, but through the mass media as well.

To date, fat acceptance research has been less influential than anti-obesity research. There are only a couple of fat acceptance researchers, including Paul Ernsberger and Steven Blair,<sup>5</sup> who publish regularly in the leading medical journals such as the *Journal of the American Medical Association* and *New England Journal of Medicine*. The *Healthy Weight Journal*, which was founded in 1988 and was renamed the *Health at Every Size Journal* in January 2004, provides an important outlet for fat acceptance research, but it had a distribution of only about three hundred subscriptions in 2005 according to the publisher. Many fat acceptance researchers exchange ideas and discuss research on a Listserv called “showmethedata” (smt.d.fullbleed.net) and many, but not all, are also members of NAAFA and other fat acceptance organizations. Fat acceptance research also has some points of affinity with the nondiet approach

5. We label Blair a fat acceptance researcher because he says in an interview with the first author that he generally agrees with fat acceptance issues, has expressed skepticism in his research and in the press about the health focus on weight, and has written a preface to Glenn Gaesser's (2002) explicitly fat acceptance *Big Fat Lies*. Because of his academic standing, Blair's support of fat acceptance has been crucial for the movement. However, Blair takes some distance from the fat acceptance movement, saying that he does not accept the most radical of their claims. He also has networks to antiobesity researchers. For instance, he has a blurb on the back of JoAnn Manson and Patricia Amend's 2001 book on the importance of exercise.

and eating disorders specialists. Both of these groups consider focusing on weight and weight-loss diets potentially harmful but do not necessarily believe one can be healthy at *any* size or that weight loss should not be recommended for those one hundred or more pounds above current weight guidelines.

Whereas researchers and medical professionals led the antiobesity movement, fat acceptance research followed in the wake of fat acceptance activism. Paul Ernsberger, neuroscientist, professor of nutrition, and one of the first fat acceptance researchers, became interested in issues such as the effects of weight cycling or yo-yo dieting—which he subsequently studied with rat experiments—after talking to NAAFA members who said their weight-loss diets resulted in temporary weight loss followed by weight gain greater than what they had lost. This work became part of his doctoral dissertation. While a graduate student in the early 1980s, he also served as chair of NAAFA and in the mid-1990s testified against the approval of weight-loss drug Redux (part of the notorious Phen-fen cocktail that ultimately was linked to heart-valve failure). In the late 1980s, AHELP (Association for the Health Enrichment of Large People) was founded for health care professionals and researchers committed to fat acceptance; many of the people now active on the showmethedata Listserv and publishing in the *Health at Every Size Journal* were active in AHELP. There are also fat acceptance researchers, particularly those who came to this perspective after the mid-1990s who had no contact with the fat acceptance movement prior to publishing fat acceptance research. For instance, fat acceptance researcher Glenn Gaesser's position that exercise—not weight loss—is the key to optimum health could be seen as a product of his intellectual training in exercise physiology. Similarly, fat acceptance researcher Steven Blair is trained in kinesiology and is president of the Cooper Institute in Dallas, which specializes in research on the relationship between aerobic exercise and health.

## Data and Methods

This study draws on a mix of secondary and original data sources. To understand the position of antiobesity activists and researchers, we draw on published works decrying the urgency of the obesity epidemic and more technical studies about the health risks associated with obesity. We further draw on original interviews with antiobesity researchers ( $N = 6$ ), defined as researchers who study obesity and who have taken a public stance that obesity is an urgent health crisis. To understand the position

of fat acceptance activists and researchers, we draw on published work destined for a general audience that argues that the risks of overweight and obesity have been greatly exaggerated and more technical studies questioning the connection between weight and health. We further draw on participant observation at the 2001 NAAFA annual convention, ongoing participant observation since summer 2001 on a fat acceptance Listserv dedicated to discussing medical research (showmethedata), and a series of in-depth interviews with leading fat acceptance activists ( $N = 9$ ) and researchers ( $N = 6$ ) who have taken part in public debates over the issue of obesity. We consider the interview respondents cultural entrepreneurs whose views are important not because they are representative of the larger research community, which they are not, but because they are likely to have particular influence on public discourse.<sup>6</sup>

The interviews lasted from forty-five minutes to over two hours. They were semistructured and open ended, meaning that a series of open-ended questions were asked in each interview but respondent-initiated questions were also encouraged and pursued. During the interview, respondents were asked to respond to some of their opponents' claims. This served to artificially reproduce and probe deeper into the logic of different positions in public debates over obesity. The inductive interview analysis involved reading each of the interviews several times and constructing theme sheets as different themes emerged.

In most cases, where respondents have taken a public stance on the issues being discussed and where explicit permission was given, we identify them by name. In a few cases, respondents asked after reviewing their interview transcripts that specific statements not be attributed to them—a wish we respect. We also disguise the identity of NAAFA members who are not public figures, as this would add little to the analysis and because some of the issues discussed are personal in nature.

### Competing Weight Frames and Social Problems

We now turn to how antiobesity activists and researchers and fat acceptance activists and researchers frame body weight and health. We discuss three competing frames for understanding fat bodies: fatness as body

6. This is akin to Howard Becker's (1963) concept of "moral entrepreneur" (see also Gusfield 1981). However, while moral entrepreneur refers specifically to actors involved in the making, promotion, and enforcement of norms, we use "cultural entrepreneur" more broadly to refer to the construction of cultural meaning (see also Saguy 2003).

diversity, obesity as risky behavior, and obesity as disease. Two areas of scientific contention that are particularly important for the relative success of these frames include (1) whether fatness is a mostly immutable characteristic such as height or a product of bad lifestyle and (2) whether high weight is a health risk, a genetic or biological defect, or harmless. We also examine a fourth social problem frame, which is compatible with both the risky behavior and the disease frames: obesity as epidemic. The success of this frame relies on showing that the incidence of obesity is increasing at an exponential rate.

### Fatness as Body Diversity

The body diversity frame builds on traditions of antidiscrimination and rights claims that have strong political roots in the United States. Since the civil rights movement, several identity groups—including women, gays, and the disabled—have "bridged" (Snow et al. 1986), or likened, claims of discrimination against their group onto more established forms of discrimination in an attempt to gain legitimacy. Thus, the term *sexism* was coined after *racism*, and the resemblance of the words was intended to assert the similarity of these forms of discrimination. Likewise, fat acceptance activists have borrowed the gay rights term *coming out* to speak of coming out as a fat person, in which they come to publicly affirm fatness as part of identity. Similarly, as gay rights activists use the term *homophobia* to speak of fear and hatred of homosexuality, fat activists speak of *fat phobia* to describe fear and hatred of body fat and fat people.

In asserting that fatness is a form of diversity, fat acceptance activists commonly compare fatness to more immutable forms of identity such as race, gender, or disability. The following fifty-seven-year-old NAAFA member, who is trained as a nurse, uses the comparison with disability to argue that fat people should not be blamed for their weight and should be accommodated in public spaces:

Disabled people approach a problem thinking, well, I'm okay, something happened to me that I became disabled, and I deserve as much as the next guy. Fat people come out in the world thinking, I'm not okay. I don't deserve this, and they don't figure out how to get what it is that they need. Somebody like me has to tell them in a workshop what you're entitled to. . . . [I tell them they can use] amenities . . . that are made for the disabled . . . and that [they] deserve it just as well, because [they] were born this way too.

Much of fat acceptance research tries to demonstrate the genetic and biological bases of obesity. For instance, the genetic determinants of obesity represent a major line of research for fat acceptance researcher Paul Ernsberger. Similarly, set point theory, which establishes that everyone has a weight to which their body will naturally revert and that cannot be changed by weight-loss diets,<sup>7</sup> is used by the fat acceptance movement to assert that “being fat . . . is a biological fact of life, an aspect of the human species’ inherent variability” (Bennett and Gurin 1982: 4). Fat acceptance activists cite empirical studies showing that intentional weight loss is elusive for 75–95 percent of participants of commercial weight-loss programs in one- to three-year follow-ups (see, e.g., Garner and Wooley 1991; Goodrich and Foreyt 1991; Kramer et al. 1989; Miller 1999; Stunkard and McLaren-Hume 1959) to further argue that weight is outside of personal control.

If one assumes that weight is largely outside of personal control, then raising concern over the health risks associated with obesity has little remedial function. On the other hand, it may worsen the stigma and discrimination faced by fat people. This is precisely the point fat acceptance activist Lynn McAfee makes:

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

### Obesity as Risky Behavior

A risky behavior frame emphasizes the extent to which body weight is under personal control and implies that those who are fat have unhealthy lifestyles while the thin make good food and exercise choices. This frame

7. But William Bennett and Joel Gurin (1982) maintain, based on their review of the literature, that a set point can be lowered by regular exercise, a point that the fat acceptance movement has generally not stressed.

also renders invisible cases in which people are fat despite healthy lifestyles or in which people are thin despite being sedentary, subsisting on candy and chips, or being anorexic or bulimic. Notwithstanding a general recognition that body weight is not completely under personal control, a risky behavior framing dominates antiobesity literature and our interviews with antiobesity researchers, especially in discussions of remedies for obesity. Antiobesity activists and researchers refer to the same studies as fat acceptance activists and researchers, showing the high failure rate of commercial weight-loss diets, but come to a different conclusion. For them, the 5–25 percent success rate means that weight loss is possible, even if it is difficult. Some antiobesity researchers have established a National Weight Control Registry to follow over five thousand people who have lost weight and kept it off, to establish that permanent weight loss is possible and to identify why these people have been successful at long-term weight loss.

Many antiobesity researchers express the personal opinion that the reason weight-loss diets have such high failure rates is that people are not truly committed to them. Moreover, they argue that most people do not monitor their weight at all. Antiobesity researcher and Harvard epidemiologist Walter Willett is coinvestigator of the Nurses’ Health Study, a longitudinal health study of over 100,000 nurses, has a long list of publications on the health risks of obesity and weight gain, and is often quoted in the mass media. He says that very few overweight people “are seriously thinking of weight loss,” and those that are can and do “lose weight and keep it off,” but it requires making dietary changes and being physically active “for at least an hour a day” for the rest of their lives. “There’s no permanent fix here.” Willett says he’s “yet to be convinced that there are very many people that if they are really serious about controlling their weight, can’t get their weight down under a BMI of 25.”<sup>8</sup> He adds: “The main excuse regardless of why they don’t get exercise is because they don’t have enough time, and you look at all the national surveys, and they say the average amount of television watching per week is 29 hours.”

Antiobesity researcher JoAnn Manson takes a similar position. She is a Harvard epidemiologist and coinvestigator of the Nurse’s Health Study,

8. BMI is calculated as weight in kilograms divided by height in meters squared. *Overweight* is defined as having a BMI over twenty-five, which translates into a woman of average height (5’4”) weighing 146 pounds or more and a man of average height (5’10”) weighing at least 174 pounds. *Obesity* is defined as having a BMI of over thirty, which means weighing at least 175 pounds for a woman of average height or at least 209 pounds for a man of average height. *Morbid obesity* is defined as having a BMI of over forty, which translates into at least 233 pounds for a woman of average height or at least 279 pounds for a man of average height.

has published numerous articles about the dangers of obesity and weight gain, and is often quoted in the mass media on this topic. In an interview, she says, people “know if they were to get up off the couch and do some more walking . . . it would be helpful to them, but they just don’t feel like it.” Every day, she says, they *make a choice* to buy “the Big Mac and French fries instead of a salad or roasted chicken.”

The fact that there is not yet a pill that results in large weight loss reinforces the emphasis on behavior modification. Available weight-loss drugs are only effective for small amounts of weight loss, either by reducing appetite, in the case of Meridia, or by blocking the absorption of fat, in the case of Xenical. Neither of these prescription weight-loss drugs is intended to correct or recalibrate a faulty biological process, and both are meant to be used in combination with a weight-loss diet and physical activity, thus still requiring individuals to “reform their evil ways.” Similarly, weight-loss surgery may assist people in changing their eating behaviors by reducing appetite and making it physically uncomfortable (even gastro-intestinally excruciating) to overeat. This is better understood as a physically enforced weight-loss diet, rather than surgery that corrects a faulty stomach. Indeed, a stomach that has been surgically altered in this way is unable to perform many of its functions, such as properly absorbing nutrients (Alvarez-Leite 2004).

The social implications of the risky behavior framing of fatness, in a context in which the risky behaviors in question—overeating and inactivity—are also considered immoral, is that fat bodies are read as evidence of both preventable illness and moral failings. Fat acceptance becomes tantamount to accepting bad behavior that knowingly contributes to ill health. In the words of antiobesity activist Fumento (1997: 130): “The fat acceptance people . . . have turned what had been two of the Seven Deadly Sins—sloth and gluttony—into both a right and a badge of honor. . . . That’s a sin in and of itself.” By presenting fatness as evidence of immorality (i.e., gluttony and sloth), the risky behavior frame may also facilitate the shaming and blaming of fat people, as when a major newspaper prints the following words of Fumento: “When somebody shows prejudice to an obese person, they are showing prejudice toward overeating and what used to be called laziness. It’s a helpful and healthful prejudice for society to have” (Lasalandra 1998: 20).

Moreover, those who adopt a risky behavior obesity frame see it as their ethical duty to draw attention to the problem to prevent further cases, even if this might worsen the stigma associated with larger bodies. According to antiobesity researcher Willett, “We don’t want to have discrimination,

but I think that can’t possibly be used as an excuse to censor information about the . . . cold reality of excessive overweight.”

The risky behavior frame bridges obesity to established risky health behaviors, especially smoking. Thus it is very common for antiobesity researchers to compare obesity to smoking. For instance, when asked about the problem of size discrimination, antiobesity researcher Theodore Van-Itallie, professor emeritus of medicine at Columbia University and founder of the Columbia weight-loss center that bears his name, says, “Well I think I’d put this in the category of smoking. I don’t discriminate against people who smoke, even though I know it’s bad for them, and I may really regret the fact that they smoke, but that doesn’t mean that I treat them badly.” By treating weight as a behavior, he can defend choices to deny health and life insurance policies to the heaviest people without directly challenging principles of antidiscrimination: “I mean the same thing is true of smokers. Why should I have to pay a high life insurance [premium] because of all the deaths that are caused by cigarette smoking?”

A risky behavior frame implies the need for education, potentially reinforcing the idea that fat people are ignorant. For instance, in discussing a nutritional program aimed at poor children and their parents in Los Angeles, Critser (2003: 162) comments, “During the three sessions I attended, it was not unusual to witness a parent walk into the class eating French fries from McDonald’s or sipping thirty-two ounce Big Gulp Coke from the local convenient mart.” Likewise Xavier Pi-Sunyer, who is a medical doctor at St. Luke’s Hospital, runs his own weight-loss clinic, is on the board of Weight Watchers Inc., and is a past president of NAASO, attributes weight gain to lack of information: “Why does the average American woman gain weight with each pregnancy and end up [after] four kids, fifty pounds heavier? It’s because nobody alerts her to the fact that this may happen and it may not be good for her to end up fifteen to twenty years later fifty pounds heavier.”

The dominance of the risky behavior frame of obesity is buttressed by a more general dominance of lifestyle theory in U.S. chronic disease prevention policy (Tesh 1988: 45–46). Sylvia Tesh (*ibid.*) argues that one reason this theory is so popular is that it is consistent with core American values of individualism and upward mobility:

In some circles, it is chic not to smoke, to jog around the streets, to exercise in gyms, to eat low-cholesterol foods. Doing these things, or claiming to do them (“We hardly ever eat meat any more”; “I’ve started running again”), testifies to membership in the affluent classes. Such

behavior means you are economically successful, or expect to be, or at least are very much like people who are. It has come to demonstrate a willingness to work to improve yourself and an eagerness to move up socially.

This theory is also popular, she argues, because it emphasizes personal control over illness rather than requiring major changes in industrial practices, in the economy, or in the government. Finally, if the science on which it is based is sound, it can offer a means to reduce health care expenses (*ibid.*). In that many antiobesity researchers and all of those we interviewed are either trained as medical doctors, conduct epidemiological research, or treat patients in a clinical setting, they are further oriented to prioritize personal behavior as part of their professional training. Similarly, the medical profession has had a great influence on the public health field, contributing to the dominance of individual—rather than structural—analyses.

A personal behavior theory of illness, which the risky behavior frame of obesity exemplifies, sees people as responsible for their own ill health. In that the poor or minority groups are more likely to be ill, this allows one to blame them for their misfortune. Moreover, in that an unhealthy lifestyle is taken as evidence of personal and civic (because of public health costs) responsibility, this perspective suggests that the poor are to blame for their disadvantaged social position.

In our interviews, antiobesity researchers often recognize many structural factors that contribute to obesity, but they fall back on a risky behavior frame when discussing how to address the problem. For instance, Pi-Sunyer, explaining why poor minority women are more likely to be heavy, says:

Some woman who's living in the housing projects and has no husband and is trying to take care of four kids and is now off welfare and has to work and has all kinds of problems: for her, diet is not [a priority]. . . . I'm not saying they're wrong, but I'm saying I don't think they're really connected to the idea that they need to lose twenty-five pounds, and so they don't try it. But the problem is their daughters are not geared to the idea that they should try to prevent becoming as heavy as their mothers.

Likewise, VanItallie acknowledges how it is difficult to exercise when one lives in a high-crime area, but, relying on a risky behavior frame, returns to self-discipline as the solution for obesity: “In an environment

like ours it's very hard to overcome the impediments to regular exercise. It requires a lot of self-discipline to exercise in an environment where you don't have sidewalks to walk on or where it's unsafe to go out.” VanItallie also refers to self-discipline and peer pressure to explain why upper-class women tend to be thin: “Peer pressure is what helps keep upper class women thin.”

Critser (2003: 111) is particularly thoughtful about the economic factors, including worse access to health care, discrimination, and living in areas with high pollution and high crime, that contribute to a higher level of obesity among disadvantaged groups:

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

One could imagine these insights leading to what Tesh (1988: 78–82) calls a “structural perspective” of illness, in which social systems of inequality and poverty are seen as the underlying causes for both chronic and infectious diseases. Tesh argues that this kind of frame shifts blame away from individual ill people and provides a health rationale for prodding the government to enact policies designed to relieve poverty. However, although Critser evokes structural causes of obesity at points in his book, he does not use this analysis as a basis for demonstrating the urgency of relieving poverty in the United States. Instead, his final chapter, titled “What Can Be Done?” relies on a risky behavior framing of obesity, which focuses on the importance of (publicly fostering) positive lifestyle changes, especially for the poor.

There is increasing discussion among antiobesity researchers and activists of how the food industry contributes to obesity and weight gain in the United States. This important trend potentially shifts some blame for obesity from individuals to large corporations. However, we would argue that this focus does not entirely remove blame from individuals, since a toxic food environment cannot pollute individuals without their consent. As Tesh (1988: 55–58) argues: “The extent to which the environmental theory of disease causality challenges current arrangements depends . . . on what is meant by the term *environment*. . . . If the concept refers to the

air, water, and soil, then the major responsibility for disease rests with those who pollute. If the concept refers mostly to smoking, eating, and other forms of behavior, then the responsibility for disease is largely personal.” Children are seen as more vulnerable to industry pressures, which may be why attacks on the food industry tend to stress how children are victimized, although advocates for individual responsibility argue that their parents should be supervising their eating and are to blame if their children are fat. Moreover, consistent with a risky behavior frame, attacks on the food industry assume that obesity is a reflection of unhealthy lifestyles—rather than body diversity or a biological or genetic defect—even if those lifestyles are encouraged by large corporate interests. Indeed, efforts to blame the food industry for obesity are based on movements to blame smoking, another risky health behavior, on “big tobacco.”

### Obesity as Disease

In addition to the risky behavior frame, there has been a move to redefine obesity as a disease in its own right rather than as a risk for other illnesses. This seems to be largely a strategic attempt to make weight-loss treatments and surgery tax-deductible or covered by Medicare (see Kolata 2004b), but some also argue that framing obesity as a disease would remove the blame associated with it. For instance, in an interview, antiobesity researcher Kelly Brownell says that if calling obesity a disease “takes away some of the blame from the people who have it . . . , then ‘disease’ is probably a good way to characterize it for the time being.” Drawing on work that argues that treating a condition as a disease removes the blame associated with it because disease is considered outside of personal control (Conrad and Schneider 1992) and noting the trend toward the medicalization of body weight, sociologist Jeffery Sobal (1995: 84) similarly argues that, whatever negative moral tinge obesity still has is but a vestige of “the overwhelming interpretation of obesity *in the past* as a moral and not medical problem” (emphasis added).

Likewise, Tesh (1988) argues that, although popular lifestyle theories of disease place blame squarely on individuals for their ailments, other framings of illness, such as germ theory, absolve individuals of responsibility for their condition and depersonalize disease.<sup>9</sup> Although Tesh does

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

not discuss them, genetic medical models would similarly be expected to absolve individuals of responsibility for their ill health since genes are considered outside of individual control.<sup>10</sup>

Indeed, genetic models of obesity have been popular among fat acceptance activists and researchers. The fifty-seven-year-old NAAFA member trained as a nurse and quoted previously, comparing fat rights to rights for the disabled, explains how she tells women in NAAFA workshops that they should not be blamed for their weight because they are genetically programmed to be heavy:

[I tell them:] You were born to have this tendency, to be the way you are. It’s not your fault, people want to tell you it’s your fault; society wants to blame it on you. It’s not your fault. If it was your fault then everybody that over-ate would be big, and that’s not true because you see tons of people who eat constantly and remain thin. It’s their genetics and their metabolism, and you look at them scarfing down stuff all the time and they never seem to gain an ounce, whereas you have to just smell the fumes from [fattening food] and you put on ten pounds.

Arguments that homosexuality is not a choice but determined by genetics are similarly politically attractive in a homophobic society because gay rights activists assume that people are less inclined to fault others for something that is beyond their control. However, as many fat acceptance activists recognize, theories of genetic inferiority can also provide justification for structural inequality and persecution, as is demonstrated by the history of racism and anti-Semitism. One NAAFA member worries that, if researchers did locate a fat gene, expectant parents would abort fat fetuses. Other fat acceptance researchers argue that, much like the eugenics movements of the early twentieth century, discussions about the health risks of obesity potentially rationalize and justify social inequality by pointing to the biological inferiority of poor and minority groups (see Smith 2004).

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

Moreover, framing obesity as a deadly disease suggests that fat people should seek medical treatment, even if it is risky and has a low probability of success. Thus, it is antithetical to a stance that fatness represents harmless body diversity. For instance, antiobesity researcher VanItallie uses the analogy to cancer—a fatal disease for which available treatment is risky and often unsuccessful—to defend weight-loss treatments, despite their low success rates and associated risks: “If I had a patient with cancer I would usually recommend treatment for it even though the patient might ultimately succumb to the cancer. You do the best you can with the tools that you have at hand.” In the words of James Hill, antiobesity researcher, professor of pediatrics, director of the Center for Human Nutrition at the University of Colorado Center for Human Nutrition, and the cofounder of the National Weight Control Registry, “I think . . . the analogy [to fat acceptance] would be [to say], ‘Let’s have a cancer acceptance movement. . . . You’ve got cancer; just accept it and live with it.’ I can’t do that because I know this is a disease . . . that has the potential to have devastating societal consequences.” Kelly Brownell makes the same analogy: “If somebody has a disease that really can be horrible for them, like cancer, and the treatments don’t work very well, you don’t give up treating, because you try to do the best you can.”

The disease frame thus implies the obligation of the sick person to get well, what Talcott Parsons (1951) referred to as the “sick role.” Furthermore, by labeling persons as biologically flawed, a disease frame can reinforce their stigma. In the words of Lynn McAfee:

Obesity researchers keep working so hard to turn this into a disease. And when I complain, they go, “Well I don’t understand the problem, Lynn, because if you have a disease then it’s not in your control and people won’t harass you.” I say, “Well you’re so wrong.” This is exactly the issue that handicapped people [and] people with disabilities face. . . . By having something biologically wrong with them, number one they’re biologically inferior and then number two, they’re . . . caught at that liminal position, where they’re not adults and they’re not children. And with that liminal position, you lose your sex life, you lose a lot of responsibility for things, you lose a lot of the adult stuff, because you have to be taken care of by society. . . . So it’s not a free ride.

McAfee recognizes that the stigma she experiences as an extremely fat woman is not due solely to people’s assumptions that she eats too much and exercises too little, but that her weight is also taken as evidence of a “spoiled identity” (Goffman 1963). Although a disease frame might chal-

lenge assumptions of personal responsibility, it reinforces the sense that she is biologically flawed (see also Wang 1992).<sup>11</sup>

### Obesity as Epidemic

Since the 1990s, obesity has been framed by antiobesity researchers and activists and others, including government agencies, as an epidemic. The term *epidemic* originally referred to the rapid and episodic onset of infectious diseases and, as such, was historically associated with fear and sudden widespread death (Rosenberg 1992). In this sense, “A true epidemic is an event, not a trend” (ibid.: 279). Today, in contrast, policy makers and the media use the term *epidemic* as an emotionally charged metaphor to speak of the increasing prevalence of a range of social ills from alcoholism, to drug addiction, to automobile accidents, and most recently, to obesity. “These clichéd usages are disembodied but at the same time tied to specific rhetorical and policy goals. The intent is clear enough: to clothe certain undesirable yet blandly tolerated social phenomena in the emotional urgency associated with a ‘real’ epidemic” (ibid.: 278–279).

In the case of obesity, which is frequently treated as a disease but is not literally contagious, it is often ambiguous whether the term *epidemic* is being used literally or metaphorically. For instance, antiobesity activist Fumento (1997: 245) argues that obesity is a disease, but one that is “socially contagious”:

Remember that obesity is a socially contagious disease. If you improve your eating and exercise habits, there’s an excellent chance other members of your family will, too. Other people will see you and if they are fat they will no longer be able to take comfort in thinking, ‘Oh well, there goes another person who’s as fat as I am.’

The identification and widespread concerns about an epidemic of obesity can be traced to the mid-1990s. In 1994, the *Journal of the American Medical Association* published a study examining the prevalence of overweight and obese individuals in the United States between 1960 and 1991 (Kuczmarski et al. 1994). The authors found that between 1960 and 1980 the U.S. population experienced only modest gains in body weight and that only about one-quarter of the population could be considered obese. However, between 1980 and 1991 the proportion of overweight or obese Americans jumped by 20 percent. By 1991, nearly one-third of

11. Thanks to Mark Schlesinger for this distinction.

the population was overweight or obese and that increase did not appear to be abating. The authors expressed alarm about this precipitous rise, claiming that overweight and obesity continued to be “a public health dilemma for which no efficacious, practical, and long-lasting preventive or therapeutic solution has yet been identified,” but stopping short of providing any additional labels for these developments. However, the press quoted antiobesity researcher Pi-Sunyer’s accompanying editorial in the journal that bemoaned the “fattening of America” and noted that “if this was about tuberculosis, it would be called an epidemic” (Pi-Sunyer 1994, quoted in Pringle 1994).

This framing of obesity as an epidemic captured the imagination of much of the mass media, which reported on the study throughout the summer. The London *Independent* reported that “new statistics on obesity [in the United States] suggest the national problem of fatness should be regarded as an epidemic” (Pringle 1994). An article by diet guru Susan Powter in the Cleveland *Plain Dealer* newspaper asked readers, “Have you heard? Obesity is an epidemic in our country” (Powter 1994). And a cover story in *Newsweek* titled “An Epidemic of Obesity” suggested, “Listen to the sounds of big America: pants splitting, stomachs roiling, buttons popping, hips spreading like kudzu. We do not need a penny scale to know which way the fat is blowing” (Beck 1994: 62).

Although many of these early reports explicitly or implicitly acknowledged the metaphorical use of the term *epidemic* to describe changes in obesity prevalence, by the winter the obesity epidemic had already undergone an ontological shift from metaphor to fact. A *New York Times* editorial in December 1994 claimed that “obesity has reached epidemic proportions in the US and nobody knows quite what to do about it” (*New York Times* 1994). A report in the *Washington Post* (Achenbach 1994) took an even stronger stand. “Fact: Fat’s an epidemic. You might be under the delusion that society is slimming down, thanks to trends like aerobic exercise and low-fat food. The tragic truth is that, despite \$33 billion a year spent on dieting, ours is an ever-widening society.” The epidemic of obesity in the United States had quickly gained the status of truth.

Fat acceptance activist Marilyn Wann and author of *Fat! So?* (1999) says that, in discussions of the “obesity epidemic,” she (and people her size) is the “bogeyman,” a warning of what the entire society will become if the epidemic is allowed to continue. Thus, she argues, the epidemic frame further stigmatizes fat—and especially very fat—people. Yet, the fat acceptance movement has not focused its energy on debunking the epidemic frame, but instead has stressed that obesity is not a health risk

or a disease, so that the rate at which it is increasing is inconsequential. Instead, the job of questioning the epidemic framing has primarily fallen to others, including researchers investigating the biological basis of obesity, perhaps because the obesity-epidemic framing has been used to counter arguments that obesity is genetic in origin. For if obesity is genetic, this argument goes, why would we see such a huge increase in its prevalence without a corresponding change in the gene pool?

These researchers have countered that although there have been large changes in the number of people with a BMI of thirty, between 1991 and 2000 the distribution of weight shifted slightly to the right and became more skewed, with the average person gaining only seven to ten pounds over a ten-year period (Friedman 2003). This presentation has been less common than the epidemic frame in the media, probably because it is more complicated to grasp. However, *New York Times* journalist Gina Kolata draws on these analyses to question whether the “fat epidemic” might not be an “illusion” (Kolata 2004a: 5). In a report on Rockefeller University researcher Jeffrey Friedman’s *Science* article,<sup>12</sup> Kolata (*ibid.*) writes:

Dr. Friedman gave an analogy: “Imagine the average I.Q. was 100 and that 5 percent of the population had an I.Q. of 140 or greater and were considered to be geniuses. Now let’s say that education improves and the average I.Q. increases to 107 and 10 percent of the population has an I.Q. of above 140. You could present the data in two ways,” he said. “You could say that the average I.Q. is up seven points or you could say that because of improved education the number of geniuses has doubled.” He added, “The whole obesity debate is equivalent to drawing conclusions about national education programs by saying that the number of geniuses has doubled.”

Kolata, however, has been quite exceptional among journalists in her questioning of the dominant obesity epidemic frame.

12. Friedman is an example of someone who does not identify as a fat acceptance researcher but who is doing work that can be appropriated by this movement. In his *Science* article, he presents his work as demonstrating the importance of genetic determinants of obesity and denies that he was questioning the seriousness of the obesity epidemic. In contrast, in his interview with Kolata, he uses the same data to challenge the obesity epidemic frame. This suggests that academic publishing and media reports entail different constraints and opportunities that shape the kinds of arguments that are made in each forum. For instance, academic publishing is reviewed by peers, who are likely to have a stake in dominant assumptions of an academic field. In contrast, journalists favor dissenting views and bold claims.

## Alternative Social Problems

We have discussed competing body weight frames, but work on social problem construction identifies a second level at which competition among social problems occurs: contests among diverse social problems for public attention (Hilgarten and Bosk 1988: 58). An important strategy of the fat acceptance movement is to argue that obesity is a false problem that is detracting attention away from real problems. For instance, as we have seen, fat acceptance activists argue that people should be concerned about size discrimination rather than the obesity epidemic. A common fat acceptance response to the risky behavior framing of obesity is that much of the negative effects associated with obesity are actually caused by poor nutrition and sedentary lifestyles. Because body size is not a reliable indicator of one's diet or level of physical activity, in their view, a focus on weight can be counterproductive. Dangerous weight-loss methods, weight obsession, and inadequate health care for fat people are other social problems the fat acceptance movement would like to see take priority over obesity and weight gain. We describe each of these competing problems in the following sections and discuss the most common antiobesity responses to these fat acceptance claims.

### Sedentary Lifestyle and Poor Nutrition

Fat acceptance researcher Gaesser (2002) argues that sedentary lifestyle and poor nutrition, not obesity, are the true public health problems. According to him, "People should be physically active, eat healthy foods, and not obsess about the numbers on the scale" (ibid: xxiv). Gaesser wants to decrease the attention given to weight both because he believes that the science suggests that physical activity and a diet high in fiber and complex carbohydrates and low in fat and sugar are more directly linked to good health than is weight and that improving diet and becoming more active do not always translate into weight loss for all people. In other words, one can be "fit and fat" just as one can be unfit and thin (ibid.: xviii; see also Katzmarzyk et al. 2005; Blair and Church 2004).

Although he rejects a focus on weight loss, Gaesser strongly urges improving personal lifestyles to improve health. He recommends that people get at least 140 minutes<sup>13</sup> of exercise (including yard work and

13. The discrepancy between the one hour per day and the 140 minutes of exercise per week recommended by Willett and Gaesser respectively echoes uncertainty in the literature about the amount (and intensity) of exercise that is needed to have a meaningful impact on health. It also

playing actively with children) per week and eat a diet low in fat and sugar and high in complex carbohydrates. Like Gaesser, a family nurse practitioner and member of NAAFA explains how she focuses on improving health behaviors rather than weight loss with her patients: "I never tell my patients to lose weight. I think that it's a horrible thing to tell people: 'Oh, you have to lose weight.' I do encourage my patients strongly to make healthy choices in eating, and I try to encourage them to exercise, because I really do believe that you can be fat and you can be fit." For the fat acceptance movement, it is crucial whether public discourses stress weight, diet, or physical activity, because a focus on weight signals that their members are unfit, both physically and socially. In contrast, if one can be healthy or fit at any size, fat bodies are not necessarily evidence of ill health or immorality any more than thin bodies automatically denote health and virtue. The argument that the negative health outcomes associated with obesity may be caused by poor diet and inactivity relies on the fact that weight is highly (although not perfectly) correlated with these behaviors. Yet, it is precisely this correlation that allows the antiobesity researchers to conflate obesity with bad nutrition and sedentary lifestyles.

Antiobesity researchers acknowledge that it is difficult to tease out the effects of weight, nutrition, and fitness on health, as these are highly correlated, but maintain that this is an "issue of semantics," to quote anti-obesity researcher Hill. According to Hill, "we're getting all hung up in the words. . . . I'm happy if you want to focus on nutrition, on physical activity, on obesity, on diabetes; it's all one cascade. . . . It's really hard to separate out what's causing what." In the words of antiobesity researcher VanItallie, "I don't think it's possible at the moment to completely disentangle the adverse effects of a sedentary lifestyle from those of obesity. . . . Whether [obesity is] a risk factor because it is, in part, a marker for lack of exercise . . . needs further investigation, but obesity is something we can measure."

Although a focus on behavior rather than body size potentially removes the stigma associated with larger bodies, it may reinforce the moral imperative to engage in healthy lifestyles. For instance, quoting Ernsberger and

reflects the fact that there is some evidence that the amount of exercise needed to lose weight and keep it off (Willett's objective) is greater than the amount needed to improve health (Gaesser's focus). For instance, the 2005 Dietary Guidelines for Americans recommend at least thirty minutes of moderate-intensity physical activity most days of the week "to reduce the risk of chronic disease in adulthood"; approximately sixty minutes of moderate- to vigorous-intensity activity on most days of the week to "help manage body weight and prevent gradual, unhealthy body weight gain in adulthood"; and sixty to ninety minutes of moderate-intensity physical activity "to sustain weight loss in adulthood" (U.S. Department of Agriculture 2005: 20).

Haskew (1986), Gaesser (2002: 165) explains that “obesity may not be a direct cause of disease, but may serve as an imprecise marker for an imprudent lifestyle.” An imprudent lifestyle can also lead to accumulation of “bad” body fat, which is visceral (or deep) abdominal fat, as opposed to “good” body fat, which accumulates on the buttocks and thighs:

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

The moral language in this passage is striking: “bad body fat,” “indulge,” “choice.” Imprudent lifestyles are clearly not being condoned, despite support for fat acceptance. Moreover, abdominal fat is being identified as a visible sign of an imprudent lifestyle. There is no discussion of how such lifestyles are constrained by factors beyond personal choice. The moral blaming associated with obesity has not been challenged as much as displaced onto diet and activity.

A minority of fat acceptance researchers have taken a more radical line. Among them is Jon Robison, who is coeditor of the *Health at Every Size Journal* and holds a doctorate in health education/exercise physiology and a master's of science in human nutrition from Michigan State University, where he is adjunct assistant professor. He and a coauthor (Robison and Carrier 2004) dispute the traditional approach to health and illness that focuses on individuals trying to control epidemiologically based risk factors—including weight, nutrition, and physical activity—rather than addressing social phenomena that detract from health, such as violence, prejudice, social isolation, and materialism. Robison is thus wary of substituting concern about weight with concern with nutrition or fitness. In a spirited debate on the showmethedata Listserv about whether health professionals should talk about foods as being “good,” “bad,” or “better” than others, Robison writes:

What is really absurd in my opinion, is suggesting that one food is “better” than the other. Good and bad is a moral judgment—it has nothing

to do with science and nothing to do with nutrition. From a nutrition science perspective, some foods are more nutrient dense or have more fiber or have less fat than others. Good and bad relating to these foods (with the possible exception of spoiled foods) adds nothing to our understanding of the foods themselves, establishes a slippery slope from which there is no escape, and sets people up for continued confusion and anxiety about eating.

On the showmethedata Listserv, several participants expressed concern that Robison's stance was too radical to be influential in mainstream medicine.

Among fat acceptance activists, most of whom—unlike fat acceptance researchers—are not professionally dedicated to health issues, there is more mistrust of a focus on health and health behaviors. At the 2001 NAAFA meetings, several participants spoke of their concerns about the recent emphasis on being fit and fat. Similarly, a fifty-year-old fat acceptance activist, weighing “somewhere around 400 pounds” and having worked in the restaurant business for most of her life, writes on the showmethedata Listserv that, although she appreciates the work done by fat acceptance researchers, she mistrusts any moral imperative to be healthy, whether that is measured by weight or by behavior:

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

### Dangers of Weight-Loss Treatment

In addition to emphasizing the dangers of a sedentary lifestyle and poor nutrition for people of all sizes, fat acceptance activists and researchers argue that a focus on weight loss leads many to pursue dangerous weight-loss treatments, including starvation diets, weight-loss pills, and weight-loss surgery. Indeed, they argue that weight-loss treatments, not obesity, constitute an urgent health threat and a more pressing social problem than obesity per se. According to them, even if there are cases in which it would be desirable to lose weight, there are currently no safe and effective ways to do so. Rather, weight-loss remedies are more dangerous than the prob-

lem they are meant to correct. “First do no harm,” from the Hippocratic oath, is commonly written on the showmethedata Listserv to criticize doctors who advocate weight-loss treatments for their patients.

Fat acceptance activists describe the personal pain and suffering they have endured because of weight-loss diets. For instance, one’s recollection of how her pediatrician counseled her mother to dilute her formula at the age of four months because she was too fat brought her to tears during an interview. Several fat acceptance activists spoke of having taken amphetamines prescribed by doctors for weight loss during their adolescence and young adulthood and the havoc this wrought on their mental and physical functioning. During the 2001 NAAFA convention, NAAFA members spoke about the recent death of a NAAFA member following weight-loss surgery. In a workshop on weight-loss surgery during this same meeting, NAAFA members who had undergone such surgery spoke of the painful complications they had suffered since the surgery and how they had regained all of the weight they had initially lost.

Similarly, fat acceptance researchers point to studies showing the negative effects of weight cycling, the heart-valve problems linked to the weight-loss cocktail Phen-fen, and the serious complications associated with weight-loss surgery. In response, antiobesity researchers dispute that weight cycling causes weight gain and, although they are critical of quack diet doctors and miracle cures, they argue that the risks of obesity outweigh those of medically supervised weight-loss treatments.

### Weight Obsession as Hazardous to Health

Fat acceptance activists and researchers further argue that discussions of the so-called obesity epidemic fuel obsession with weight. Americans should be concerned about this obsession, they argue, rather than obesity per se. For instance, the subtitle to fat acceptance researcher Paul Campos’s (2004) *Obesity Myth* is “Why America’s Obsession with Weight Is Hazardous to Your Health.” Many fat acceptance researchers worry that fears about becoming fat will contribute to eating disorders and smoking, which can help control weight. They advocate intuitive eating, in which a person eats according to internal hunger cues rather than external cues such as calorie counting and thus they oppose calorie-restricted diets, which they liken to anorexia.

Antiobesity researchers dispute that medical warnings about the risk of obesity lead to anorexia. Moreover, they argue that, even if this were the case, concerns about anorexia should not lead to silencing about obesity,

which is a problem of much greater magnitude. James Hill says, “Not to sound cruel about it, but one problem [obesity] is a huge problem for society. The other problem [anorexia] is a smaller problem, and it’s not at all clear that the two are connected.” According to Walter Willett, “I don’t think there’s evidence that [people are] anorectic because of general concerns about chronic disease development due to being overweight. [Even] if it were the case, the problem of overweight and obesity is a hundred times more of a problem than the problem of anorexia, if we look at morbidity and mortality. And so [we can’t] avoid giving people . . . accurate information about the consequences of overweight and obesity.” When asked about the prevalence of dieting, Pi-Sunyer noted that “people are not dieting all the time. They’re not. A few people are dieting all the time.”

Antiobesity activists and researchers further argue that eating disorders and weight obsession concerns mostly upper-middle-class women and girls, rather than the poor women of color they want to target with information about obesity. Thus, according to this logic, neglecting the issue of obesity because of concerns about worsening eating disorders is a form of class bias. So Critser (2003: 123) argues that anorexia has received a disproportionate amount of media attention, as compared to obesity, because most anorexics are from the upper middle class and the media are biased toward problems that concern this social group. Critser (*ibid.*: 121) writes, “Speaking anecdotally, [Dr. Richard MacKenzie, a physician who treats overweight and obese girls at Children’s Hospital in downtown Los Angeles] adds: ‘The problem with that is this: For every one affluent white anorexic you create by overemphasizing obesity, you foster ten obese poor girls by downplaying the severity of the issue.’”

There is evidence that women are affected more than men by social pressures to be thin. Our interview respondents were more likely to discuss women’s weight than men’s. Women are penalized more for being fat than men, in terms of family income, occupational prestige, likelihood of marriage, spouse’s occupational prestige, and spouse’s earnings (Conley and Glauber 2005). Judged more on their appearance, women are also more likely to be invested in their looks than are men (Feingold and Mazzella 1998), are more likely to be unhappy with their appearance (Cash 2000), and are more likely to develop anorexia or bulimia (American Psychiatric Association 1994). Women and girls are much more likely than males to try to lose weight by a range of methods, including restricting food intake, taking weight-loss pills, vomiting, taking laxatives, and undergoing weight-loss surgery (Blanck, Khan, and Serdula 2001; Connor-Green 1988; Krowchuk et al. 1998; Zizza et al. 2003). If, as fat acceptance activ-

ists and researchers argue, discussions about the medical importance of weight loss reinforce cultural dictates to be thin—an empirical question that warrants further research—then women can be expected to bear the brunt of this pressure. Although eating disorders and body image problems have been identified as a concern for primarily white middle-class women, recent studies have suggested that they may be more prevalent than thought among poor or minority women (Williamson 1998).

Quoting Judith Stern, a professor of nutrition and internal medicine at the University of California at Davis, Critser (2003: 121) says, “We’ve got to stop [talking about anorexia] and get on with the real problem.” The media, which have reported relatively less on eating disorders compared to obesity since the 1990s (Saguy and Almeling 2005), seem to be heeding Stern’s message.

### Inadequate Health Care

Finally, the fat acceptance movement has tried to draw attention to how fat people’s health is compromised, not by their weight per se, but by negative attitudes toward fat people on the part of health professionals (Yanovski 1998; Price and Desmond 1987). They point to how medical equipment, medical gowns, and equipment such as MRI machines often do not fit people who weigh over 350 pounds, compromising their medical care and leading these people to avoid preventive care. The fat acceptance movement further argues that neglectful health care—rather than any direct effects of obesity—may be responsible for some of the negative health associations with obesity. For instance, some refer to research showing that obese women are less likely to receive cervical exams (Adams et al. 1993) to argue that this—rather than any independent effects of their weight—explains the higher incidence of cervical cancer among obese women.

Fat acceptance activists draw on their personal experience to argue that doctors assume any health problem that a fat patient suffers, from infertility to blood clots, is due to their obesity without doing adequate exams. They say that fears about being harangued about their weight contribute to the reluctance of many fat people, especially women, to seek preventive medical care, thus leading to health problems that could have been prevented with early screening. When asked, the antiobesity researchers interviewed readily acknowledge the bias and discrimination that fat patients experience at the hands of health care professionals. However, they dispute that such discrimination accounts for all of the negative

health effects associated with obesity or that it is worsened by antiobesity research and activism.

### Credibility Struggles

Given lack of unanimity about how to interpret scientific evidence, assessments of scientific credibility tend to focus on claimants and not just on claims (Epstein 1996: 333). This section discusses how interview respondents establish their own credibility, while undermining that of their opponents. All appeal to academic prestige to affirm their own credibility and the credibility of some of their supporters; the antiobesity camp also frequently questions the academic standing of their most visible opponents. Fat acceptance activists evoke their personal experiences with weight-loss techniques and fat prejudice as an alternative form of expertise. The fat acceptance camp invokes conflict of interest, pointing to the fact that many antiobesity researchers receive research funds from pharmaceutical companies, run weight-loss clinics, and advise weight-loss companies, whereas the antiobesity researchers point to the physical bodies of their opponents as evidence of a different sort of conflict of interest, in which denying the health risks of obesity is read as making excuses for personal fatness.

### Academic Authority

To shore up support for the position that obesity is an important health risk factor, antiobesity researchers typically refer to both the numbers of articles establishing this and the prestige of the research. According to an interview with VanItallie, “So many studies have shown this relationship that it makes no sense to question it.” One researcher says of fat acceptance researcher Paul Ernsberger,

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

When asked about the fat acceptance position that obesity research intensifies the stigma fat people experience, this same researcher responds: “Well you know, when you listen to what people say, you have to think about what their qualifications are for saying it. I think the Vatican came out with some kind of statement that said all opinions are not equal, and if your opinion is rendered by somebody who has no qualifications to render the opinion, it shouldn’t be given much attention.”

Fat acceptance activists are acutely aware that their lack of advanced degrees translates into a lack of credibility, which is why fat acceptance research has been so important in strengthening their position. In response to a question about how the fat acceptance movement is different from the Health at Every Size movement, Lynn McAfee responds, “I think they [HAES researchers] have credibility and we [fat acceptance activists] don’t. I think that’s really it in a word. . . . People would say to me all the time when I come up with these studies, ‘you don’t know what that means, you’re not a doctor.’ Well, I don’t have to be a damn doctor to know what a 98% failure rate is.”

In that body weight is generally discussed in medical (as opposed to political, sociological, or legal) terms, medical doctors have an automatic advantage in credibility struggles. So, for instance, in a *USA Today* article (Hellmich 2004), antiobesity researcher Willett, identified as chairman of the department of nutrition at the Harvard School of Public Health, discredits Paul Campos’ book *The Obesity Myth* in these terms: “This is one lawyer with no experience and no medical training.” Similarly, his colleague JoAnn Manson, in an op-ed in the *Rocky Mountain News* (Manson 2002), writes that Campos “has no apparent credentials in medicine or public health to challenge medical researchers or public health professionals who caution the public about the health hazards of obesity (he’s a lawyer).”

### The Authority of Personal Experience

Fat acceptance activists, on the other hand, invoke their personal experiences with weight as an alternative source of expertise. For instance, several speak about how draconian weight-loss diets lead to weight gain over time, as after each diet was over they regained back all the weight lost plus additional weight until they had, in the words of a forty-four-year-old administrative assistant and member of NAAFA, “doubled my weight through dieting in a little over twenty years.” She explains,

I wasn’t always fat even though I thought I was. My height and weight sort of maxed out at 5’2” and 125 lbs, and at that weight I had people telling me I was fat, and my friends were my height [and] around 100 lbs, and then I had friends quite a bit taller than me who weighed 115 and 120 [pounds], and this wasn’t too long after the Twiggy thing, and when I first started reading women’s magazines the rule in all these magazines was you should be 100 lbs for 5 feet and 5 pounds for every inch over that, so I should have weighed 110, and I weighed 125. . . . And I still believe that had I never dieted, I’d still be pretty close to that 125.

When presented with these arguments during interviews, antiobesity researchers typically dismiss them as anecdotal. Like others, Hill responds, “Well, you really don’t have the control condition there, you really don’t know what would have happened to their weight if they hadn’t dieted, do you?”

### Economic Conflict of Interest

Fat acceptance activists also point to diet industry funding to discredit antiobesity researchers. For example, official NAAFA policy statements ([www.NAAFA.org](http://www.NAAFA.org)) argue that “most obesity researchers experience a profound economic conflict of interest.” They point to the increased revenue that accrues to researchers, the commercial weight-loss industry, and physicians with each redefinition or renewed concern about the effects of obesity. NAAFA states that “most leading obesity researchers are either consultants to diet or pharmaceutical companies, conduct research for these companies, presenting [*sic*] their results at conferences sponsored by these companies, or sometimes all three.” The organization “condemns those obesity researchers who use their position as public health policy-makers to further their own economic interest.”

Concerns about how economic interests fuel attention to the obesity epidemic are also echoed among individual activists. Fat acceptance activists and researchers tend to be openly critical of antiobesity researchers, referring to them as the *obesity mafia*. The term *mafia* expresses internal cohesion, danger, and crime, but perhaps most significantly implies the extent to which researchers illegitimately profit from the exploitation of antiobesity health rhetoric.

During interviews, antiobesity researchers generally admit that obesity research is influenced by funding sources. According to one researcher, “Industry can . . . probably identify people that they feel like they can get a

positive result from” and “if you’re out there taking money from industry . . . you better worry because you walk a very fine line doing it.” Another researcher says more generally, “Well, it may not be overt, but I think that there’s a tendency to expect that the investigators will come up with a favorable report.”

Brownell acknowledges that pharmaceutical companies do sometimes fund studies of the health and economic cost of obesity because “they want to sell their drugs, and . . . one of the barriers they face is that the physicians weren’t dealing with obesity as a disease.” However, he argues that the benefits of having the pharmaceutical companies fund these studies outweigh the costs: “Here’s this massive problem, it’s getting basically ignored by the government. And [now] the drug companies are putting all that money in. Great. We need those studies.” Another researcher also points to the value of industry funding: “At the moment the funding situation is such that . . . it’d be very difficult to function without some financial support.” In other words, although the fat acceptance activists and researchers see obesity researchers as driven by the interests of the weight-loss industry, antiobesity researchers see the weight-loss industry as providing additional resources for work they independently consider important.

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

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

To resolve the tension between the need for industry funds and the risks involved, researchers generally agree on the importance of taking measures to safeguard against bias, including by disclosing sources of funding, by stipulating in grants that the work will be published regardless of the findings, and by insisting that the funding source will have no input into the publications. For Hill, a researcher’s integrity is the best safeguard against bias: “For most of us, our reputation is the most valuable thing we have.”

Several of the antiobesity researchers interviewed defend the science establishing the health risks associated with higher weights by pointing out that the major studies have been funded by the U.S. government and not by pharmaceutical companies. However, as Hill points out, although government grants provide the “more non-biased way to get funding. . . . people are potentially biased by all sorts of funding,” including NIH funding: “Your whole goal in NIH research is to get that grant funded, and there’s a whole bias toward showing that your hypothesis works. . . . You [also] tend to focus on the things that you think NIH is interested in, so if they have an RFA [Request for Applications] out for this particular area, you focus your work toward that area.” In other words, Hill suggests that one reason the amount of research on obesity has exploded in recent years is that funding agencies such as NIH have made more money available for obesity research.

### Fatness as Conflict of Interest

Although the fat acceptance camp suggests that obesity researchers cannot be trusted because of their financial interests, the antiobesity camp argues that fat acceptance is just an excuse for bad health behavior. In interviews, obesity researchers suggest that the fact that most fat acceptance activists are very fat women discredits them as simply making excuses for their weight. According to antiobesity activist Fumento, the claim that one can be five to fifty pounds over current weight guidelines is of little or no consequence as long as one is physically fit “gives self-deceiving obese people something to hide behind, because they can (and do) assure themselves that while, yes, they burst through the ceiling of the height-weight charts long ago, they ‘feel like’ or ‘just know’ they’re in damned good condition” (Fumento 1997: 23). Likewise, when asked about the risk that public recommendations that people try to lose weight by dieting lead to yo-yo dieting, antiobesity researcher Pi-Sunyer responds: “I’m worried about the opposite message, that people use [the risk of yo-yo dieting] as an excuse not to deal with obesity.”

This attitude appears to be widespread. Glen Gaesser says in an interview that his book editor agreed to publish *Big Fat Lies* only when she saw that he was tall and thin because she reasoned that, if he had been fat, the book “would have been viewed as almost a rationalization for being fat, [as if he had] a personal axe to grind.” Fumento (1997: 119), in a section titled “The ‘Fatlash’ Books,” expresses concern that Gaesser’s weight status might indeed give his book authority: “Gaesser’s book came out just

before another fat acceptance book, Richard Klein's *Eat Fat*, and half a year before yet another, Laura Fraser's *Losing It*. But it has the potential to do much more damage because the Klein and Fraser books come across as written by fat people trying to justify their conditions rather than change them. . . . But Gaesser is thin!" Researchers—even those with impeccable academic credentials—who fall in the overweight or obese categories run the risk of being discredited because of their weight. For instance, when asked about research findings showing that one can avoid health risk by being fit and fat, an antiobesity researcher evokes the author's personal health history to undermine his findings: "[Steve Blair] is fat, and he's been exercising a lot, but he can't lose weight. But he's had a bypass himself, and he's had a myocardial infarction. . . . He might have been better off with weight loss as well as fitness."

That a fat person is incapable of speaking objectively about weight seems to be readily accepted, although the idea that a thin person would be biased in a different but equally strong direction seems less intuitive.<sup>14</sup> In this case, thinness functions as the "unmarked category," much as whiteness or maleness are considered unmarked categories for race and gender, respectively. In all of these cases, the biases of the dominant group are ignored. However, although in the contemporary United States women are considered legitimate commentators on gender and blacks well positioned to comment on race, an author who is fat is seen as disqualified from commenting on body weight, particularly as it relates to health risk.

### A Paradigm Shift?

Despite seemingly having less institutional power than the antiobesity movement, the fat acceptance movement seems to be having a surprisingly great amount of influence over mainstream medical practices and scientific expertise regarding weight and health. In this section, we argue that political traditions of antidiscrimination provide an opportunity for fat acceptance, in that activists can "bridge" (Snow et al. 1986) the issue of fat discrimination onto discrimination based on race, gender, sexual preference, or physical ability. Fat acceptance activists have also been able to exploit structural opportunities for influence. The influence of the fat acceptance movement is most evident in the increased recognition

14. The extreme positions of one female antiobesity researcher are often discredited by fat acceptance researchers as a product of distorted thinking deriving from her history of anorexia. However, in this case, it is this woman's relationship with food and her body, and not her body size per se, that is highlighted.

of problems related to size discrimination. According to fat acceptance researcher Ernsberger, NAAFA used to be "considered part of the lunatic fringe" for discussing the stigma associated with obesity; "now everyone talks about fat discrimination." Indeed, discrimination is now included as one of the hazards of obesity in most current reviews and consensus statements on the issue. For instance, the "Healthy People 2010" report (U.S. DHHS 2000: 29) describes the health impact of overweight and obesity in the following terms: "Overweight and obesity substantially raise the risk of illness from high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances, and problems breathing, and certain types of cancers. Obese individuals also may suffer from social stigmatization, discrimination, and lowered self-esteem." Ironically, as Ernsberger points out on the showmethedata Listserv, the group that has embraced, or one might say co-opted, the concept the most is weight-loss surgeons, who "argue that societal discrimination is one of the main justifications for surgery." For instance, the Web site of the American Society for Bariatric Surgery ([www.asbs.org/html/patients/rationale.html](http://www.asbs.org/html/patients/rationale.html)) includes under its "Rationale for the Surgical Treatment of Morbid Obesity" the following statement: "There are widespread negative attitudes that the morbidly obese adult is weak-willed, ugly, awkward, self-indulgent, and immoral. This intense prejudice cuts across age, sex, religion, race, and socioeconomic status. Numerous studies have documented the stigmatization of obese persons in most areas of social functioning. This can promote psychological distress and increase the risk of developing a psychological disorder."

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

The influence of fat acceptance is also evident in several authoritative health publications. For instance, the Weight Realities Division of the Society for Nutritional Education produced an October 2002 report titled "Guidelines for Childhood Obesity Prevention Programs: Promoting Healthy Weight in Children" (Society for Nutrition Education 2002), which adopted an explicit fat acceptance approach. According to Bur-

gard, “many HAES folks were instrumental in getting that written and published.” Indeed, several health professionals and researchers associated with the fat acceptance movement are listed among the committee of nutrition experts that developed the guidelines. This report stresses the importance of setting “goals for health, not weight, as appropriate for growing children” and says that it is “unrealistic” to expect all children to be at an ideal weight range. Instead, this report defines “healthy weight” as “the natural weight the body adopts, given a healthy diet and meaningful level of physical activity,” which it later specifies to be one hour of physical activity each day. It stresses the importance of fostering self-esteem, body satisfaction, and positive body image in all children.

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

This influence of patient representatives is evident in several official health documents that have been released in recent years. For instance, an article published by the National Task Force on the Prevention and Treatment of Obesity (2002; henceforth NTFPTO 2002) and two pamphlets published by the NIH (NIH Publication No. 03–5335 and NIH Publication No. 00–4352), on which McAfee played an important advisory role, promote a fat acceptance approach. NTFPTO 2002, titled “Medical Care for Obese Patients: Advice for Health Care Professionals,” discusses how “health problems experienced by persons who are obese are worsened by lack of access to care because of their obesity” and how “patient concerns about being disparaged by physicians and/or medical staff because of their weight” may “decrease patients’ willingness to seek medical care”

(82–83). Although the article *does* assert that obesity constitutes an “independent health risk,” the stated purpose of the article is “to provide guidance on ways to optimize the medical care of these patients, independent of recommendations for weight loss treatment” (ibid.: 83).

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

Many of the recommendations made to health care professionals in this article are also stressed in an NIH pamphlet (NIH 2003) targeting health care professionals. These included adapting the office for obese patients by providing sturdy, armless chairs; sturdy, wide examination tables, “preferably bolted to floor to prevent tipping; extra-large examination gowns; split lavatory seat and specimen collector with handle; large adult blood pressure cuffs and thigh cuffs; extra-long phlebotomy needles and tourniquets; and large vaginal speculae” (NTFPTO 2002: 83). Doctors are also informed of the importance of providing weight scales with capacity for patients over 350 pounds and weighing patients privately and only when necessary.

Readers of both the article and the NIH pamphlet are told to be careful about “word choice” and that “patients may respond extremely negatively to the use of the term obesity, but be more amenable to discussion of their difficulties with weight or being overweight” (ibid.: 84). This reflects some understanding of fat acceptance arguments about how the medical language of obesity can be stigmatizing, but does not go so far as to reject that pathologization or medicalization of fatness, which is also implicit in the word *overweight*. The suggestion to use *overweight* instead of *obese* when discussing people who would be categorized as morbidly obese according to current guidelines also blurs the lines between different weight categories.

Neither publication completely rejects the goal of weight loss, but both also urge doctors to encourage lifestyle changes independent of weight loss and to stress the importance of avoiding further weight gain. The NIH pamphlet urges medical professionals to discuss even minimal weight loss—as little as 5 to 10 percent of body weight—as a treatment for weight-related medical conditions but also advises them, as does the NTFPTO 2002 publication, to encourage physical activity to improve cardio-

vascular health and to “promote self-acceptance and encourage patients to lead a full and happy life” (NIH 2003: 4).

McAfee’s influence on an NIH pamphlet on physical activity for “very large” individuals is also evident. With photos of several NAAFA members, visibly weighing about 250–600 pounds, engaged in a variety of physical activity, the pamphlet’s message, “If you are a very large person, you can still be physically active,” is clearly targeted at even the heaviest. The pamphlet highlights the health and personal benefits of exercise, from protection against diabetes to boosting one’s mood. It advises readers to start their exercise routine slowly, set realistic goals, track progress (of fitness, not weight), fit activity into daily life, get support, and have fun. It explains the advantages and disadvantages of different kinds of exercise and provides practical tips, such as standing up straight and relaxing one’s shoulders when walking. Sounding like a Health at Every Size advocate, it informs the reader that “healthy, fit bodies come in all sizes. Whatever your size or shape, start exercising now and keep moving for a healthier life!”

In that feminist research has raised concern about women’s obsession with body weight and eating disorders (e.g., Hesse-Biber 1996; Chernin 1995; Thompson 1994; Wolf 1991), this also provides an opening for critiques about weight-focused health recommendations. On the showmethedata Listserv, Burgard argues that fat acceptance research can take partial credit for new understandings that one cannot “white-knuckle” through a diet and then “go back to eating normally,” but that dietary and activity changes must be permanent. Likewise, Ernsberger says, “Outside of the expert NIH panels, most clinicians and lay people alike [now] accept that it is unhealthy to lose and regain large amounts of weight,” known as weight cycling or the yo-yo syndrome.

The FDA is one of the institutional arenas in which the AIDS movement has made the most inroads in terms of consumer representation (Epstein 1996). The fat acceptance movement has made use of these avenues, as well as public concern about dangerous consumer products, to push for regulation of the most egregious weight-loss claims and products. For instance, the FDA postponed the approval of specific kind of weight-loss surgery largely because of McAfee’s intervention. Several fat acceptance activists were also “involved in getting the Federal Trade Commission (FTC) to ban the worst of the weight-loss gimmicks/ads,” according to Burgard.<sup>15</sup> But fat acceptance advocates point to local successes as well,

15. By contrast, according to fat acceptance researcher Francie Berg, writing on the showmethedata Listserv, fat acceptance and eating disorder researchers have had less success influencing the Healthy People Reports, despite having sent several group and organizational letters requesting, for instance, that eating disorders be considered a health risk for Healthy People 2010.

such as, in the words of Burgard, “The time I prevented my desperate hospital from embarking on an Optifast-type program to make money; or [when I squashed] a workplace weight loss contest called the ‘Lard-Off’ at the university where I was working.”

Finally, some fat acceptance clinicians say that these fat acceptance messages are influencing practicing physicians. Burgard writes on the Listserv that, due in part to the effect of fat acceptance workshops provided to medical professionals, “I now have many patients who tell me their docs no longer harass them about their weight but instead pay attention to whether they are getting out and about.” Burgard further points to the greater “interest in movement for large people” among physicians. Thus, there is some indication that this paradigm shift has begun to move beyond mainstream medical authorities and into the daily practices of medical professionals.

## Conclusion

This article provides a detailed analysis of current debates over body weight and health. Strikingly, we found that what one might assume to be strictly arguments over scientific method and empirical facts are actually heated struggles over framing and morality. These struggles, in turn, potentially have important implications for social inequality. For instance, framing obesity as risky behavior may serve to legitimate social inequality and health disparities. For if obesity is understood as visible proof of bad food choices and refusal to exercise, then the relatively higher rate of obesity among poor and minority groups may be invoked to blame individuals—instead of structural issues such as poverty, lack of health insurance, or violence—for their poor health.

We have also shown how the risky behavior frame of obesity can be used to challenge an alternative framing of fatness as body diversity. For, if fatness is a preventable behavior leading to life-threatening illness, it should not be tolerated. Similarly, scientific debates over whether homosexuality is a lifestyle choice or an innate characteristic have been important for gay rights because it is currently more socially acceptable to condemn choices than immutable traits. However, the “gay plague” notwithstanding, those who consider homosexuality bad stand on primarily religious—not medical—grounds. This contrasts with the obesity case, in which medicine—rather than the church—is the moral authority. This means that, to successfully advance similar rights claims, gay rights activists and fat activists need to debate very different kinds of evidence. While

gay rights activists need to counter religious claims that homosexuality is a sin, fat activists need to address medical arguments that fatness is a preventable cause of mortality and morbidity. This explains why medical disputes have been so central to fat activism. It also sheds light on the particular challenges fat activists have had in advancing their cause, for, in debates about medical science, those with advanced degrees in medicine have more authority and credibility than laypeople, especially fat laypeople who can be portrayed as making excuses for their weight.

Declaring an epidemic has historically lent a sense of urgency that can—like declaring war—justify abridging civil liberties. Quarantine, in which people with infectious diseases are isolated to prevent the spread of disease, illustrates how having a (highly infectious) disease can compromise one's civil liberty. It is thus not necessarily surprising that the framing of obesity as an epidemic may undermine the status of fat people. But obesity is not an infectious disease in any literal sense and any associated health consequences occur at some unknown future date. Instead, the epidemic framing of obesity conflates the literal and metaphorical meaning of *epidemic*. In the latter, the *epidemic of obesity* represents concern about the spread of immoral behavior. We would argue that, just as alarm over teen pregnancy draws on fear of unchecked sexual appetite especially in unmarried girls, so concern over obesity expresses unease with unchecked appetite for food. However, unlike teen pregnancy, “moral panic” (Cohen 1972) over obesity gains legitimacy by being articulated—including by medical authorities such as the surgeon general or the WHO—as a *medical* concern.

Discourses about risk became a dominant theme in the late twentieth century—both as a means of discussing health (Lupton 1999) and within society at large (Giddens 1990, 1991). Discussions of health risk also serve as part of the increasing surveillance functions of modern medicine, which shifts the medical gaze from the individual patient to the population at large and encourages individuals to adopt increasing vigilance over their own bodies and behaviors (Armstrong 1995; Lupton 1995). In that sense, the targeting of obesity as a health risk is part of a general trend that is not unique to weight but concerns other areas such as smoking, alcohol consumption, or drug use. However, unlike such behaviors, obesity is a (stigmatized) physical characteristic. Although smokers may feel targeted by policies that ban smoking in public restaurants, most are able to step outside to smoke and then return to their meal. In contrast, fatness is at best indirectly linked to behaviors, rather than a behavior in itself. A fat person cannot walk out of her or his fat body to enjoy a meal free from

comments about how he or she should not be eating so much high-caloric food. Moreover, although smoking is cool in many social settings, there are few places—especially for children and teens—where it is hip to be fat. Thus, the case of obesity is unique in that discussions of health risk are likely to reinforce negative sentiments about a highly visible and stigmatized group.

As one would expect based on the literature, we found that both academic and personal experience are invoked in credibility struggles over obesity. We also found that fat acceptance activists and researchers cite economic conflict of interest to discredit antiobesity research. Often such arguments refer vaguely to the interests of the weight-loss industry in promoting general concerns about obesity, rather than identifying a conflict of interest of a specific researcher with a particular company. This provides a reason to dismiss much antiobesity research out of hand. Likewise, antiobesity researchers and activists speak of fat activists' and (when applicable) researchers' fatness as if it were a form of conflict of interest. Obese people, they argue, cannot be trusted to assess the health risks associated with obesity because it is in their personal interest to deny them. Once again, this argument relies on the assumption that weight is under personal control, but that fat people are too lazy or self-indulgent to manage it and thus welcome excuses to be complacent with their obesity. It also allows fat acceptance arguments to be dismissed out of hand. The mistrust between these two camps can make it difficult to find middle ground.

The hostility of the fat acceptance movement to medical labels of fat people as ill distinguishes them from many identity groups based on disease categories such as breast cancer, chronic fatigue, multiple chemical sensitivity, and Alzheimer's, which assert political and scientific claims based on these new identities (Epstein 1996: 347–348). The obesity case highlights several reasons certain identity groups embrace medical models whereas others reject them. For instance, the obesity case suggests that medical models blaming individuals for their ill health are likely to be rejected. But it also shows that framing illness as a disease beyond personal control does not necessarily mean the medical frame will be embraced, because this implies that the diseased person is biologically flawed.

Whether groups accept such stigma may depend on their alternatives. If the choice is between being seen as criminal or sick, the sick label may be relatively attractive (see Conrad and Schneider 1992). However, being neither criminal nor sick will usually be preferred. We would argue

that groups will thus be most likely to reject the sick label when they do not perceive available medical treatment as effective or even necessary. Currently, there is no magic cure for obesity so there are few perceived benefits for fat people in framing obesity as a disease. Weight-loss surgery can result in dramatic weight loss but is only recommended for people who are at least one hundred pounds over the current weight guidelines. Moreover, its long-term efficacy is not known and it has major associated health risks including a relatively high rate of death. Despite its limitations, the perceived benefits of weight-loss surgery do seem to be leading some individuals to assert that obesity is a disease to advocate reimbursing weight-loss surgery by health insurance. If a pill were discovered that produced major weight loss, we would expect to see more groups organized around the assertion that obesity is a disease. There are many diseases for which available medical treatments are ineffective, but, unlike, say, cancer, people categorized as obese can live long lives without medical treatment for their weight. If being diagnosed as obese implied a quick and certain death, we would expect people so diagnosed to embrace the disease category and clamor for any available treatment no matter how ineffective.

Ironically, given their hostility to being labeled as ill, fat acceptance activists have been given a seat at the table in NIH and FDA meetings as representatives of an obese patient group. This suggests that, depending on institutional arrangements, the disease framing of a condition may open up avenues for influence that can subsequently be used to challenge the disease framing of that condition. Future work should further investigate how the frames we identified are used in political struggles over policy recommendations and official guidelines, as well the extent to which different frames are invoked in media discussions of obesity. Further work on this topic is critical, not only for advancing sociological understanding of framing contests, but also for evaluating the social impact of current approaches to the obesity epidemic.

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