CONTESTED MEANINGS ABOUT BODY, HEALTH, AND WEIGHT:

FRAME RESONANCE, STRATEGIES OF ACTION, AND THE USES OF CULTURE

by

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A Dissertation Submitted to the Faculty of the

DEPARTMENT OF SOCIOLOGY

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

THE UNIVERSITY OF ARIZONA

2007

THE UNIVERSITY OF ARIZONA

GRADUATE COLLEGE

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entitled: CONTESTED MEANINGS ABOUT BODY, HEALTH, AND WEIGHT: FRAME RESONANCE, STRATEGIES OF ACTION, AND THE USES OF CULTURE

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ACKNOWLEDGEMENTS

I would like to thank the members of my committee for their support throughout the dissertation process. I am especially grateful to Louise Roth for her ongoing support throughout my graduate school years. I am also indebted to members of my dissertation group (Laura Auf der Heide, Matt Brashears, Jeff Larson, Steven Nelson, and Claude Rubinson) for their friendship, helpful feedback, and support. I am very grateful to Mary Nell Trautner for her friendship, advice, and mentorship and to Christine Sheikh for her friendship, kindness, and support. I am thankful to be part of an incredibly supportive intellectual environment and for the inspiration and encouragement of peers such as Jeremiah Coldsmith, Jamie Dolan, Jessica Epstein, Han Yi, Brian Hewlett, Julia Kanago, Lorien Lake, Christina Liu, Scott Savage, and Bill Tsitsos; faculty members such as Celestino Fernandez and Joe Galaskiewicz; and others such as Tricia Lopez and Camilla Strausfeld. Special thanks to Steve Corral, Jeff Larson, Steven Nelson, Jeff Sallaz, Garrett Schneider, and Mary Nell Trautner for the laughs, workouts, and memories on the tennis court and to Sav Ferrie, Mette Klingenbeck, Susan Kwan, and Raj Prasad for their ongoing friendship, love, and support over the years. Finally, I would like to thank my interview respondents for taking the time to share their perspectives and stories.

Data collection and analysis were made possible by a Doctoral Dissertation Improvement Grant from the National Science Foundation's Sociology Program (SES#0602027) and grants from the University of Arizona's Social and Behavioral Sciences Research Institute. These grants provided valuable undergraduate research assistance. I am especially thankful to Crystal Richmond and Michelle Perry for their thoroughness and hard work.

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ABSTRACT

There has been much talk in the public arena about the meanings of the overweight body. While feminist scholars have long theorized and studied the oppressive effects of hegemonic beauty norms, in recent years several groups such as the Centers for Disease Control, the National Association to Advance Fat Acceptance (a non-profit fat acceptance organization), and the Center for Consumer Freedom (a non-profit organization representing the food industry), have stepped up claims-making about the fat body and what it represents. How are these competing cultural messages promulgated by these cultural producers? Do these messages resonate with individuals? Moreover, how meaningful are these cultural messages in shaping day to day lives?

Using content/frame analysis, survey data (n=456), and in-depth qualitative interviews (n=42), my dissertation examines framing competitions and dynamics among four competing cultural frames about the overweight body (the health frame, beauty frame, market choice frame, and social justice frame). I also examine the relationship between these cultural frames and individual agents. Specifically, I look at how respondents use culture by accepting, redefining, and rejecting elements of various frames.

In the frame analysis, I document the "signature elements" of the health, social justice, and market choice frames and discuss each frame's social and cultural significance. Analysis of the health frame shows how overweight and obese respondents redefine and reject health messages and how their uses of culture affect their self-perceptions of healthiness and health motivation for weight loss. Analysis of the beauty frame confirms the prevalence of the desire for weight loss, despite critique or acceptance of the cultural ideal. Results also highlight the interconnection between the health and beauty frames. Because

beauty provides status, weight loss motivation stems in part from the health frame but, at times, even more from the beauty frame. In my analysis of the beauty frame, I also explore and theorize women's body consciousness and their attempts at body management. Finally, analysis of the market choice frame indicates strong resonance of the food industry's perspective, particularly the claim that individuals (and not corporations) are responsible for their bodies. Respondents generally do not support government regulation of the industry. Analysis of the market choice frame also connects the food industry frame to a main tenet of the social justice frame, pointing to a significant and positive relationship between perspectives on responsibility and anti-fat views. In the dissertation, I elaborate on these findings about health, beauty, individual and corporate responsibility, and social justice; the relationship between culture and agents; policy implications; and directions for future research.

CHAPTER 1

INTRODUCTION

Feminist Scholarship on the Overweight Body: Body Aesthetics

Feminist scholars have long studied cultural messages about the overweight body and its social significance.[1] Among others, Bordo (1993), Hesse-Biber (1996), and Wolf (2002) have written extensively about the presence and oppressive effects of a cultural beauty ideal that privileges the thin body. It is an ideal that is ubiquitous and perpetually reinforced in mainstream and popular culture. It is also an ideal that is supported by the fashion, beauty, and diet industries that profit as individuals attempt to realize this ideal (Fraser 1994; Seid 1989).

While this ideal affects both men and women, it tends to affect women more profoundly. This is because "ideologies of weight closely parallel ideologies of womanhood" (McKinley 1999: 97) where "body work" (Gimlin 2002) aimed at changing one's appearance is really about "doing gender" (West and Zimmerman 1987). In other words, a hallmark of femininity is possession of a slender body. In this cultural climate, women are judged more harshly than men on attractiveness, especially as they age (Deutsch, Zalenski, and Clark 1986) and studies show that weight causes more pain and problems for women than men (Rothblum 1992).

In this literature, the relationship between culture and agents is depicted mainly in dichotomous terms; individuals are either passive recipients of larger cultural forces or they resist them. On the one hand, gender scholars observe that this anti-fat cultural ideal is

[1] Overweight and obese are often used as clinical or medical labels (see Bray and Bouchard 2004) while the terms fat and corpulent are considered politically correct terms (see Braziel and LeBesco 2001; Wann 1998).

really about creating normal, docile, and compliant bodies (Bordo 1993; Foucault 1978; Wolf 2002). The psychological, social, and economic effects of obtaining this unattainable beauty ideal are well known (Hesse-Biber 1996; Saltzberg and Chrisler 2000; Seid 1989). Women's weight is closely tied to, and often erodes, their self-worth (Rodin, Silberstein, and Striegel-Moore 1985). Pursuit of this "beauty myth" (Wolf 2002) also places women at physical risks when they try to attain what sometimes amounts to an unhealthily thin ideal (Saltzberg and Chrisler 1995; Sprague-Zones 1997) and many young women report that they smoke to curb their appetites (Sorensen and Pechacek 1987). Preoccupation with body weight and shape is often accompanied by depression and social anxiety (Cash and Deagle 1997; Cash and Grant 1996; Cash and Pruzinsky 1990; Freedman 1986; Thompson 1996).

On the other hand, resistance is evident. Individuals can be "savvy cultural negotiators" (Gimlin 2000, 2002). Since fat is not a fixed concept, individuals can revalue it through performance (Kuppers 2001; Mazer 2001). In the identity negotiation process, some obese individuals actively fight back and resist the stigma of obesity (Cordell and Ronai 1999; Joanisse and Synnott 1999). At the collective level, fat acceptance groups such as NAAFA practice resistance (Sobal 1999). A growing literature on beauty attitudes and racial minorities, specifically African-American women, also suggests a revaluation of the white beauty ideal at the individual level (Parker et al. 1995; Russell, Wilson, and Hall 1993).[2]

While the feminist literature focuses primarily on women, men too are becoming increasingly concerned with body images (Grogan and Richard 2002; Hatoum and Belle 2004; Pope, Phillips, and Olivardia 2000). Built into the leading social construction of

[2] Chapter 5 provides an overview of the gender literature on beauty, including six correlates of body dissatisfaction: gender, race, sexual orientation, age, class, and BMI.

masculinity are assumptions about the ideal male body (Connell 1995; Kivel 2003). With men and young boys, the desire to achieve a muscular, lean body type has led to a number of physically harmful practices including excessive bodybuilding, the use of anabolic steroids and untested dietary supplements, and the development of eating disorders (Labre 2002; Pope, Phillips, and Olivardia 2000).

Regardless of gender, embedded in cultural beauty ideals are norms about body type, including the overweight and obese body. And simply put, these norms dictate that the beautiful body is a thin body. Fat bodies are ugly deviations – an irony as an estimated two-thirds of Americans are overweight and a third are obese (Flegal et al. 2002). Increasing obesity rates are observed in all U.S. states, in both sexes, and across all age groups, races, and educational levels (Mokdad et al. 2003). All estimates are based on the Body Mass Index (BMI), a numerical computation using an individual's body weight and height. Specifically, BMI = [Weight (lbs)/Height (inches)^2] * 703. According to the government, an "overweight" individual has a BMI greater than twenty-five and an "obese" individual has a BMI greater than thirty.[3]

While these feminist contributions provide valuable insight into cultural standards and their potentially oppressive effects, they focus primarily on body aesthetics. The central focus is how bodies deviate from an aesthetic ideal that is culturally constructed and narrowly defined. However, in recent years, there has been growing discourse in the public arena about the meanings of the overweight body. It is in this recent cultural climate that

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[3] For example, a 5'3" woman is "underweight" if she weighs less than 107 lbs; "normal" if she weighs 107 to 140 lbs; "overweight" if she weighs 141 to 168 lbs; or "obese" if she weighs more than 169 lbs. A 5'9" man is "underweight" if he weighs less than 128; "normal" if he weighs 128 to 168 lbs; "overweight" if he weighs 169 to 202 lbs; or "obese" if he weighs more than 203 lbs.

several groups have stepped up claims-making about the body and, specifically, what the fat body represents.

Alternative Approaches to the Overweight Body: Health, Social Justice, and Market Choice

Since the mid-1990's, the U.S. government has expressed increasing concern over growing rates of obesity. It has gone so far as to label the problem an "epidemic" or one of "epidemic proportions" (USDHHS 2001). In response, it disseminates what can be labeled a medical or health message, one that is largely supported by the medical community at large. For example, the Centers for Disease Control (CDC) warn about the health dangers of being overweight or obese, along with the economic costs to both the individual and society. Specifically, it claims that obesity results in 110,000 excess deaths per year relative to the "normal" weight category (Flegal et al. 2005) and is associated with an increased risk of type 2 diabetes, heart disease, stroke, and hypertension, among a long list of other medical conditions (USDHHS 2001). Notably, an earlier figure of 400,000 (Mokdad et al. 2004) was recently discredited and retracted after internal criticism and revaluation. According to the government, overweight and obesity also result in $117 billion in both direct and indirect yearly economic costs (Wolf and Colditz 1998). Direct economic costs include preventive, diagnostic, and treatment services, while indirect costs include lost wages due to illness or disability, as well as lost future earnings because of premature death.

At the same time government officials warn of the dangers of an obese body to both self and society, others dispute this position. For example, members of the National Association to Advance Fat Acceptance (NAAFA), a non-profit human rights organization

dedicated to improving the quality of life for fat people and eliminating body size discrimination, express a social justice perspective on fat. NAAFA members and allies, including advocates of the Health at Every Size (HAES) movement, challenge medical data linking obesity to disease, claim that fat bodies can still be healthy, and draw the public's attention to fat discrimination and the dangers of yo-yo dieting (Campos 2004; Ernsberger and Haskew 1988; Gaesser 2002; Katrina, King, and Hayes 2003; Wann 1998). These "fat acceptance activists" and HAES advocates challenge the aesthetic body ideal that they claim has fostered social stigma and discrimination against fat bodies (see Gimlin 2002; Saguy and Riley 2005). In their endeavors to promote social justice, they encourage embracing body diversity.

Similarly, but for very different reasons, food industry representatives at the Center for Consumer Freedom (CCF), a non-profit public interest group representing over 30,000 restaurants and taverns in America (SourceWatch 2005), challenge the government's medical position. CCF representatives question medical research linking obesity to disease, argue that obesity's economic toll is exaggerated, and charge that obesity researchers are influenced by a $40 billion a year weight-loss industry (Center for Consumer Freedom 2004). In its media campaigns and publications such as *An Epidemic of Obesity Myths*, the CCF forwards a free market approach to obesity. They promote the message that American adults are sensible enough to make their own decisions about what to consume. In a capitalist democracy, individuals should have the right to consume whatever they want. Unlike NAAFA's ideological interests, the CCF's interests are primarily economic and geared at maintaining food sales.

The Social Construction of Fat: Frames and Cultural Producers

Competing views about the meanings of fat are expected. Obesity is not just a medical fact; it is also a social fact that various groups, industries, and "moral entrepreneurs" vie to define (Becker 1963; Sobal 1995). Sociologists have long recognized that social problems do not solely derive from objective conditions but from a process of collective definition (Blumer 1971; Mauss 1977). Social actors come together to define social problems and their meanings. While some groups assert the existence and offensiveness of some condition (Spector and Kitsuse 1973a, 1973b, 2001), others attempt to convince authorities and the public that there is a moral problem at hand (Becker 1963, 1966). When the medical profession is involved, the medicalization of deviance may occur and medical definitions may take precedent (Bury 1986; Conrad 1992; Conrad and Schneider 1980). As Hilgartner and Bosk put it, "within each substantive area, different ways of framing the situation may compete to be accepted as an authoritative version of reality" (1988: 58).

At the core of some social problems are competitions and, specifically, framing competitions – struggles over the production of ideas and meanings (Benford and Snow 2000). As Goffman writes, framing is an attempt to define "What is it that's going on here?" (1974: 25). Frames are cognitive shortcuts that enable actors to make sense of everyday social experiences. As "schemata of interpretation," they help an actor "locate, perceive, identify, and label" complex events, making otherwise meaningless events meaningful. Actors can arrive at a "definition of a situation," organize and interpret experience, and act accordingly (Goffman 1974). Frames enable efficient information processing, suggesting what is at issue and a course of action. In other words, framing states

what is at the heart of a situation or problem. This process involves selection and salience; selecting some aspect of a perceived reality and making it salient as to promote a particular definition of the problem (Entman 1993). It also involves diagnosing cause(s), making moral judgments, and suggesting policy remedies (Gamson 1992; Iyengar 1991; Ryan 1991). While frames perform interpretive functions, as social movements scholars discuss, they can also be action-oriented sets of beliefs that are designed to mobilize, garner support, and to demobilize antagonists (Snow and Benford 1988). With socially contentious issues, framers participate in a dialogical process of framing and counter-framing (Esacove 2004). In sum, a frame is a "central organizing idea for making sense of relevant events, suggesting what is at issue" (Gamson and Modigliani 1989: 3). Various framers or frame sponsors – whether they are media representatives, public health officials, social activists, or lobby groups – can participate in the framing process of a wide array of social issues.

Recent Work on Obesity Models and Fat Frames

Sociological work on defining obesity and its meanings can be traced to Sobal's (1995) earlier writings on obesity models. According to Sobal, fat shifted historically from a sign of health and wealth in traditional societies to being seen as bad, sinful, and ugly in modern societies. With the agricultural and industrial revolutions that assured more regular food sources, fat began to be viewed unfavorably. This shift provided the basis for a "moral model of fatness," suggesting that fat people are responsible for their condition and should be punished as a means of social control (Sobal 1995: 69). This moral model was prominent until the medicalization of obesity took place in the 1950s (Brown 1995; Conrad 1992). This medicalization involved naming the problem officially as obesity, defining obesity as a

disease, a surge of professional activities, and the application of medical treatments. More recently, NAAFA's attempt to demedicalize obesity has led to a new political model aimed at combating discrimination and educating the public about body diversity. In sum, according to Sobal, obesity models shifted from "moral deficit" to "medical disease" to "political discrimination," although all three, but particularly the moral model, remain evident today.

Saguy and Riley's (2005) novel study, which uses a mix of secondary and original data sources, participant observation, and in-depth interviews, is the first systematic examination of obesity frames. Their study examines how groups at the forefront of the obesity controversy – antiobesity researchers, antiobesity activists, fat acceptance researchers, and fat acceptance activists – talk about obesity. They observe several frames. While members of fat acceptance groups like NAAFA embrace a "body diversity" frame, those in the antiobesity camp frame it as an "epidemic" and "risky behavior," i.e., life-threatening behavior like smoking that individuals choose. At times, both camps frame obesity as illness. Their study also examines credibility struggles and the appeal by various camps to academic authority and personal experience. While their study does not systematically document the influence or uses of frames, they note some success of the body diversity frame in the medical arena, perhaps suggesting a paradigm shift in the public's understanding of weight, body, and health.

Lawrence's (2004) work on obesity causal claims in the news media suggests a reframing of obesity over the past two decades. Popular understanding of the causes of obesity in the news has moved from "individualizing frames" that focus on individual responsibility, biology, and personal behavior, towards the realm of environmental causation.

Unlike individualizing frames, "systemic" frames situate individual choice in the larger context of environmental factors that shape eating and activity behaviors. Systemic frames have a broader focus, shifting responsibility from personal moral deficit to government, business, and larger social forces such as the abundance of inexpensive unhealthy foods, poverty, and lack of nutritional knowledge. In popular culture, Spurlock's *Super Size Me* (2004) and Schlosser's (2001) *Fast Food Nation* promote a systemic frame of obesity, moving the spotlight away from individuals and onto corporate responsibility.

Research on tobacco frames and the parallels between smoking and obesity (Kersh and Morone 2002) suggest that the implication of big business as one of the structural influences on obesity may lead to the food industry's articulation of a self-serving frame. Specifically, tobacco interest frames often "conjure up images of an America whose citizens are free to pursue happiness and the American dream by making their own choices in an environment of economic prosperity" (Menashe and Siegel 1998: 321). Has the food industry responded to accusations that it is one culprit in the health epidemic with similar rhetoric? While nutritionists such as Brownell and Horgen (2004) and Nestle (2002) have discussed the food industry's perspective on obesity, it has yet to be sociologically and systematically documented and analyzed. Moreover, no sociologist has mapped the cultural terrain of obesity and explicitly laid out the defining elements of each frame. Building on this recent work on obesity frames, my dissertation examines how food industry representatives, along with public health officials and fat acceptance activists, disseminate meanings about the overweight body in the public arena.

The Social Construction of Fat: Cultural Agents

Cultural frames are not just about the frames themselves and the interplay between competing and complementary frames, but also about the relationship between frames and agents. Framing is not just about framers articulating a position or the "production process," it is also about the interaction of frames with an active audience engaged in negotiating meaning (Gamson 2001).

Social movement scholars and sociologists of culture have theorized the relationship between frames and agents. While individual or biographical differences in the susceptibility to framing are important (Goffman 1974; Iyengar 1991), other factors also contribute to "frame resonance," the extent to which a frame is effective, adopted, and/or has mobilizing potency (Snow and Benford 1988). Snow and Benford (1988) note that frame resonance rests on frame credibility and relative salience. Credibility is contingent upon frame consistency (congruency between a frame's beliefs, claims, and actions), empirical credibility (fit between framing and events in the world), and the credibility of the framer (framer's status, expertise, credentials, etc.). Salience is measured by centrality (essentiality of beliefs, values, and ideas), experiential commensurability (resonance with everyday experiences), and narrative fidelity (the extent frames culturally resonate) (Snow and Benford 1988). The more a frame reflects personal experience and familiar cultural themes the more likely it will be accepted as a natural way to interpret reality (Ryan 1991; Snow and Benford 1988). Additionally, the more a frame resonates with a "master frame" (for example, the women's movement, gay rights movement, and animal rights movement all successfully borrowed from the rights master frame), the more likely it will be effective and/or adopted. These

master frames are broad in scope and function as a kind of master algorithm for other frames (Snow and Benford 1992).

Sociologists of culture have also provided some insight into the relationship between frames and agents. For example, Swidler suggests that because cultures are complex and contradictory and because even a common culture can be used in varying ways, "effective cultural explanation depends on understanding how culture is put to use" (2001: 6). According to Swidler, culture is best understood as a "tool kit" or "repertoire" of habits, skills, and styles from which individuals construct "strategies of action" and the self. Strategies of action are ways actors routinely go about attaining their goals. With body issues, these strategies include an individual's activity level and food consumption patterns, two external determinants of body size. Individuals draw on their cultural repertoires to make sense of their lives and themselves. Notably, culture has different functions during settle and unsettled times. During settled or stable periods, culture is taken for granted and people use culture to justify existing action or their identity. However, during unsettled or unstable times, actors take a more active role in imbuing and creating cultural meaning. Thus challenging Geertz's (1973) approach to culture as a coherent system or structure, Swidler urges sociologists to "start with those who use culture, asking what they do with the different ways of framing meaning they have available" (2001: 22). The focus of cultural analysis is on varied cultural meanings and the uses of culture, especially in everyday life. Or, as Spillman simply puts it: "Cultural sociology is about meaning-making" (2002: 1).

Fat Frames and Social Inequality

Frame resonance is important for at least two reasons. First, successful framing involves tangible benefits. For example, framing obesity as a personal choice, right, or preference in a democratic capitalist society helps maintain sales of certain foods that may be accused of causing the "epidemic." Similarly, framing obesity as an individual and surmountable problem caused by moral shortcoming encourages weight loss, thus translating into profits for the diet and fitness industry (Fraser 1994; Hesse-Biber 1996; Sobal 1995). There are even profits through legal and insurance benefits (Center for Consumer Freedom 2004; McCann and Haltom 2004; Sobal 1995). Simply put, when a frame resonates with audiences there are potentially large financial returns.

Second, because frames not only define a social problem but also prescribe its solution (Gamson 1992), frames have the ability to reduce or contribute to social inequality (Saguy and Almeling 2005; Saguy and Riley 2005). As Menashe and Siegel claim "[t]he concept of framing has important implications for individuals' opinions and attitudes" (1998: 310). Thus framing obesity as an individual health problem suggests that its cause is a lack of restraint and laziness. This frame blames individuals for their bodies and suggests policy that encourages change in individual consumption, exercise, and lifestyle patterns. It also endorses moral judgments of obese individuals, thus legitimizing social inequality and health disparities (Saguy and Riley 2005). In contrast, framing obesity as a result of structural influences, such as a lack of nutritional knowledge, access to high quality foods, or time to prepare high quality meals, suggests that individuals are less blameworthy. Here, an appropriate line of action involves addressing these structural disparities, a strategy that

removes some blame and stigma from overweight and obese individuals. In short, how individuals frame obesity has implications for social justice.

The relationship between frames and social inequality is particularly important because obesity is a visible status characteristic that has tangible social-psychological implications for a large segment of the population. For obese individuals, it potentially affects how others relate to them and also how they think of themselves. For example, extensive research points to widespread size-based discrimination in various arenas of social life such as employment, medicine, education, and law (Allon 1982; Cahnman 1968; DeJong 1980; Puhl and Brownell 2001, 2004; Sobal 2004). Obesity has also been linked to both self-esteem and self concept (French, Story, and Perry 1995; Friedman et al. 2005). Discrimination is especially noteworthy in America given the emphasis on individualism and the belief that weight is controllable (Crandall et al. 2001; Crandall and Martinez 1996).

Summary of Frames: Two Dominant, Two Reactionary

My dissertation begins by identifying four major frames that comprise the contested field of obesity. Gender scholars highlight the "aesthetic or beauty frame" and discuss at length the oppressive effects of hegemonic beauty ideals primarily on women. The U.S. government and the medical community put forth a "health or medical frame" that focuses on the health effects and costs of being overweight. NAAFA and HAES advocates promote a "social justice frame" that underscores size-based discrimination and promotes size diversity in a culture that privileges the thin body. Finally, the food industry forwards a "market choice frame," arguing that individuals should be able to choose what they want to consume and, by extension, their body type.

Two of these frames, the aesthetic and health frames, are dominant because they possess several dominant attributes not present in the other two frames. First, these two frames are pervasive. The thin body ideal is ubiquitous and fills, among other media sources, countless pages of magazines and air time on television. Its representations in popular culture are nearly impossible to escape. Similarly, the medical message is widespread. It is not only present in formal public education but also in numerous public health campaigns such as the recent United States Department of Agriculture (USDA) MyPyramid campaign. The plethora of *Journal of the American Medical Association (JAMA)* articles on the dangers of obesity as an epidemic also suggests a general consensus in the health community about the health risks of obesity. Indeed the cultural messages of the aesthetic and medical frames, both containing a normative component, are inextricably linked. Individuals ought to be thin and healthy, often with the presupposition that thin signifies healthy. The former rests on cultural legitimacy while the latter rests on scientific legitimacy.

Second, the aesthetic and medical frames are patrolled. Individuals who do not comply with the aesthetic frame are labeled unattractive while those who do not comply with the medical frame are labeled unhealthy. As mentioned, the social stigma of fatness and the discriminatory treatment of obese individuals are well documented. From name calling to job discrimination, overweight and obese individuals are constantly reminded that their bodies do not conform to either the aesthetic or health ideal. While doctors, family members, and friends may express concerns about the health risks of obesity, recent initiatives such as the practice of including students' BMI in report cards (Kantor 2007) suggest that monitoring agents may be expanding. In short, both dominant frames are

patrolled and overweight individuals are reminded on an ongoing basis that they are unattractive or unhealthy.

Finally, both frames are influential. Research points to a large number of individuals who work to attain the beauty ideal even at high physical and psychological costs. The medical message also has, to some extent, been getting through to individuals. American consumers show fairly high levels of awareness of the relationship between their diets and serious chronic diseases (Guthrie, Derby, and Levy 1999). This is especially true of diet-disease relationships targeted by major public health campaigns (Derby and Fein 1995). Recent survey data also indicates that most Americans are aware of physical activities that provide health benefits, even if they are less aware of specific exercise guidelines (Morrow et al. 2004). This recent data also suggests that knowledge about physical activity has improved over time (Caspersen, Christenson and Pollard 1986; Morrow et al. 2004).

The aesthetic and medical frames are dominant because they are pervasive, patrolled, and influential. In contrast, the social justice and market choice frames are considered reactionary frames. They are reactions to the aesthetic and medical frames insofar as they directly challenge, albeit in very different ways and for very different reasons, the two dominant frames. NAAFA is explicitly rebelling against traditional conceptions of the aesthetic body while both NAAFA and the CCF challenge the government's central medical claim that fat, in and of itself, signifies unhealthy. With the dominant frames, fat is seen in negative light. With the reactionary frames, fat is placed in more positive or, at least, neutral light.

The Present Study

Despite the important implications for social equality, little is known about the relationship between fat frames and agents. While sociologists have conducted frame analyses on various health issues such as child sexual abuse (Beckett 1996) and abortion (Esacove 2004; Rohlinger 2002), obesity only recently appears on the framing agenda (Lawrence 2004; Martin 2002; Saguy and Almeling 2005; Saguy and Riley 2005). This scholarly interest in obesity frames may be attributed to recent calls to "think sociologically about obesity" (Peralta 2003) and to "make fat a sociological issue" (Crossley 2004) – attempts to broaden the understanding of obesity beyond the domains of psychology and genetics. It may also be attributed to government concern over rising obesity rates and corresponding challenges to obesity as a medical fact (Campos 2004; Gaesser 2002) that parallel sociological interest in the work of fat acceptance activists, especially at NAAFA (Gimlin 2002; Martin 2002; Sobal 1999). My dissertation contributes to this growing body of literature by providing an in-depth understanding of, not only the four frames, but the relationship between these frames and agents. Specifically, I set out to understand the frames themselves; the resonance and uses of competing frames; and how they surface in the daily lives of those who do not conform to the aesthetic and health ideals.

My dissertation therefore addresses two general research questions. *First, how do cultural producers who have a direct interest in defining fat frame obesity?* Through content/frame analysis, I examine how cultural meanings are produced and played out among three groups: government medical researchers, social movement activists, and food industry representatives. *Second, what is the relationship between competing frames and cultural consumers or*

agents? If culture is about meanings and meaning-making, then how do cultural consumers use competing cultural frames? What are the meanings of these frames in individual lives? As tools in one's cultural repertoire, when, where, and why do agents use certain frames to navigate their daily lives and to inform strategies of action and sense of self? By surveying a sample of individuals of various body sizes, I tap into frame resonance. Furthermore, by interviewing individuals who are overweight or obese, I explore in depth how frames are played out in the ordinary lives of non-conformists. That is, I examine how culture is used in everyday life.

Overview of the Chapters

In Chapter 2, I discuss the methods and data used in my study. I detail the processes involved with the content/frame analysis, along with my selection of cases. I then discuss the methods involved with the collection of data from 456 survey respondents and 42 interview respondents. In this chapter, I also describe both the merits and disadvantages of my data. Chapters 3 through 6 present the empirical results of the content/frame analysis, survey analysis, and interview data analysis. In Chapter 3, I present and discuss the results of the content/frame analysis of the health, social justice, and market choice frames. Using the framing matrix, I highlight each frame's key signature elements and discuss its social and cultural significance. In Chapter 4, I examine how overweight and obese individuals respond to and use the government's health frame and universal health mandate. Chapter 5 examines the resonance and uses of the beauty frame and how it is salient in the lives of individuals who do not conform to the cultural beauty ideal. Chapter 6 examines the food industry frame and its relationship to the social discriminatory views that fat acceptance activists have

brought to the public's attention. Finally, in Chapter 7, I provide a summary of the study's empirical findings and theoretical contributions. I also discuss the implications of these findings and propose directions for future research.

CHAPTER 2

RESEARCH DESIGN, METHODS, AND DATA

Before addressing the core research questions about the relationship between culture and agents, it was first necessary to establish a thorough understanding of the key cultural frames. This descriptive research, using content analysis, provides the backdrop of the dissertation. With a basic understanding of the key frames, it was then possible to unpack the relationship between competing frames and individual behavior. To this end, I turned to two other research methods, surveys and in-depth qualitative interviews, thus relying on "methodological triangulation" (Denzin 1978). By using multiple methods, both quantitative and qualitative, I was able to approach the study of culture and agents from multiple vantage points. I was also able to corroborate the data collected in the various phases. Below I outline the procedures involved in all three methodological phases: the content/frame analysis, surveys, and interviews.

Cultural Producers: Content Analysis

To document each producer's position, I turned to frame analysis, a specific form of content analysis. According to frame analysts, frames are the core of a larger unit of public discourse called a *package* (Gamson and Modigliani 1987; Ryan 1991). Packages have a *signature* – "a set of elements that suggest its core frame and position in a shorthand fashion" (Gamson and Lasch 1983). "Signature elements" are divided into two types of devices: "reasoning devices" and "framing devices." Reasoning devices provide justifications or reasons for the frame and include: (1) causal roots (the implied causal source of the problem); (2) policy consequences (the policy stemming from the frame); and (3) appeals to

principle (the underlying value on which the frame rests). Framing devices suggest a framework within which to view the issue and include: (1) metaphors (analogies and symbols used to depict the frame); (2) exemplars (events to illustrate a key point); (3) catchphrases (theme statements or slogans suggestive of the frame); (4) depictions (characterizations of relevant subjects and opponents); and (5) visual images (icons and other illustrative descriptors). Identifying a frame's signature elements is at the core of frame analysis. Essentially, frame analysis is a content analysis of a frame producer's materials (in any form, i.e., texts, audio recordings, images, etc.) in an attempt to document systematically the main position of a frame in a "signature or framing matrix." This matrix is a table of the key frames as rows and the signature elements as columns (or vice versa). A major advantage of this type of analysis is that it permits cross-frame and inter-frame comparisons as each frame's signature elements are clearly presented in tabular form.

I began by identifying three cultural producers associated with the health, social justice, and food industry frames. I excluded the aesthetic frame in this background research because it is not clearly tied to a single cultural producer. Instead, this frame is promulgated by and reinforced in various mainstream and popular cultural sources and is generally supported by the fashion, beauty, and diet industries. It also draws from the health frame. I elaborate on the aesthetic frame and hegemonic beauty norms in Chapter 5.

I selected for analysis three groups that could be considered leading, vocal, and strong proponents of each frame. Respectively, they are: (1) The Centers for Disease Control (CDC), a branch of the U.S. Department of Health and Human Services (USDHHS); (2) The National Association to Advance Fat Acceptance (NAAFA); and (3)

The Center for Consumer Freedom (CCF), a nonprofit interest group representing the food industry.

The Centers for Disease Control and Prevention (CDC) is a branch of the U.S. Department of Health and Human Services (USDHHS) that oversees overweight and obesity as a chronic disease. The CDC specifically – and the U.S. government in general – is mainly interested in obesity in order to create a healthy populace. Government researchers at the CDC conduct research on obesity and publish their findings in peer-reviewed outlets such as the *Journal of the American Medical Association (JAMA).* State funds are also used to fund health campaigns such as the MyPyramid Plan campaign that educate the public and encourage healthy lifestyles.

The National Association to Advance Fat Acceptance (NAAFA) is the most prominent political fat organization in the U.S. Established in 1969, it describes itself as a non-profit human rights organization dedicated to improving the quality of life for fat people and eliminating body size discrimination. NAAFA says it provides fat individuals with the tools for self-empowerment through public education, advocacy, and member support. Members pay fees to join the organization, there is an annual convention, and local chapters are found throughout the country. Special Interest Groups (SIGs), such as Couples SIG, Mental Health Professionals SIG, and the Lesbian Fat Activist Network, also provide programs for members who share common concerns. There are approximately 2,500 members (Grossman 2003) who are predominantly white middle-class women in the highest weight categories (Saguy and Riley 2005; Sobal 1999).

The Center for Consumer Freedom (CCF) represents over 30,000 restaurants and taverns in America (SourceWatch 2005) and is an organization that is extremely outspoken about obesity. The CCF has been described as the "most vocal and perhaps well-funded" (Brownell and Horgen 2004: 268) public interest group representing the food industry. According to SourceWatch, a project of the Center for Media and Democracy, the CCF (formerly called the "Guest Choice Network") is a non-profit public interest group founded in 1995 by Philip Morris, a tobacco company. The ties to tobacco are evident today as the CCF not only represents the restaurant industry, but also the alcohol and tobacco industries. The group's interest in making obesity claims appears to be primarily economic and geared at maintaining or generating food sales, especially sales of foods such as chips, cookies, and soda that might be threatened by the health epidemic because they have been labeled unhealthy. The CCF runs major media campaigns to disseminate its message.

I gathered recent print materials produced and/or endorsed by all three groups. (Endorsed materials are not written by the group but are nevertheless posted on their websites as supporting information.) I took most of these materials from organizational websites: the Centers for Disease Control and Prevention at http://www.cdc.gov/nccdphp/dnpa/obesity/; the National Association to Advance Fat Acceptance at http://www.naafa.org/; and the Center for Consumer Freedom at http://www.consumerfreedom.com/. While I included general website information in the frame analysis, 42 documents retrieved from the sites formally comprise the sample. I selected these documents because they were considered highly representative of the frame. They were also documents that extensively, openly, and directly *generate* the frame by stating

the organization's perspective on the overweight and obese body. This is not to say that the documents excluded do not reflect the organizational frame; to the contrary, they do. But unlike the sample documents, these omitted documents, such as *JAMA* publications by CDC researchers, NAAFA's quarterly newsletter, and op-ed pieces on CCF's website, indirectly *support and reinforce* the frame and, as such, are considered frame supporting, as opposed to frame generating, documents.

For the CDC, I included in the sample the publication *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (2001) (herein *The Surgeon General's Call*) and a series of overweight and obesity fact sheets (n=6). For NAAFA, I included all official NAAFA documents (n=14), all of NAAFA's information brochures (n=12), and Marilyn Wann's (1998) cleverly titled book *Fat!So?*. Wann is the current Activism Chair on the Board of Directors at NAAFA and her book is akin to a manifesto for fat activism and the fat rights movement. Finally, for the Center for Consumer Freedom, I included in the sample their print advertisements relating to obesity and/or food consumption (n=7) and their publication *An Epidemic of Obesity Myths* (2004).

I read the documents for general content and then analyzed them a second time in light of the signature elements (the framing and reasoning devices). I then entered the information into the framing matrix. Whenever possible, I used in vivo coding (i.e., verbatim excerpts) from the frame documents. When direct quotes were either inappropriate or impossible, I summarized the key ideas succinctly and accurately, preserving the framer's word choice as much as possible.

Cultural Agents: Survey Data

With a basic understanding of the frames, I then turned to the relationship between frames and agents. In order to gauge efficiently the resonance of these frames in the general population, I conducted a survey. This fourteen page survey instrument consisted of both open-ended and closed-ended questions, many in the form of Likert scale items, that asked respondents if they "strongly disagreed, disagreed, were neutral or had no opinion, agreed, or strongly agreed" with a statement. See Appendix A for the survey instrument. The survey opened with a series of basic demographic questions about respondent characteristics such as age, sex, marital status, education, race, household income, employment status, number of children, and parents' occupations. Likert scale items prompted respondents to report their level of agreement with various statements, each of which tap into the resonance of a separate cultural frame. Statements about the health frame referred to knowledge about exercise and nutritional guidelines, the causes of being overweight and obese, and overweight and obesity as a medical issue. Sample Likert scale items include, "obesity is a health epidemic," "obesity is a medical disease," and "being obese increases your risk of hypertension, diabetes, and stroke." Statements about the aesthetic frame include "fat is beautiful" and "fat is ugly." Statements pertaining to the social activist frame referred to discrimination and fat acceptance. Examples include "fat people are generally lazy," "an individual can be both fat and healthy," and "fat people who take up two airline seats should pay for two seats" – three key issues in the fat acceptance literature. Finally, the survey presented respondents with a series of statements about the food industry frame. These statements reflect current industry issues such as "unhealthy food products should have

warning labels to indicate that they are unhealthy," "there should be special taxes on unhealthy foods," and "fat people should sue companies whose food contributed to their size."

To understand the relationship between frames and individual behavior and self-perception, I also asked survey respondents to disclose their exercise and eating habits, including the amount and reason for exercising, along with their levels of consumption of certain foods such as fast food, soda, and diet soda. The survey closed with a series of Likert scale statements about self-perception, labels, and identity. For example, respondents were asked to indicate their level of agreement with statements such as "I live a healthy lifestyle," "I am physically fit," and "I am overweight."

I pre-tested the survey with several undergraduate and graduate students, solicited feedback from faculty, and revised it several times before finalizing it. Once I received Institutional Review Board (IRB) approval, I administered the survey to students at Pima Community College (PCC), a local community college in Tucson, Arizona. I recruited respondents from PCC instead of my home institution, the University of Arizona (UA), in order to generate an older and more racially diverse sample. Previous studies on the body primarily employ convenience samples of young college-aged women, often from middle or upper socio-economic status (SES) backgrounds. According to feminist scholars such as Steinem (2000), these young women have yet to experience a substantial amount of gender inequality in the form of workplace discrimination and having to work the "second shift" (Hochschild 1989). Moreover, they are in a phase of their life when others view them as the most attractive they will ever be (younger and thinner) and also when their metabolisms are

most likely to help them maintain a weight within the "normal" BMI range. Additionally, college-aged respondents are likely to have fewer workplace and family responsibilities, giving them more time to exercise and to focus on aesthetic concerns, compared to many older individuals. They therefore possess a rosier world view that may be reflected in their perspectives of body issues.

In contrast, by turning to a community college instead of a large state research institution, I was able to generate a sample with a wider age range that was, not only more racially diverse but, socio-economically diverse. By recruiting at PCC, I advantageously recruited a group of lower SES/working class respondents – a group that is not usually the subject of body studies. There is generally an inverse relationship between obesity and SES and, in general, there are more low SES individuals who are overweight or obese. Although the relationship between higher BMI and SES is stronger for women and more inconsistent or weaker for men (Sobal and Stunkard 1989; Zhang and Wang 2004), SES is nevertheless an important correlate of BMI. However, because previous studies rely on convenience samples drawn from more economically advantaged college-aged women, lower SES respondents have been overlooked in body studies. My sample therefore allows me to speak to this group of individuals who face more barriers to healthy eating and exercise than higher SES individuals and especially high SES women. Indeed, these respondents are more likely to have significant work and family obligations that interfere with their ease of following health guidelines. In fact, 68.2% of respondents in the sample were working as they completed their college courses. (All respondents were taking college courses as this was a

criterion of sample inclusion.) Moreover, 39.9% were working full-time (defined as 30 hours/week or more), 11.0% were married, and 14.7% had children.

Sampling at PCC had other advantages as well. By sampling at PCC, I generated a sample that reasonably reflects the Tucson population. According to the most recent PCC Factbook, the average age of regular fall semester students is 28 and 48% of students are between 20 to 29. According to the 2000 Census, the median age in Tucson is 32 and a large proportion of residents (30.6%) are between the ages of 25 and 44. Racially, 46% of PCC students are white, 37% are Hispanic, 4% are African-American, 4% are Asian, and 3% are Native American. Similarly, approximately 36% of Tucson identified as Hispanic ethnicity and about 70% identified their race as white.[1] The median annual household income in Tucson is just under $32,000.

The survey sample demographics approximated both the PCC and Tucson population. Survey respondents' ages ranged from 18 to 62 with a mean of 24.8. Women comprised 55.9% and men 44.1% of the sample and the sample mean and median household income (based on midpoints of a respondent's income range) are both $25,000. About half (48.8%) the sample identified their race as white, 21.5% Hispanic, 6.0% Asian, 4.2% African-American, 2.4% Indian/Native-American, 0.4% Hawaiian/Pacific Islander, and 0.2% Other. A third (34.2%) of the sample identified their ethnicity as Hispanic.[2] Nearly a-fifth (16.4%) said they were mixed-race. Using government-defined Body Mass Index (BMI) cut-off points, 46.9% of the sample is considered "normal" weight, 14.5%

[1] Percents do not total to 100% because race and ethnicity are separate categories in the U.S. Census.
[2] This number is higher than the number of survey respondents who identify as Hispanic race. This is because many mixed-raced respondents identified their ethnicity as Hispanic.

"underweight," 22.8% "overweight," and 12.5% "obese." The remaining 3.3% did not provide either their weight or height information that is required to compute BMI. The mean BMI was 24.5, or "normal," ranging from 15.7 or "underweight" to 48.8 or "extremely obese." The number of obese and overweight individuals in the sample is below the national average given that about two-thirds of the U.S. adult population is overweight and about one-third is considered obese.

Gaining access to PCC classrooms was not a straightforward task. Using the schedule of classes, I emailed close to one-hundred PCC instructors, explaining who I was and what my research goals were. I selected instructors who taught large general education classes such introduction to accounting, business, psychology, sociology, and math. In my email, I briefly discussed the nature of my research, emphasized that I received IRB approval from both PCC and UA, and requested twenty-five minutes of class time. Most instructors did not respond to my email and most who did said they had no class time to spare. A handful of instructors wanted proof of IRB approval before granting access. Interestingly, two instructors granted me access in exchange for a lecture on research process and research methods. I obliged. Eventually nineteen instructors gave me access and I entered thirty-three classrooms (several instructors let me into two or three classes they were teaching).

In the classroom, I began by reciting a one minute IRB-approved script describing the age requirements and voluntary nature of the survey. Only in three cases did students indicate that they could not do the survey because they were under eighteen. Moreover, only on rare occasions did a student decide not to participate, opting instead to sit at his or her desk while peers completed the survey. In general, most students appeared eager to

participate. After collecting the completed surveys, I recited a short disclosure that revealed to participants that I was interested in four cultural frames about the overweight body and the relationship between these frames and identity and health behavior. The study has no deception and, as such, very few questions were asked during the disclosure Q&A. One respondent did take the opportunity to express his disgust with obese people as he was completing the survey and during the closing Q&A. However, as a whole, most questions were cordial and many respondents wished me well with my research and expressed interest in helping me. Most PCC classes are small and I would usually leave a classroom with about a dozen completed surveys.

After administering the survey for approximately four months, I collected a total of 456 surveys. This number includes surveys completed by respondents who were interviewed, but not recruited through the survey. (I discuss these procedures shortly.) Survey responses were then coded by an undergraduate student majoring in math using a coding sheet that I explicitly prepared. I discuss how specific variables are coded in both Chapters 5 and 6 where I report survey data results.

I then conducted statistical analyses, i.e., descriptive statistics and logistic regression analysis, on the quantitative data. While the non-random nature of the sample does not permit me to make claims that are completely generalizable to the entire population, the survey data can still be used to describe the resonance and salience of competing cultural frames in this age, race, and SES-diverse college sample that is reasonably reflective of the Tucson population.

Cultural Agents: Interview Data

While the survey data provide a blanket overview of the resonance of the four competing cultural frames, with in-depth interviews I could tap more thoroughly into how culture surfaces in the every day lives of individuals who do not conform to the dominant beauty and health ideal. The qualitative data I collected was not intended to test theory, but to ground future theorizing and to produce an in-depth understanding of individuals' relationship to their bodies and their perspectives, interpretations, and uses of cultural meanings. I was interested in exploring the lived experiences of overweight and obese individuals. I also designed the qualitative data phase of the study to complement and corroborate the survey data or to illuminate any discrepancies.

Again, because body issues are often assumed to be more meaningful for women and because of convenience, studies tend to focus on women and to rely on young college students. These convenience samples limit generalization and they also do not permit gender comparisons. I avoided these limitations by interviewing both male and female respondents who were at least 24 years of age. Table 2.1 presents my purposive sample that contains three axes of variation: (1) gender, (2) race, and (3) Body Mass Index (BMI).

Table 2.1: Distribution of Interview Respondents Based on Three Axes of Variation

	BMI "overweight"		BMI "obese"		
	White	Non-White	White	Non-White	Total
Men	5 [6]	4 [6]	4 [6]	6 [6]	19 [24]
Women	5 [6]	6 [6]	6 [6]	6 [6]	23 [24]
	10 [12]	10 [12]	10 [12]	12 [12]	42 [48]

Note: The number of respondents recruited is accompanied by the original target number in square brackets.

First, I included gender as an axis because body issues, especially the aesthetic mandate, are gendered. I discuss this further in Chapter 5. Varying gender in the sample allows me to compare cultural meanings and processes for both men and women. Again, this gender variation is a merit of the interview sample given that most studies focus exclusively on women. Second, race is an important axis in light of the higher obesity prevalence rates for racial and ethnic minorities, especially Hispanics and African-Americans (Paeratakul et al. 2002; USDHHS 2001) and the observation that these groups are more likely than whites to be categorized as overweight or obese (Flegal et al. 2002). It is also important as there is a growing body of literature suggesting that African-American women respond differently to the beauty frame than white women (Parker et al. 1995; Russell, Wilson, and Hall 1993). In other words, race is a meaningful status characteristic for body studies. Finally, I include body type as a key comparison axis as my qualitative research focuses specifically on how individuals who do not fit into the "normal" weight category use culture. I compare "overweight" and "obese" individuals to see if there are important differences associated with increased body weight. Although the BMI is a problematic measure, particularly for pregnant or lactating women and muscular individuals (American Obesity Association 2002; Prentice and Jebb 2001), it nevertheless provides a pragmatic cut-off point. I expected, documented, and explored inconsistencies between BMI and how individuals think of their bodies during the interview, mainly during the section on labels and self-identity.

Notably, I omitted socio-economic status as an axis of variation. Instead, I permitted it to vary without systematically comparing by SES. This is because I needed

reasonably to limit sample diversity. Initially, I set out to obtain a middle-class sample. However, rather serendipitously (just like the survey sample), I recruited primarily a working/lower-class interview sample. Again, this is an advantage of the sample as this group is not often the subject of body-related studies. Despite the plethora of research on body image (reviewed in Chapter 5), these studies focus primarily on middle/high SES college women. Low SES individuals, both men and women, are therefore understudied in research on body images and the responses to cultural messages about bodies. My study provides an in-depth look at how these economically disadvantaged individuals prioritize health and aesthetic ideals.

In retrospect, it is not surprising that I recruited a primarily lower SES/working class sample since I sampled exclusively from a community college environment and not at a large public research university. PCC courses are less expensive and, because some PCC courses are transferable to the UA, lower-income students tend to gravitate towards PCC classes. I attempted to recruit forty-eight respondents because meaningful qualitative comparisons are possible with this sample size. However, I only successfully recruited forty-two.

I recruited interview respondents through two methods. First, the second-to-last page of the survey administered at PCC asked participants for two pieces of information: height and weight. The survey also asked respondents if they would be willing to participate in a paid follow-up interview. No monetary amount was disclosed on the survey as to avoid providing an incentive. In accordance with IRB provisions, the monies paid were to be compensation and not incentives. Only two people asked during the survey disclosure Q&A

how much the interviews paid. If survey respondents were interested in participating in a follow-up interview, they were to provide their contact information on the final page of the survey. After I collected the surveys and assigned random Case ID numbers, I immediately removed this last page from the rest of the survey. Thus the only information connecting the respondent's contact information and the survey responses was a Case ID number. (These contact information sheets were stored in a locked cabinet separate from the survey data to protect the respondent. As such, I minimized any linkages between the data and personal identifying information.) Using this height and weight information, I calculated each respondent's BMI. I also checked each respondent's response to the Likert scale statement "I am overweight" and "I am very muscular." By doing so, I could potentially avoid scheduling an interview with a respondent whose BMI was misleading. (I did not contact two muscular respondents for this reason.) Using the contact information provided, I then emailed or phoned respondents with a BMI greater than 25, who agreed to a follow-up interview, and who fit the demographics in the purposive sample. There were only two cases (due to oversights) where I recruited erroneously respondents who were not (based on my visible assessment and respondents' statements) overweight. While I completed the interviews, these two respondents are not included in the final sample.

I employed a second recruitment technique. While about half (53.2%) the survey respondents agreed to an interview, I excluded many survey respondents from the interview sample because they did not fit the demographics of the purposive sample and/or because they did not satisfy the minimum age requirement of 24. Because I did not have a sufficient number of interview respondents for the purposive sample, I recruited subjects through

print advertisements. These IRB-approved print advertisements were placed on several PCC campuses with the help of Campus Life coordinators. Interested respondents were to contact me at a phone number provided. A screening protocol was created and, to ensure that I was recruiting from the same population, only individuals who were PCC students were permitted to participate in the study. When a potential respondent called and was deemed appropriate for the purposive sample, I scheduled an interview.

Although both methods may result in the selection of respondents who are especially vocal or passionate about body issues, I do not see this as a disadvantage. With self-selection, I obtained respondents from multiple social environments who were not merely peripherally interested in the topic. As I discovered, these respondents were motivated to talk. Though these sampling techniques do not control for sampling bias, it is preferable to a snowball sample since the target sample size of 48 would not allow me to get beyond networks effects. Network effects may be especially prevalent since similar perspectives on weight issues are often shared among friends and family members. In other words, a snowball sample with friendship networks and respondents with only a few degrees of separation would confound the separation of cultural effects from network effects. I also felt it would be awkward and unethical to ask respondents to recommend their overweight or obese friends and family members.

Follow-up with respondents, like access to PCC classrooms, was not as straightforward as I had anticipated. Despite both courtesy calls and reminder emails the day before the interview, several respondents did not show up to the scheduled meetings. About a dozen respondents required follow-up on two occasions before a successful

interview took place. To provide comfort and maximum privacy, I conducted most interviews at two locations: PCC's Downtown Campus (the faculty meeting room or a private library study room) or at my university office. At the request of a respondent who did not wish to take the bus to either PCC's Downtown Campus or the UA, I conducted one interview at PCC's Desert Vista Campus' cafeteria.

Of the forty-two interview respondents, 23 (54.8%) were women and 19 (45.2%) were men; 20 (47.6%) self-identified as white and 22 (52.4%) as non-white; and 20 (47.6%) were overweight and 22 (52.4%) were obese. The mean BMI was 32.5 (obese), ranging from 25.1 (overweight) to 46.3 (extremely obese). The average age of respondents was 34.5, ranging from 24 to 49. Slightly over half the respondents were single (24 or 57.1%). Of the remaining, 8 (19.1%) were married and 10 (23.8%) had significant others (stable girlfriends or boyfriends). Fifty percent of the sample was childless while the remaining half had between one and four children, averaging 2.1 children. In order to participate in the study, respondents had to be students at the community college and, as such, they were all either part-time or full-time students. Fifteen (35.7%) respondents did not work as they completed their education, while the remaining worked either part-time (7 or 16.7%) or full-time (20 or 47.6%).[3] Thus nearly half the sample was working full-time and simultaneously taking community college courses. Not unexpectedly, lack of time and energy to exercise was a recurring theme. Over one-third of the sample (16 or 38.1%) indicated a household income under $20,000 and just over a quarter (or 28.6%) had an income in the $20,000s. The mean midpoint income was approximately $30,000. In their narratives, the majority identified as

[3] Two respondents who worked part-time during the school year and full-time during the summer were coded as part-time workers.

lower- or working-class. Not unexpectedly, monetary struggles were another recurring theme.

Similar to the survey, interview questions asked respondents to share their perspectives about the various cultural frames, their bodies, self-concept, and eating and exercise habits. See Appendix B for the interview instrument. The interview opened with general questions about respondents' lives eliciting what they do for a living, their educational pursuits, their marital status, and whether they have children. Following this, I asked respondents if there was anything unusual happening in their lives. This allowed me to a get sense of whether the data they provided would be considered normal or unique by them and to also establish if they were in a transitional or normal life phase (following Swidler 2001). I then asked respondents to discuss their current priorities and to describe a typical weekday and weekend. Following, I asked questions about the respondent's childhood and how the respondent felt about his or her body when he or she was younger; whether weight was important to them; and whether there were any particular childhood moments or experiences about weight that stood out. As a natural transition point, I then asked respondents to reflect on their current perspectives about their body, body satisfaction, and body work, including eating and exercise habits. After covering the beauty frame, including questions about popular culture, I asked respondents a series of questions about the health, social justice, and industry frames. I evoked these frames directly by, for example, asking about respondents' health knowledge, what it means to be healthy, their health concerns, and what their health concerns were; discrimination experiences, differential treatment, and society's treatment of overweight individuals; and their views of the food

industry, including issues of responsibility, regulation, and control. However, I also evoked frames indirectly by asking respondents to tell stories about their dating, clothes shopping, and eating-out experiences. Finally, I included a series of questions about self-perception, labels, and coping strategies to gauge how respondents viewed themselves and the techniques they used to neutralize or cope with "deviant" labels such as unhealthy and ugly.

At the close of the interview, I asked respondents to comment on four vignettes. These fictional scenarios describe overweight and obese individuals in various circumstances, with each vignette corresponding to a cultural frame. These vignettes provided further opportunity for respondents to discuss the frames and to see how respondents talk about the overweight body in various contexts. They provided an opportunity to compare how individuals talk about their situation versus similarly situated others. Advantages of vignettes include allowing actions in context to be explored; clarifying people's judgments; and providing a less personal and thus less threatening way of exploring sensitive topics (Barter and Renold 1999). In qualitative research, vignettes provide a non-threatening means for individuals to define situations on their own terms (Bartner and Renold 1999). They also permit discrepancies to surface. In may case, there may be discrepancies in the way respondents naturally talked about the frames and how they assessed the frame from the vantage point of an observer. Interestingly, when I presented the vignettes to respondents, many were suddenly faced with the realization that if the person in the vignette was overweight or obese (according to government-defined BMI standards), then they too must be. This point of realization was an illuminating moment as several obese respondents did not consider themselves obese.

Before implementation, faculty and graduate student peers critiqued the interview schedule. I also pre-tested the instrument with two respondents. While the interview schedule underwent revisions after the two pretests, I include one of these pretests in the final sample; the second pre-test was removed because I found a replacement interview during the study period. With the one pretest I included, there was nothing in the responses that would suggest that it could not be used. The only difference between the pre-test and sample interviews is that the pre-test is missing questions that were subsequently added.

While the interview schedule was semi-structured, I often did not follow it in a highly structured fashion. I saw this is a good sign; it meant that respondents wanted to talk. However, I quickly realized as a neophyte researcher that it would be a struggle balancing the desire of respondents to tell their stories freely with my need to have my research questions addressed. Fortunately, in many cases there would be overlap; respondents' free flowing narratives would often organically touch on the cultural frames and key research issues.[4]

When respondents arrived, I chatted briefly with them, offer them bottled water and a snack (granola bars), and give them a few minutes to go through the consent form. I walked them through the consent form, having them initial each page. I proceeded to do a short introduction before turning on the digital recorder. I then conducted and recorded the interview. I did not take many notes during the interviews, knowing that they would be

[4] However, this was not always the case. One respondent disclosed a psychologically abusive marital relationship as the impetus to her severe weight gain. As she seemed quite emotionally upset with both her body weight and marriage, I allowed her to tell her story freely. She spent a significant time telling me about her abusive marriage. Because I was not comfortable cutting off her emotional narrative and her stream of consciousness, she continued to talk freely and only touched peripherally on the cultural frames and questions in my interview instrument. After 2 hours, I realized I needed to reschedule a follow-up interview. It was only in the follow-up that I had success eliciting responses that addressed my research agenda. This was in part because I made a concerted effort to redirect her. There was also some awareness on the respondent's behalf that she was sidetracking and this helped when I gently guided her back to the core questions.

transcribed shortly. Notably, during both pretests I took copious notes but found this to be distracting in terms of creating rapport and also processing their responses. Most interviews lasted about 2 hours, ranging from 1 to 4 hours.

At the end of the interview, I thanked respondents for their time, did a short disclosure (the same disclosure script used for the surveys) and fielded any questions. I asked respondents whom I did not recruit through the survey to voluntarily complete the survey. Respondents who I recruited through the ad were also asked to complete a sheet with basic demographic information such as age, weight, height, race, and income at the end of the interview. This was to confirm basic demographic data (despite obtaining it over the phone).

I compensated respondents at the end of the interview. The payment of respondents involved processing the necessary forms. I paid $15/hour respondents for their time.[5] This hourly amount was considered fair compensation – many of the respondents are employed full-time – but not sufficiently large to influence respondents' replies.[6]

As a whole, most respondents were either neutral or expressed enjoyment and appreciation after completing the interview. One male respondent was particularly appreciative and expressed that it was really great that he could finally talk to someone about his weight concerns. One female respondent exclaimed that she thought the interview

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[5] The National Science Foundation, through a Doctoral Dissertation Improvement Grant (SES#0602027), provided compensation to interview respondents.

[6] While most of the respondents expressed appreciation for the compensation, one respondent did not accept payment. This respondent was an anomaly insofar as she did not identify as lower or working class. This is the same respondent who disclosed an abusive marital relationship. This 48 year old full-time nurse whose household salary was in the $90K range, refused to accept payment asking that I donate the money to charity (refer to footnote 4). I did not process any compensation paperwork for her.

would be boring, but it wasn't! Only two female respondents, both obese white women (including the respondent who disclosed an abusive marital relationship), showed emotional distress during the interview. Interestingly, both respondents contacted me through the print advertisements. Even though both respondents cried at several points in the interview, they nevertheless thanked me at the end of our interaction for the opportunity to talk about the issues. At the end of every interview, I provided respondents with my contact information and emphasized that they should feel free to contact me if they had any follow-up questions or concerns. Several respondents expressed an interest in reading forthcoming publications.

Immediately following each interview, I downloaded the audio recording onto a hard drive and created a pseudonym for the respondent. I also backed up the audio files (labeled only with a Case ID number and a pseudonym) to a CD. All files in transit (to transcribers) were also password protected. I transcribed about a third of the interviews myself while undergraduate workers transcribed the rest.

I converted completed transcripts from Word documents to Rich Text Format so that they could be read in Atlast.ti, a qualitative software program. In Atlast.ti, I created a summary sheet for each respondent. After reviewing eight documents, I created approximately one-hundred codes that documented the key themes and patterns. I then coded each transcript using these codes. In the analysis, I retrieved these codes and systematically searched for recurring patterns among codes while taking into consideration the larger interview context in which the codes are embedded.

CHAPTER 3

CONTESTED MEANINGS ABOUT BODY, HEALTH, AND WEIGHT: GOVERNMENT, ACTIVISTS, AND INDUSTRY FRAMING COMPETITIONS OVER THE FAT BODY

Chapter 3 examines framing contests and how cultural meanings about the overweight and obese body are developed and promulgated. Specifically, I map the contested field of obesity and the jurisdictional battles that occur within it. I examine how three cultural producers – the U.S. government, fat acceptance activists, and food industry representatives – frame this social issue. Each producer has a different perspective on obesity and each purposively promotes these varied meanings. What is each producer's cultural message and how is it disseminated? Given that frames are interactive, dynamic, and dialogical (Esacove 2004), what is the relationship between competing frames? Furthermore, given the salience of body issues in contemporary American culture, what is the relationship between each frame and hegemonic body norms?

In this chapter, I identify three competing "fat frames" that correspond to each cultural producer respectively – the health frame, the social justice frame, and the market choice frame. I do not consider the beauty frame here because, unlike the medical, social justice, and market choice frames that are associated with identifiable cultural producers (and their allies), the beauty ideal is not tied to a single and easily identifiable cultural producer. Instead, the ideal is produced and is perpetually reinforced in an array of mainstream and popular cultural sources – from Vogue magazine to Gap advertisements to Hollywood movies. I discuss the beauty ideals literature further in Chapter 5.

Using the "framing matrix" (Gamson and Lasch 1983; Gamson and Modigliani 1987; Ryan 1991; Winnett 1997), I explore each frame's key signature elements and discuss its social and cultural significance. Notably, each cultural producer uses different devices to disseminate their cultural message. While I explore each frame separately, there is noticeable and rather unexpected overlap between the signature elements of all three frames. That is, even when frames compete they borrow from each other's devices, at times to reinterpret and imbue new meanings on them. The specific elements of the framing matrix are presented in Table 3.1 and Table 3.2. Whenever possible, the framer's own words and phrases are used.

The Health Frame

"America is just too darned fat."

—Secretary of Health and Human Services, Tommy Thompson, keynote speaker at the Time/ABC Obesity Summit (June 2-4, 2004)

According to the CDC, obesity is a "chronic disease and condition" that has reached "epidemic proportions." An alarmist tone is present throughout the government documents. If the situation is not reversed, the government claims, it could wipe out gains made in areas such as heart disease, diabetes, and some forms of cancer. At the overweight and obesity homepage, the CDC informs that 30% of U.S. adults, or 60 million people, are obese. Concern is also expressed over the growing number of obese children as the percentage of young people who are overweight has more than tripled since 1980. In their words "[t]hese increasing rates raise concern because of their implications for Americans' health."

The CDC frame is best described as a medical or health frame. Repeatedly, the health costs of obesity are emphasized. The CDC websites warns:

> Being overweight or obese increases the risk of many diseases and health conditions, including the following: hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some cancers (endometrial, breast, and colon).

The *Health Consequences* fact sheet provides in-depth information about these health consequences while the *Surgeon General's Call* provides further evidence for the government's health concern:

> An estimated 300,000 deaths a year may be attributable to obesity. Morbidity from obesity may be as great as from poverty, smoking, or problem drinking. …A gain of approximately 10 to 20 pounds results in an increased risk of coronary heart disease (nonfatal myocardial infarction and death) of 1.25 times in women and 1.6 times in men (USDHHS 2001: 8, notes omitted).

Data used to support the medical claim that obesity is unhealthy rely on the Body Mass Index (BMI) – a calculation based on an individual's weight and height. Obesity is first defined as a BMI greater than 30 (an overweight individual has a BMI between 25 and 29.9). The CDC relies on the BMI because, as it claims, "for most people, it correlates with their amount of body fat." While the measure has been criticized as a misleading indicator of body fat, especially for very muscular individuals and pregnant or lactating women (American Obesity Association 2002; Prentice and Jebb 2001), the CDC adopts the BMI as an appropriate marker and valid measure of health. Subsequently, according to the CDC, individuals with a BMI over 30 put themselves at significant health risk.

Alongside health costs, the CDC details the economic costs of obesity. Citing a national study, it claims that medical expenses attributed to both overweight and obesity reached as high as $78.5 billion in 1998 (Finkelstein, Fiebelkorn, and Wang 2003). Approximately half of these costs, they point out, were paid by Medicaid and Medicare. It also cites data for individual states (Finkelstein, Fiebelkom, and Wang 2003). For example, New York, with an estimated obese population of 5.5%, is predicted to have $6,080 million in annual medical expenditures attributable to obesity. Not surprisingly, "catchphrases" of the medical frame (indicated in Table 3.2) include "obesity is an epidemic," and "obesity is a major public health problem." For the government, it threatens the population's livelihood, both physically and economically.

While there are many causes of obesity (see "causal roots" in Table 3.1), including various genetic, behavioral, and cultural influences, the CDC strongly implicates behavioral variables. For example, the *Surgeon General's Call* states that "For the vast majority of individuals, overweight and obesity result from excess calorie consumption and/or inadequate physical activity" and the *At a Glance* fact sheet states that "Behavioral and environmental factors are large contributors to overweight and obesity and provide the greatest opportunity for actions and interventions designed for prevention and treatment."

The medical frame rests on an appeal to medical science and health sensibility. In terms of the reasoning devices presented in Table 3.1, these are its overarching "principles." Medical research is used and cited extensively to support its major claims and the public message that citizens should be concerned about obesity since it results in imminent disease, disability, and/or premature death. While government documents do not expressly depict

opponents, embedded in the medical frame are built-in assumptions. Those who contest the medical frame are implied to be lazy and foolish to reject scientific research linking obesity with impending health debility. Numerous statistical tables and graphs, including BMI tables, are used to support the frame and to illustrate that obesity is in fact a pressing public health problem that afflicts a large and growing segment of the population.

Given the causal roots of the medical frame, "policy" (the third reasoning device presented in Table 3.1) logically focuses on prevention and halting the increase in obesity rates. Specifically, the goal is to reduce the prevalence of obesity to less than 15% by the year 2010. Solutions are said to lie with interventions at the individual, community, and national level. The national government's C.A.R.E. vision, as described in the *Surgeon General's Call* and also the *A Vision for the Future* fact sheet, combines **C**ommunication, **A**ction, **R**esearch, and **E**valuation to accomplish its goal. While local governments are encouraged to educate and communicate to the public in a sensitive manner the health issues related to overweight and obesity, strong emphasis is placed on assisting Americans in balancing healthy eating and regular physical activity. The *What You Can Do* fact sheet encourages individuals to "activate themselves" and to "Make fitness a priority…COMMIT TO IT." The *Surgeon General's Healthy Weight Advice for Consumers* fact sheet also deals with the problem at the individual level. Imperatives such as "Aim for a healthy weight," "Be active," and "Eat well" are exemplary. Explicitly, the goal is not for obese individuals to lose weight in order to conform to beauty ideals. Rather, the goal is to be healthy. The opening line of the *Health Consequences* fact sheet makes this very clear: "*The primary concern of overweight and obesity is one of health and not appearance."*

The Social Justice Frame

"'Fat' is not a four-letter word."

—National Association to Advance Fat Acceptance

Unlike the medical frame, NAAFA's message about obesity is not focused on death, disability, or disease, but instead on discrimination and a different interpretation of what is considered sensible health. Refer to the social justice frame in Table 3.1. For activists at NAAFA, there are difficulties with diagnosing obesity and the number on the scale, just like the BMI, has little to do with the determination of health. Thus unlike the government that adopts "the greater than 30 BMI" as a meaningful cut-off point, fat activists reject what are considered artificially contrived meanings associated with both BMI and weight. These numbers' importance lies not with their ability to predict good or poor health, but instead with other's ability to use these numbers to label, stigmatize, and to discriminate against fat bodies.

Consistent with this perspective, NAAFA claims that there are multiple causes of obesity. In Table 3.1, these are listed under social justice "causal roots." NAAFA activists argue that a person's body weight is determined by numerous factors such as "genetics, metabolism, and dieting history" (*Dispelling Common Myths About Fat Persons).* Weight is described as something, more or less, beyond one's control. It is an ascribed, rather than an achieved characteristic. NAAFA documents suggest that even if weight were controllable, weight loss is not desirable. The dangers of dieting are repeatedly emphasized alongside diet failure rates, especially the claim that the National Institutes of Health (NIH) and other studies show that 98% of people who lose weight gain it back within five years (*Weight Loss:*

Fact and Fiction). As such, in their policy statement on dieting and the diet industry, they discourage participation in weight-reduction dieting. Similarly, weight loss surgery and weight loss drugs are condemned for their health risks and ineffectiveness (*NAAFA Policy: Weight Loss Drugs*; *NAAFA Policy: Weight Loss Surgery*).

At the same time that weight loss is discouraged, NAAFA promotes health as an attainable goal for fat individuals. Here the medical and social justice frames converge. Both frames claim that physical health is a desirable and achievable outcome. Yet how health is defined for each organization is remarkably different. For government officials, a BMI greater than 30 is a red flag for bad health while for NAAFA members, "just being fat does not signify poor health" (*NAAFA General Information).* Consistent with this statement is a key motto associated with the fat acceptance movement: "health at every size" (see "catchphrases" in Table 3.2).[1] This is confirmed by their policy on physical fitness: "individual fitness can be achieved despite a high ratio of fat-to-lean body mass … fitness is a desirable and attainable goal for most fat people" (*NAAFA Policy: Physical Fitness*).

While fitness and health are desired goals for many fat people, NAAFA explains how difficult it is for fat people to be fit because of discrimination. Prejudicial medical treatment and harassment by health care professionals deter fat individuals from seeking medical assistance. And, they argue, even when treatment is provided, it is inadequate. The stigma of fat also makes many fat people uncomfortable participating in physical activities that would lead to higher fitness levels and better health. Indeed a major goal of NAAFA is to expose both the social and psychological costs of being fat in a society that rejects fat bodies

[1] NAAFA activists and allies of the Health At Every Size (HAES) movement (see Katrina, King, and Hayes 1996), share similar views (also see Saguy and Riley 2005).

and portrays fat people as "unhealthy, unattractive, asexual, weak-willed, lazy, and gluttonous" (*NAAFA Policy: Dieting and the Diet Industry*).

The organization's preferred use of the term "fat" reflects an attempt to refute the societal meanings associated with fat:

> 'Fat' is not a four-letter word. It is an adjective, like short, tall, thin, or blonde. While society has given it a derogatory meaning, we find that identifying ourselves as 'fat' is an important step in casting off the shame we have been taught to feel about our bodies (*NAAFA General Information*).

Much of Wann's book is devoted to rejecting popular assumptions about and portrayals of fat and fat people. Visual images are rare for this social justice frame, but Wann does use satirical drawings and caricatures, especially of the fat female body, likely to reclaim it. Text accompanying the drawings such as "You, Too, Can be Flabulous!" and "What do you like about being Fat?" (Wann 1998: 184, 24) support this.

Table 3.1, under "principles," shows that the medical and social justice frames have another framing device in common. Both frames appeal to medical science and health sensibility. However, the research each organization draws attention to, and how health sensibility is defined, significantly differ. While government officials turn to mainstream medical research linking obesity to health debility, NAAFA underscores medical research showing that weight loss drugs, weight loss surgery, and diets are not only ineffective, but that they are actually dangerous to one's health. Notably, while NAAFA documents make myriad claims based on research studies, specific citations are not provided that would allow one to verify the existence and factuality of such studies. This is in contrast to the use of research in both the medical and market choice frames where numerous studies are cited and

bibliographic references are included. So while NAAFA calls into question the medical frame's key claim that there are serious health risks associated with weight *per se*, there is no specific study referenced to support this claim. Instead, they simply state that research "shows that the health risks once associated with weight may instead by [sic] attributable to yo-yo dieting" (*NAAFA General Information*).

Instead of a fixation with weight and weight loss, NAAFA encourages its members to be sensible and to focus on improving health. Being sensible about health is not about dieting to obtain a targeted number on a scale. Instead, it involves striving for fitness by making sensible food choices, participating in an exercise program, and getting regular doctor check-ups (*NAAFA General Information*). Just like the medical frame, the goal is health, but for NAAFA activists the emphasis is both physical and psychological health.

NAAFA's social justice frame appeals to human rights. Established in 1969 as a human rights organization, one of its major goals, at least on face value, is combating size-based discrimination and seeking equal treatment for fat people.[2] NAAFA's *Declaration of Health Rights for Fat People* declares nine rights pertaining to the administration of health care. For example, the group asserts the right to non-discriminatory quality health care, to refuse participation in weight loss programs of all kinds, and to be free from ridicule, coercion, and harassment from all care givers. The declaration is a direct response to what they feel is a lack of sensitivity that comes with moral judgment and condemnation by health care providers (*NAAFA Guidelines for Health Care Providers In Dealing with Patients*). The appeal to

[2] While conducting her ethnographic research on NAAFA, Gimlin notes that, despite describing itself as a civil rights organization, very few of the group's activities are politically oriented (2002: 114-5). Others have observed that most NAAFA members are not activists but instead participate in NAAFA to socialize and meet romantic partners (Gimlin 2002; Goode 2002).

human rights is also evident in their campaign to have height and weight included as protected legal categories in existing local, state, and federal civil rights statutes (*NAAFA Policy: Size-Related Legislation*). The assumption is that, just like other historically disadvantaged groups, fat people need equal protection. There are references to other disadvantaged groups. For example, they note that while members of other disenfranchised groups such as African Americans, Latinos, and women are usually consulted when health research affecting these groups is conducted, advocates for the fat community are rarely or never consulted by the NIH or by obesity researchers, despite offers of assistance.

Unlike the medical frame that does not explicitly mention its opponents, its "depictions" of enemies (under "framing devices" in Table 3.2) are explicit. Of their major opponent, obesity researchers, NAAFA writes:

> Obesity researchers' hypotheses often incorporate personal or cultural biases against fat people. Unproven assumptions about fatness frequently invalidate the basic premise of research studies. …mainstream obesity researchers never study alternatives to weight loss (such as exercise) in improving comorbidity factors. …the obesity research community has refused to see that fatness is not only a health issue, but a psychological, cultural, and political issue (*NAAFA Policy: Obesity Research*).

Opponents, then, are considered narrow minded, biased, and essentially bad researchers who cannot conduct research objectively. Wann's (1998) opening discussion of obesity is especially representative of NAAFA's overall perspective. She writes:

> Obese. This is a doctor's fancy way of saying, 'I'm looking at you, and I find you disgusting. Would you like this ineffective but wildly expensive weight-loss treatment? If you don't, you could die. Besides, my country club membership fees are due' (Wann 1998: 19).

Simply put, "[m]ost obesity researchers experience a profound economic conflict of interest" (*NAAFA Policy: Obesity Research*). Opponents, like Wann's doctor, are depicted as self-serving. Obesity researchers are not necessarily interested in improving the health of fat people but reaping the financial rewards that come with defining obesity in a specific manner. This is especially evident when they discuss the 1985 NIH consensus conference that proclaimed obesity to be a "killer disease." According to NAAFA, the conference led to a redefinition and call for treatment that "translated into billions of additional dollars of research money, commercial weight loss industry profits, and physician's revenues" (*NAAFA Policy: Obesity Research*).

As Table 3.1 indicates, fat activism best captures NAAFA's policy approach. The organization focuses mainly on debunking myths (notably what the government claims as medical fact), working for equal rights for fat people, and educating the public not only about the physiological, but also about the sociological, psychological, medical, and legal aspects of obesity. This involves fighting size-based discrimination in all realms of social life and advocating the inclusion of height and weight as protected legal categories. Given their critique of obesity researchers and mainstream research, they also advocate and sponsor "responsible" research (*NAAFA General Information*).

The Market Choice Frame

"Everyone should have the right to make their own choices about what to eat and drink…"

—Center for Consumer Freedom

Like NAAFA, the CCF challenges the medical frame promoted by the federal government. For the CCF, however, the issue is neither prevention nor discrimination. It is

about personal choice. In a capitalist democracy, individuals should have the right to consume whatever they want. Responsibility is a personal matter and the only authority over consumption is the individual. The themes of individual choice, common sense, and personal responsibility permeate their print advertisements:

> Some government officials want warning labels on food. *Warning labels on food to "protect" us?* At the Center for Consumer Freedom, we think adults are smart enough to choose what to eat and when to move. The only warnings you really need are about food cops, bureaucrats, and scheming trial lawyers.
>
> Did you hear the one about the fat guy suing the restaurants? It's no joke. He claims the food was too cheap so he at too much! *Learn more about the erosion of personal responsibility and common sense. Go to:* ConsumerFreedom.com.
>
> YOU ARE TOO STUPID…to make your own food choices. At least according to the food police and government bureaucrats who have proposed 'fat taxes' on foods they don't want you to eat.

Table 3.1, under the "causal roots" of the market choice frame, shows that the CCF does not articulate what it thinks are the causes of obesity. However, the CCF does openly state what is not a cause. According to the CCF, obesity is not a disease and is not caused by overeating. Specific research is cited to support their claims. For example, citing the *American Journal of Clinical Nutrition*, they write: "Energy intakes per person were [about] 7% lower in 1994 than in 1977-78" (CCF 2004: 14). Moreover, while they do not directly blame (a lack of) physical activity, they implicate it. *An Epidemic of Obesity Myths* details the state of physical activity in the United States, showing for example that only one half of U.S. young

people regularly participate in vigorous activity and that a quarter of the population reports no vigorous physical activity. The group also points out the decline of physical activity in America over time, a decline that correlates with rising obesity rates. Similarly, they highlight smoking cessation as a possible correlate of weight gain.

Like the fat acceptance activists, the CCF rejects the myth that "you can't be overweight and healthy." Citing scientific research, they show that fat in and of itself does not mean unhealthy. Specifically, the CCF (2001: 7) cites the *Harvard Health Policy Review* and The President's Council on Physical Fitness and Sports that claim, respectively: "[A] fit man carrying 50 pounds of body fat had a death rate less than one-half that of an unfit man with only 25 pounds of body fat" and "Active obese individuals actually have lower morbidity and mortality than normal weight individuals who are sedentary." Furthermore, like NAAFA, the CCF rejects the BMI as a valid measure of health. One ad featuring a photograph of the current California governor demonstrates the signature sarcasm present in most CCF ads and makes clear the organization's position on the BMI:

> Actor. Governor. Fatso? According to the U.S. government, Arnold Schwarzenegger, Tom Cruise, and Sammy Sosa are all obese!

Subsequently, claims invoking the BMI are also rejected. A total of seven myths are outlined and refuted (primarily with the use of counter-research) in *An Epidemic of Obesity Myths*: obesity kills 400,000 Americans per year; you can't be overweight and healthy; obesity is a disease; overeating is a primary cause of obesity; soda causes childhood obesity; 65% percent of Americans are overweight or obese; and obesity costs the U.S. economy $117 billion annually. Thus like NAAFA, a large part of CCF's message is redefining obesity "facts" and

separating fact from fiction. According to the CCF, most of these myths are hype generated by the government that stem from "junk science" fueled by the $40 billion weight loss industry, a charge that is particularly interesting since food industry revenues in 2001 were over $780 billion (Plunkett 2003).[3] Regardless, the organization's primary "principle" in the framing matrix, like the two other cultural producers is an appeal to scientific research.

To a large extent, opponents of the food industry overlap with NAAFA's opponents. Again, refer to "depictions" of enemies in Table 3.2. The CCF, however, does not shy away from targeting specific obesity researchers:

> [Dr.] Pi-Sunyer reclassified millions of Americans as 'overweight,' published a study that insists obesity is tremendously costly, and played a crucial role in funding, supervising, reviewing, and editing a wealth of obesity-related research – all while he was working for Weight Watchers (CCF 2004: 12-3).

The group accuses Dr. Allison, a lead author of the *JAMA* study reporting that obesity causes a significant number of deaths a year, of having a conflict of interest, charging that he conducted obesity research while simultaneously working as a consultant to at least nine pharmaceutical companies that make anti-obesity drugs. Their portrayals, however, go beyond greedy, money-hungry opponents. They paint "food cops" and government bureaucrats that propose food taxes as extremists. The group associates adjectives such as "radicals," "hype," and "self-righteous" with these challengers.

As seen in Tables 3.1 and 3.2, none of the frames overtly employ the framing devices of "metaphors" or "exemplars" to promote their message. However, there may be one

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[3] This figure includes payroll for all U.S. food manufacturing employees, production worker wages, and the total cost of materials and value of shipments.

turning-point akin to an exemplar (an event used to illustrate a frame's key point) that likely bolstered both the claims of the social justice and market choice frames. Specifically, internal government conflict and dissent, along with a USDHHS memo, called into question the methods used to study the link between obesity and premature death. Subsequently, the claim that 400,000 deaths per year can be attributed to obesity was also called into question. This memo eventually led to new research on the relationship between obesity and death and the publication in *JAMA* of a significantly reduced figure (Flegal et al. 2005). Both the memo and this new research are used to support the claims of NAAFA and the CCF that the government's medical position is flawed or, at the very least, exaggerated. This more conservative estimate also clearly illustrates how the medical risks of obesity are socially constructed by experts at the CDC.

The policy implications of the market choice frame suggest a laissez faire approach that invokes a libertarian individualistic logic. While the CCF, like fat acceptance activists, sets out to debunk obesity myths, the main action suggested by the frame is little action at all. Individuals, as responsible autonomous adults, are able to make their own decisions about consumption. The CCF thus protests food taxes. Supply and demand should regulate the free-market and consumers should be able to make their own choices in a capitalist consumer-driven society.

Discussion

The CDC constructs obesity as a growing health epidemic with major health and economic consequences. Mainstream medical research is used to support the health frame, under the assumption that sensible people will adopt it. This frame is promoted by the U.S.

government, endorsed by antiobesity researchers and the medical community in general, and largely confirmed by the plethora of *JAMA* articles on obesity as a serious medical disease and epidemic. However, others also borrow the frame to promote and legitimize their interests. For example, Weight Watchers, a leading diet company with 15 million members in over thirty countries, uses the medical frame when selling its diet program and food products. In their philosophy statement, they write:

> Weight Watchers has always believed that dieting is just one part of long-term weight management. A *healthy* body results form a *healthy* lifestyle – which means mental, emotional and physical *health*. Weight Watchers does not tell you what you can or can't eat. We provide information, knowledge, tools and motivation to help you make the decisions that are right for you about nutrition and exercise. We help you to make *healthy* eating decisions, and we encourage you to enjoy yourself by becoming more active (Weight Watchers 2005, emphases added).

Medical rhetoric is evident throughout the text; it is about a healthy body, healthy lifestyle, mental health, emotional health, and physical health. While the end product of a successful Weight Watchers' diet is a body that conforms to the thin body ideal, Weight Watchers does not explicitly promote this ideal. Instead, they claim to be promoting health. So even if Weight Watchers products allow a consumer to adhere to societal body norms, their official rhetoric does not explicitly acknowledge this. Unlike the marketing of fashion and beauty products, the attainment of ideal beauty is not necessarily central to the promotion of their products and services.

The medical frame works within the existing cultural structure of the thin beauty ideal. While government documents do not engage debates about cultural standards of

beauty, their message nevertheless reinforces the thin ideal body. That is, the government, indirectly, promotes a thin body type. Their message, however, is not that one should make oneself thin in order to possess a beautiful body. Rather, because fat is bad (merely by association with myriad health maladies), not-fat is necessarily good. Even while the government and medical community promotes the medical frame neutrally in the name of health, the health frame can be used to support a narrow conception of the acceptable body, affecting the self-esteem of those who cannot attain the thin ideal.

The moral implications of the medical frame are implied in the remedies suggested by the medical frame. If fat is undesirable and thin is good (but not too thin – the government also warns of the dangers of anorexia and bulimia), then individuals ought to change their bodies, or at least attempt to, in order to reach the thin ideal. As Saguy and Riley put it: "framing fatness as a preventable health risk or illness in and of itself suggests that less tolerance and more public vigilance is needed" (2005: 873). Weight loss becomes a primary goal. Those who do not reach it are blameworthy and morally culpable. They are, as NAAFA describes, depicted as "weak-willed, lazy, and gluttonous." Although the government documents suggest that obesity is a national, state, community, and individual problem, the CDC admits that the greatest intervention can take place at the individual level. In this way, the health frame is very much an individualistic frame. Individuals are responsible for making the right choices to ensure their health. The government's job is to provide public health information to facilitate this goal. The health frame therefore appeals to an individual's sense of responsibility and public good. Individuals should exercise and eat healthfully because it is the right thing to do for both self and society. To be fair,

government policy is likely driven by a strong element of pragmatism. Educating and motivating individuals to adopt healthier lifestyles is a lot easier and cheaper than assuring access to high quality foods or engaging in battles with the food industry about regulation. In sum, the medical frame legitimizes, even if unintentionally, moral judgments of the fat body because individuals are seen as largely individually responsible for their "deviant" bodies.

In contrast is NAAFA's social justice frame – an example of a collective action frame that expresses moral indignation, the belief that it is possible to alter conditions through action, and a collective identity (Gamson 1992). Because NAAFA activists consider weight beyond an individual's control, they believe that moral judgments should not be placed on fat bodies. NAAFA condemns weight fixation as unhealthy since responses to it like yo-yo dieting and the use of weight loss drugs and surgery all have detrimental health effects. They refer to research, however vaguely, to legitimize their position. Indeed this is a commonality of all three frames – the appeal to research and subsequent sensible action, however uniquely defined by each frame. So while Saguy and Riley (2005) observe that antiobesity activists rely on personal experiences in their claims-making, I found that they also rely on scientific claims, claims that are generally considered to be legitimate. However, unlike the CDC, which extensively details scientific research, NAAFA does not delve into scientific specifics because their overall appeal is to human rights and social justice. They leave this task to the fat acceptance researchers in their camp (Saguy and Riley 2005). As such, even when scientific studies are referenced, they are ancillary. The reliance on medical science, by all three frames, reinforces science's centrality as a legitimate claims-making device.

Although NAAFA has an economic stake in its claims – to survive even as a not-for-profit organization it needs members to join – their primary goal is not economic.[4] It is ideological. Specifically, their frame challenges the cultural structure and how it defines the beautiful body. NAAFA's overall philosophy rejects social norms that stigmatize fat bodies as ugly and "deviant." Wann's manifesto is, at bottom, about reclaiming the fat body. For NAAFA activists, society's definitions of beauty are narrow and they foster discrimination. The revaluation and redefinition of beauty will, in turn, they hope increase public tolerance of all body sizes. With this redefinition, healthy bodies of all sizes will be accepted.

In recent years, the market choice frame has become more prominent. The launching of the Smart Spot logo and the www.smartspot.com website by Pepsi Co. is an example of how food companies are directly, and not just through their representative organizations, attempting to change popular understandings of obesity and consumption. It is also an example of how frames draw on one another to further their interests. The Smart Spot logo is a program that assists consumers to identify "healthy" products, if they so choose. Over 100 products including Baked Lays, Gatorade Thirst Quencher, and Diet Pepsi display the logo. The website encourages and provides information about S.M.A.R.T. living.[5] In many ways then the frame has a built-in contradiction. Individuals are told to be sensible, to exercise, and to be healthy (key signature elements of the medical frame), but mainly so that they can partake in the consumption of certain foods that are often labeled bad, sinful, or unhealthy. Or, in the case of the Smart Spot products, foods that are

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[4] In fact, the first step they recommend for joining the size acceptance revolution is purchasing a membership to their organization.

[5] Where consumers are encouraged to: **S**tart with a healthy breakfast; **M**ove more; **A**dd more fruits and vegetables; **R**emember to hydrate, and; **T**ry lower calories and fat.

considered relatively healthy, considering their alternatives such as regular chips and non-diet soda.

At the same time that there is an attempt to change how consumers think about food consumption, there are few challenges to the current social and cultural structure. First, the language of individualism that is integral to the health frame is also evident in the market choice frame. However, unlike the individualism of the health frame that encourages healthy lifestyles for a person's own good, the individualism of the consumerist frame is presented as libertarian rhetoric. That is, the market choice frame argues that individuals should be empowered to make whatever choices, good or bad, they wish to make. It is therefore entirely up to the individual whether s/he wants to lead a healthy lifestyle. Second, the capitalist economic system supports the food industry's objectives. The industry works within, and benefits from, the free market. Finally, while the CCF is like NAAFA insofar as it challenges the dominant medical frame, it is unlike NAAFA ideologically. The CCF proffers no critique of prevailing body norms. These norms are seemingly outside and irrelevant to the frame and its promoters. At bottom, the market choice frame is morally ambivalent when it comes to bodies. It makes no claims about what bodies are right or wrong, beautiful or ugly. All bodies are tolerated, so long as they consume.

Conclusion

Obesity is not just a medical fact. Like most social problems, it is a social fact and various cultural producers vie to place meaning on it. Little is known about overweight and obesity frames and this frame analysis presents a basic foundation for understanding cultural fat frames and their social significance. While all three frames appeal to scientific research

and sensible action, each frame draws on different research and defines sensible action differently. In turn, each frame has different outcomes for social equality and how society thinks of fat bodies. The medical frame, even when suggesting that obesity has multiple causes, places responsibility on the individual. Using mainstream scientific studies, this frame has the potential to continue legitimizing social inequality and size-based discrimination while reinforcing stereotypes. In contrast, by rejecting hegemonic body ideals, the social justice frame challenges the stigma associated with fat, along with the prevalent belief that overweight and obese individuals are morally lacking. Members of the fat acceptance group promote responsible research, public tolerance of body-diversity, and sensible health defined outside the currently constructed fiction of the thin aesthetic. Finally, the market-choice frame suggests a laissez faire approach to obesity. Challenging the dominant medical frame is not for the purpose of creating a more egalitarian society but for the sake of generating sales.

While this frame analysis provides an important starting point for understanding the culturally and socially constructed overweight body, questions about the relationship between these cultural frames and individuals remains unaddressed. How do individuals use and interpret these various cultural messages? As tools in one's tool kit, when, where, how, and why do individuals use these frames to inform their lives and sense of self? These are questions I address in Chapters 4 through Chapter 6.

Table 3.1: Framing Matrix: Reasoning Devices

Package		Medical	Social Justice	Market Choice
Cultural Producer		Government officials at the Centers for Disease Control and Prevention (CDC)	Fat acceptance activists at the National Association to Advance Fat Acceptance (NAAFA)	Food industry representatives at the Center for Consumer Freedom (CCF)
Frame		The issue is how to prevent obesity, a serious medical problem.	The issue is discrimination.	The issue is individual choice, personal responsibility, and common sense.
Position		Relying on the BMI, obesity is considered a growing health epidemic that results in many serious health consequences. Overweight and obesity afflict two-thirds of the population and have medical, social, and economic costs.	Obesity is a medical term that has been used to discriminate against fat individuals. Fat people can still be healthy.	Individuals should be able to consume whatever they personally think is sensible. Individuals can be overweight and healthy.
Reasoning Devices	Causal Roots	While obesity is caused by many factors including genetic, metabolic, behavioral, environmental, cultural, and socioeconomic influences, behavioral and environmental factors are large contributors.	Obesity is caused by many factors including genetics, metabolism, and dieting history.	Obesity is not a disease and is not caused by overeating. Lack of physical activity and sedentary living are (implied to be) major contributors.
	Princi-ples	Appeal to medical research linking obesity to death, disease, and disability. Appeal to a fear of death, disease, and disability and a health sensibility that would lead to actions to avoid these outcomes.	Appeal to research showing that obesity does not have dramatic health costs and to research showing that weight loss drugs, surgery, and diets are ineffective and dangerous. Appeal to health sensibility, and psychological well-being. Appeal to human rights.	Appeal to research that debunks obesity myths, e.g., research showing that obesity does not have dramatic health costs, that a lack of physical activity (and not overeating) causes obesity, that individuals can be overweight and healthy, that obesity is not a disease, and that soda does not cause childhood obesity. Appeal to individual choice and right. Appeal to personal sensibility and responsibility.

	Policy	C.A.R.E.: **Communication** with the public about the goals of a healthy public; **Action** including interventions and activities that encourage changes in behavioral (consumption and activity) patterns; **Research** and **Evaluation** into the causes, prevention, and effective treatment. Encourage efforts to maintain a healthy weight starting in childhood and continuing throughout adulthood. Dietary and physical activity recommendations.	Dispel common myths about fat persons. Educate the public about the sociological, psychological, medical, legal, medical, and physiological aspects of being fat. Advocate and sponsor research. Fight size-based discrimination in all realms of social life. Include height and weight as protected legal categories.	Laissez-faire approach; against government regulation of industry. Rejection of the proposed food taxes that would tax high fat, low-nutritional foods.

Table 3.2: Framing Matrix: Framing Devices

	Package	Medical	Social Justice	Market Choice
Framing Devices	Catch-phrases	Obesity is a major public health problem. Obesity is an epidemic. Obesity is a personal and community responsibility.	Fat is not a four-letter word. Fat!So? Health at every size. Diets don't work. War on fat.	Obesity hype. Obesity myths. Personal responsibility. Common sense.
	Depic-tions	Opponents are (implied to be) lazy and foolish to reject scientific studies linking obesity with death, disability, and disease.	Opponents, namely obesity researchers, have an economic conflict of interest and are depicted as individuals who are primarily economically motivated.	Opponents are depicted as greedy and self-serving. Opponents include trial lawyers who are suing food companies and obesity researchers who are funded by the weight-loss industry. Activists, "food cops" including the Center for Science in the Public interest, and government bureaucrats who are proposing warning labels and taxes on certain foods are depicted as extremists, radicals, and hysterical.

	Visual Images	Statistical tables, including BMI tables, and graphs illustrating the prevalence and rise of obesity.	Visual images are rare although Wann (1998) uses satirical drawings of the fat body in an attempt to reclaim it.	Visual devices are varied and often employ sarcasm to emphasize personal choice and responsibility or to debunk obesity myths.

CHAPTER 4

REDEFINING HEALTH AND HEALTH MOTIVATION

Authoritative Knowledge: Fat as Unhealthy

As I discussed in Chapter 3, according to the U.S. government and the medical community in general, obesity is a public health problem and health epidemic. Being overweight or obese is linked to disease, disability, and premature death and is associated with a long list of medical conditions including Type 2 diabetes, heart disease, stroke, and hypertension (USDHHS 2001). The government's logic and public health message is linear; being overweight or obese is unhealthy and leads to medical problems. Relying on the BMI, it argues that those who possess a BMI higher than twenty-five put themselves at health risk.

The government's health message is widespread and is taught through public education and health campaigns such as the recent MyPyramid Campaign and the 5-A-Day Campaign. It is also formally patrolled by, among others, medical practitioners and teachers. This formal patrolling comes hand-in-hand with informal social controls that stigmatize and socially isolate overweight individuals (Puhl and Brownell 2001). Individuals who do not comply are labeled unhealthy with the social and medical expectation that they should institute lifestyle changes.

There is a strong normative component to the health frame. The CDC's health standards are seen as universal and overweight individuals are expected to lose weight. They are told to balance healthy eating and regular physical activity. Both the CDC and the American College of Sports Medicine (ACSM) recommend 30-minutes of moderate-intensity physical activity most days of the week and about a 2000 calorie diet (CDC/ACSM 1993; USDHHS/USDA 2005). As I discussed in Chapter 3, public health fact sheets encourage

individuals to "Aim for a healthy weight," "Be active," and "Eat well" (USDHHS 2007a). Although government documents acknowledge discrimination and the social stigma associated with a heavier body type, the government explicitly states that it is not directly concerned with beauty matters. It is a matter of health. In sum, the health mandate states that being overweight is unhealthy and overweight individuals should lose weight.

The government's health frame is powerful because it is considered "authoritative knowledge" (Jordan 1997). It is authoritative not because it stems from the knowledge of people in authority positions, but because it is "knowledge the participants agree counts in a particular situation, that *they* see as consequential, on the basis of which *they* make decisions and provide justifications for the courses of action" (Jordan 1997: 58). In other words, there is some consensus within and outside the medical community that being overweight or obese is unhealthy, has real consequences, and should be the basis for healthful action. The concept of authoritative knowledge illustrates that despite competing knowledge systems, some systems carry more weight than others. So even when fat acceptance activists point out that obese individuals can be still be healthy or when the food industry lobbyists say that it is not overeating that leads to obesity, there is a sense that this counters our natural beliefs. This is because when one kind of knowledge gains ascendance and legitimacy (in this case, medical/health knowledge), alternative knowledge systems are often dismissed and viewed as backward, ignorant, or naïve. Struggles over credibility and the competition of knowledge systems are evident, not just with obesity, but with other public health issues such as AIDS and childbirth (Davis-Floyd and Sargent 1997; Epstein 1996). Similar to a master frame, authoritative knowledge comes to be seen as part of a natural order, the way things are and

ought to be. Competing frames therefore face difficulty dismantling this epistemological stronghold.[1]

Knowledge, Motivation, and Health Behavior

To a large extent, this public health information is being absorbed. Research shows that American consumers have fairly high levels of awareness of the relationship between diet and serious chronic diseases (Guthrie, Derby, and Levy 1999). This is especially true of diet-disease relationships targeted by major public health campaigns (Derby and Fein 1995). Recent survey data also suggests that most Americans are aware of physical activities that provide health benefits, even if they are less aware of specific exercise guidelines (Morrow et al. 2004). This recent data also suggests that knowledge about physical activity has improved over time (Caspersen, Christenson, and Pollard 1986; Morrow et al. 2004).

There is some consensus, however, that while knowledge is an important condition of behavioral change, it is not a sufficient condition (Parcel and Baranowksi 1981; Rudd and Glanz 1990; Sallis and Hovell 1990). In other words, knowledge provides little guarantee of compliance and there is often a gap between knowledge and practice. This knowledge-practice gap has been theorized extensively and empirically studied for an array of behaviors, not just health behavior (Hornik 1989; Rimal 2000; Silgo and Jameson 2000). A key variable

[1] While medical knowledge is considered authoritative today, this was not always the case. In the early nineteenth century, many Americans refused to accept physicians as authoritative and believed instead that common sense and native intelligence could deal as effectively with health and illness problems (Starr 1982). Among others, homeopaths, folk healers, and midwives, were considered legitimate sources of knowledge. According to Starr, several forces transformed medicine into an authoritative profession including internal developments (greater cohesiveness and dependency within the profession because of the growth of hospitals and specializations); broader changes in social and economic life (genuine advances in science and technology along with urbanization and increased division of labor that led to greater access to and trust of specialized strangers); and institutional changes (standardized education and the licensing of physicians). Abbott (1988) also observes an overall shift in the legitimation of professions – from social origins and character values to a reliance on scientization or rationalization of technique and on efficiency of service. These changes all contributed to the rise of the medical profession and medical claims as authoritative. The authoritativeness of the medical professional then led to the de-legitimization of earlier and other systems of knowledge.

in this literature is motivation. Understanding health motivation is important. Tapping into the resonance and uses of the health frame is really about understanding how individuals process the government's health mandate and what they do with this information, including whether or not this information is used to motivate lifestyle changes.

Social psychologists have developed various motivation models of health behavior (Armitage and Conner 2000), including the health belief model (Becker 1974; Rosenstock 1974); protection motivation theory (Rogers 1983); self-efficacy theory (Bandura 1997); and the theory of reasoned action and related theory of planned behavior (Azjen 1991; Ajzen and Fishbein 1980; Fishbein and Ajzen 1975). Literature reviews and meta-analyses of these various motivation models show statistically significant correlations between various measures of these social psychological theories and health behavior, including weight loss and exercising behavior (Boer and Seydel 1996; Conner and Sparks 1996; Dzewaltowksi, Noble, and Shaw 1990; Godin and Kok 1996; Harrison, Mullen, and Green 1992; Hausenblas, Carron, and Mack 1997; Hodgkins, Sheeran, and Orbell 1998; Janz and Becker 1984; Sheeran and Abraham 1996; Sniehotta, Scholz, and Schwarzer 2005; Tinker and Tucker 1997).

While these social psychological theories provide valuable insight into the pushes and pulls motivating individuals to engage in healthful behavior or to avoid harmful behavior, most of this work is quantitative (involving regression or path analyses) and focuses on the gap between motivation and actual behavior. That is, this literature attempts to explain empirically why individuals are, or are not, able to translate motivation into actual behavior. However, this focus ignores the formation and sources of motivation. With a few exceptions, investigations of motivation for weight loss behavior have not examined at

length the source and formation of motivation itself, along with the interconnections between competing motivations that draw from competing cultural frames (Brink and Ferguson 1998; Clarke and 2002; Hankey, Leslie, and Lean 2002; Young et al. 2001). Furthermore, while gender scholars have focused on the motivating effects of hegemonic beauty ideals, especially for women, they focus narrowly and exclusively on the beauty discourse, at the cost of understanding the interplay between health and beauty. Chapters 4 and 5 focus on the health and beauty frames, respectively, along with the qualitative context for weight loss motivation. In this chapter, I examine how overweight and obese individuals process the meanings around this authoritative health frame and how these meanings relate to body work/weight loss motivation. My goal is not to understand how and whether these motivations are put into action, but rather the source, formation, and in-depth stories of health motivation per se. How do respondents approach this health knowledge? Does it motivate? Specifically, I turn to the in-depth interviews with the forty-two overweight and obese respondents to examine the resonance of the health frame and how this frame is or is not used to motivate weight loss behavior.

Expanding and Redefining Health

Confirming the notion that the health frame constitutes authoritative knowledge, the majority of respondents agreed with the government's universal health mandate. There was large consensus that being overweight or obese is unhealthy and tied to disease, disability, and premature death. Health is about having a body that possesses physical integrity and is disease-free. For example, when I asked Adele,[2] a 36 year-old, African-American, with a BMI of 28.9, what healthy means to her, she responded: "Good health, within normal

[2] All names are pseudonyms.

numbers. Not having any diseases…Knowing that I'm going into nursing, being overweight leads to a lot of disease states." Similarly, Meena, who is 31, overweight (BMI 29.8), and of South Asian (Indian) descent, says "being healthy means to be skinny and not have any of those rolls and being free from disease." Melanie (27, white, BMI 32.0), spoke especially candidly about body issues: "Obese, you've got a problem. This is going to kill you. You're going to die. You need to do something."

Respondents overwhelmingly knew that being healthy meant maintaining active lifestyles while eating "right." They spoke of eating in moderation, drinking plenty of water, and consuming "good foods" such as fruits and vegetables. Ayleah, a 32-year old African-American with a BMI of 29.3, echoes the government's position when she claims that not only do most people know these health standards, but that these guidelines are universal:

> Being active and eating the right things. By the right things, I think that everybody should eat the right things. I think that's universal and I don't think that that's what according to what you believe is the right thing. I think that we know what the right things are. We know what the wrong things. And we produce the wrong things in abundance and make it cheaper for people to afford. …I do believe that. …Yeah, eating all the goods things and being active. And getting out, walking. I do believe that half an hour a day is cool. I think it works. I'm not saying I do it [laughs]. I'm just saying I should (Ayleah, 32, African-American, BMI 29.3).

In general, there was agreement that being fat was unhealthy, led to health problems, and that there was a known prescription for change. As Ayleah emphasized, it is not what one individual believes is the right thing. These widespread health guidelines are known.

At the same time respondents agreed that being fat is unhealthy and defined health in terms of physical integrity, nearly two-thirds (26 or 61.9%) expanded upon or redefined

the government's understanding of health. Respondents redefined health in three ways that were not mutually exclusive. First, in their description of health, they included some psychological, mental, or spiritual component; second, they defined health in pragmatic terms, measuring health in terms of their ability to perform certain tasks; and third, they individualized health by rejecting the universality of government standards. As I later show, these expanded redefinitions are important as they are linked to respondents' self-perceptions of healthiness and also to their body work motivation.

Mind, Body, and Spirit: "Feeling Good"

Javier, who is 43, Hispanic, and obese (BMI 31.8) expressed a spiritual component of health in his understanding of healthiness. According to Javier, healthy is about "having good blood, not having diabetes, not having high blood pressure, not having high cholesterol [and] having a strong heart, healthy mind." While the earlier portion of his statement resonates with the dominant government understanding of health, he also includes a psychological component. He continues, "I think all those things come together. Holistic approach – body, mind, and spirit." So while Javier acknowledges disease states, he also claims that possessing a strong mind and spirit are essential to a healthy body. The nexus of mind, body, and spirit, as fundamental to healthiness, along with the theme of balance and harmony, is salient throughout Johnavon's (BMI 29.5) narrative. As a 27 year-old Native-American (Navajo), he experiences an ongoing conflict that arises from living in two different cultural worlds that define health, among other things, in contrasting ways:

> Being Native American is a little different from, for us because you have to live in two worlds, in a sense. You have your traditional world, which is going to encompass your traditions, your cultures. That sort of thinking is very different from the society's, you could

> call it. So when I come out here [off the reservation], the thinking is different. So, if I come out here, if you ask me 'what is healthy to you?' healthy is, to me, maybe being in shape. Physically that kind of seems to be the importance that they put on it. But if I go home, healthy is not so much just the physical part. [It's] the mental aspect of it too, like being in harmony, having healthy relationships. Does that make sense? A broader focus on many external components rather than just the physical part (Johnavon, 27, Native-American, BMI 29.5).

As Johnavon observes, the dominant interpretation of health focuses on physicality while his understanding, stemming primarily from Native American upbringing, embraces a spiritual component. In his view, health extends beyond the physical body; it encompasses a larger harmonious relationship to oneself, community, and the environment.

Respondents' narratives also illustrate the interconnectedness of psychological, spiritual, and physical health. This was particularly evident in the ongoing theme of "feeling good." Respondents articulated that health was not only something that is tangible, as seen in good blood work and disease-free states, but also something that they could "feel." Feeling good is so salient that it sometimes takes precedent over official measures such as good physical outcomes. For example, several respondents discuss this idea of "feeling good" when they define health:

> Healthy. I think if you're healthy then you feel good. You feel good about yourself and you can do about just anything you want to do. You're not limited by medical problems (Rhonda, 40, white, BMI 38.1).

> You can move around without pain. You don't cough all the time. You don't have, don't get anything more than a cold. And you feel good. You have to feel good. If you're not feeling good there's something wrong (Jeanette, 35, white, BMI 46.3).

> Well, number one, feeling good is huge. And that I do. Number two, healthy means, you're paying attention to feeding your body right and exercising your body right and making sure that you're maintaining a lower stress level which for me is almost always been through a meditation with prayer process (Jim, 43, white, BMI 27.4).

> It means balance and health is primarily, I think, a feeling of how you feel, how your body feels, how your mind is, how your emotions are, more so than something you can say, 'well, your blood pressure is this,' or, 'your weight is that,' or, you know, 'flexibility is this.' I think that you can really feel health when you have it (Malaki, 33, mixed-race, BMI 29.4).

So while respondents were not disagreeing with the dominant health message that healthy is about being physically fit and disease-free, they simultaneously voiced a more encompassing understanding of health. For these overweight and obese respondents, health was measured beyond physicality and including a salient emotive or psychological component. Health is a feeling that could not be gauged, say, by blood work, blood pressure, or weight alone.

Pragmatic Measures of Health: Work and Play

While respondents measured health using these non-physiological measures, they also measured health in pragmatic ways. When asked what being healthy means, Melanie (27, white, BMI 32.0) initially responds: "Being able to walk up a flight of stairs and not pant [laughs]." While she then proceeds to discuss cardiovascular health and muscle tone, her jovial statement nevertheless resounds with other respondents. For example, Jay (37, Hispanic, BMI 39.9), who works full-time as an airport shuttle driver and part-time as a cosmetics salesman, defines healthy first and foremost by his ability to work: "Healthy means that I'm able to go to work, I don't have to call in sick. And that I can wake up

feeling fine. I have a lot of energy to do whatever I need to do." Similarly, Sol (48, Hispanic, BMI 28.5) says "healthy is being able to visit my kids and doing things with them, and, say, with my family and friends. Being able to continue on my lifeline." Rhonda's (40, white, BMI 38.1) earlier response that being healthy means, "do[ing] about just anything you want" also reflects the notion that practical considerations are central to defining health. While respondents agreed that being overweight or obese is connected to serious maladies, they also measured health in tangible terms, specifically their ability to execute certain tasks.

Individualizing Health and Rejecting the Universality of Standards

Respondents also redefined health by individualizing it. For example, when talking about health, John (35, Hispanic, BMI 37.7) simply replies: "I think it has a lot to do with the individual, really. But, you got to find out what works for you." Shawntea's standpoint captures well the notion of individualized health. Health is not a specific number on the scale or a point on the BMI charts. It is something, just like a feeling, with which one is comfortable. Indeed, the three ways respondents redefined or expanded upon health overlap. The extremely obese, 36 year-old, African-American says:

> I know they have the ideal weight that we're all supposed to be at if you're this height and this. I don't always necessarily agree with those because some of us, we can't help how tall we are or how short we are. Those are things that you just can't, even if they say, oh yeah, you're this, this, this, and this, I think that is too harsh. …But I think it's so overrated at times that people end up killing themselves just to be the size that they're supposed to be. So I think healthy is what you're comfortable with. Eating right and not as many health issues and doing whatever it is you need to do in order to feel good about yourself. This constitutes a healthy person because you can eat right all day long and still die of cancer.

> And so, I think, how you feel about your eating habits (Shawntea, 36, African-American, BMI 44.4).

Again, like those who adopt a broader definition of health, Shawntea does not openly reject the government's health message and standards. Throughout her narrative, it is clear that she is fearful of heart disease and dying young. Her parents are both overweight; her father had a heart-attack and her mother had gastro by-pass surgery. Yet she embraces an individualized notion of health: "healthy is what you're comfortable with." So, unlike Ayleah, there is no single-standard, universal notion of health. In many ways, then, Shawntea adopts a middle-ground. While acknowledging the medical authority's health message, she simultaneously individualizes it to suit her situation. Health is about comfort and what she believes is best for her.

Similarly, Jeannette adopts an individualized notion of health. She questions the applicability of universal standards. Jeanette is white, 35, and extremely obese (BMI 46.3). She has been dieting for most of her life and has experienced the ups and downs of her many dieting cycles. She is frustrated with medical professionals whom she claims do not take her seriously and are not wiling to design a unique health and diet plan for her:

> I'm very different from everybody else. …All the doctors wanted me to fit with their stuff on their papers and their projects, what the research shows, and I don't fit the research. At least I don't think so, I don't think anybody does. It's just the middle of the road and we're going to treat everybody like that and that's how I feel I get treated as far as the weight goes. You know, the simple thing they say is eat less than you use. I don't eat more than you can possibly use in a day. That's pretty trite. You can't use that advice. It's stupid (Jeanette, 35, white, BMI 46.3).

Despite being borderline diabetic and experiencing problems with her vision, she is critical of the universality of government standards. As she puts it, she does not fit the research. Consequently, she tailors her own health plan that is suitable to her own unique physical and emotional needs. Based on her own experiences, she will follow her own plan.

Critiquing the BMI and Government Health Mandate

Acceptance of the government health mandate to lose weight through proper diet and regular exercise, along with agreement that being overweight or obese represents poor physiological health, does not necessarily translate into wholesale acceptance of the formal classification tool used by the government to gauge health, namely the BMI. While a handful of respondents were not familiar with the BMI and even after explanation were ambivalent or reluctant to comment on whether they felt it is an appropriate measure of health, ten (23.8%) respondents openly expressed some criticism of the BMI. Dissent on this classification tool ranged from mild disapproval to unreserved outrage. For example, according to Malaki (33, mixed-race, BMI 29.4), who earlier stated that health is something one can feel, the BMI is "such a small part of the equation" while for Kelly (37, white, BMI 46.0), the BMI is a problematic health measure insofar as it does not take into consideration "muscle weight" or "bone mass." Jack (37, white, BMI 39.4) was told by medical professionals that, according to BMI charts, he was supposed to weigh 194 lbs. He jokes that as a man who is 6'7" he does not "want to be the size of a coat rack." He continues to state that the BMI "was based on a bunch of skinny people." He cannot imagine being 6'7" and only weighing 194 lbs. That would be unhealthy he says.

Three respondents passionately disagreed with the BMI as a useful measure of health. Kirk says:

> Who's to say that's obese? I mean, okay, and who came up with the BMI? I really rebel against this whole thing. Because it's really, I kind of have that kind of Poindexter, tape on the glasses kind of guy in a basement going, 'if we just do this,' kind of image of the person who came up with the BMI because it is so disproportionately wrong every time (Kirk, 26, white, BMI 37.7).

Similarly, when I asked Jamie, a 27 year-old, African-American with a BMI of 33.0, to comment on the measure, he says:

> I think that's just a bunch of B.S. to be honest with you. Because who can classify anybody? What's normal to you is not normal, may be abnormal, to me. I understand the efforts that may be put into the research, but again, it's like you really can't classify on a bunch of standards (Jamie, 27, African-American, BMI 33.0).

Or as Denzel, a 27 year-old African-American with a BMI of 27.7, said when his doctor wrote on his chart that he was obese, bluntly puts it:

> I mean, I didn't give it any thought because I'm happy with who I am. Yeah, he may be reading the BMI and he looked up my height. And yeah the BMI says I'm fat. Screw the BMI. I'm happy. I'm fine (Denzel, 27, African-American, 27.7).

Disapproval of the BMI is thus tied to the earlier notion of individualized health. Respondents felt that it was not fair to use the BMI to place them into this blanket category, especially because it does not accurately reflect their physical or psychological state. Denzel's offense at the doctor's label is in part because there is often some assumption that obese connotes unhappiness, and, as he claims, he is happy. The BMI, and the medical professionals who endorse it, labels and judges respondents in ways they felt were unjust, inaccurate, and misleading.

Vocal critique of the BMI is also tied to rejection of the government's health mandate. Earlier I stated that the majority of respondents agreed with the government's

position. Three respondents who were exceptionally critical of these universal health claims were excluded from the majority. While those who individualized health could be seen as mild dissenters to the government's ideal, the following respondents overtly challenged the government dictate. These three respondents were also different from those who individualized health. As I discuss below, those who individualized health were still motivated to change their bodies, while these "rebels," expressed little desire to do body work. For example, Stella (43, white, BMI 30.9) joins Jamie and Kirk when she questions the government's message. When I ask her what being healthy means, Stella claims that having one of the medical conditions of which the government warns does not necessarily mean that someone is unhealthy:

> I think healthy is just living life the way you want to live it, without intentionally hurting other people, including yourself. I think healthy is, let's see [pause]. I don't know, there's a lot of people who are healthy and have diabetes. Does having diabetes make them unhealthy? Does having heart disease make them unhealthy? I don't know. I think healthy is self-care. And if that means taking care of something that you have to live with like diabetes, like cholesterol, high blood pressure…I'm going to think about that one for a while (Stella, 43, white, BMI 30.9).

Thus while government health definitions explicitly state that diabetes and heart disease are unhealthy, Stella questions this. For her, healthy is self care. Kirk does something similar. When I ask him if he believes that obesity is connected to disease he responds with some uncertainty, saying that the understanding of obesity-disease link is more complex than the government claims:

> Has anybody ever proven that? I don't know. I don't know if there's really as much, it really is kind of that whole, 'Twinkies will cause cancer' kind of thing. Because, yeah, overweight

> is going to be the cause of heart disease and emphysema and, you know, leukoplakia or whatever. And then next week it's going to come out and it's going to be, 'Oh, you can be as overweight as you want! The truth is that if you have ingrown toenails, you're going to die from this.' And so, I don't know [laughs] (Kirk, 26, white, BMI 37.7).

When asked to comment on the connection between weight and premature death, he responds:

> Premature death, okay, first of all, premature death, these are the things that I latch onto…What is premature? Who phrases this? Premature death? Like, do I have a schedule? Does somebody have a book that I don't know about? You die when you die, it's not like it came early. And we're back to that, you know, you're fighting for six extra months or a year. I mean, does the Grim Reaper show up and be like, 'Well, you've missed it by five lbs, you're gone' (Kirk, 26, white, BMI 37.7).

Kirk then questions the idea that being overweight significantly shortens one's lifespan. Specifically, he expresses reservation about whether losing weight will add months to his life. Following, he questions the meaning of these added months:

> Over the span of seventy years, is a year going to really matter? I mean, because that's one of the problems that you have with like this health culture thing going on right now, is you're fighting for a year. You're fighting for a year, maybe six months. You know, if you eat this bran flake or whatever. You're going to add six months to your life. What happens at the end of somebody's life? Do you really want to extend what happens to most people? I mean, you're wearing diapers. You can't talk, you're, you know, it's really not the golden years that people romanticize about. So do you want to add another six months onto that? Because they don't insert that in the middle of your life. You know, somebody doesn't come down and go, 'you get six more months of your fortieth year.' No, you get it at the end, when things may not be great. Just live yourself [laughs] (Kirk, 26, white, BMI 37.7).

So even if the government mandate is correct and obesity shortens lifespan, Kirk does not want these extra months. In his view, they come precisely at a time when he does not want them. In similar vein, Jamie questions whether it is worth obsessing about health issues. "Life is too short. Don't limit your time, it's your time" he reminds me. He says he would be happy to live to 60 or 70, god willing, but is not enthusiastic about living to 80 or 90. Because, in his words, "that's just too much work." In this way, Kirk and Jamie work outside a central claim implicit in the government health framework – that individuals ought to be concerned about living long healthy lives.

Kirk and Jamie's comments contrast remarkably Johnavon's (27, Native American, BMI 29.5) and Sol's (48, Hispanic, BMI 28.5) approach to longevity. Johnavon aspires to be just like his grandpa who was turning 102 in the weeks following our meeting. He not only acknowledges that "diabetes is more or less a very prevalent problem amongst Native Americans," he is strongly motivated by health in order to live a long life. In his words: "I know that for myself I want to see a lot of the world and just kind of the world is so big that you won't probably get to see all of it in a lifetime. So living to a 102 kind of gets to what allows me to do so much." Similarly, Sol repeatedly emphasized that he wanted to extend his "lifeline" so he can start a business, travel, and spend more time with his children.

Along with the legitimacy of the government's claim linking weight to disease and death, Stella also questions the universality of these health guidelines. Again, the notion of individualized health surfaces; a rejection of dominant standards means that what works for one person does not necessarily work for, or is applicable to, her:

> So who says you have to do a certain exercise type for 20-minutes a day, seven days a week, three days a week, whatever. Who decides that? So these are all the things I've started

> taking apart. You know, who gets to dictate that? Is that the right plan for everybody? Well, I was thinking, what did they do before the food pyramid? People ate hearty and worked hard. They didn't have someone saying you need to eat three to five servings of this, and a serving is this size, and you need to get this much exercise. I started just trusting myself more as opposed to trusting someone else to decide for me (Stella, 43, white, BMI 30.9).

She then turns to the research and critiques the development of these standards, claiming that they are not really universal and are, effectively, based on political influence:

> A lot of research…is that whatever you want to look for you can find in statistics. You just measure what you want measured and you get the result you want. You know, eggs are bad for you. Now they're okay. Salt is good. Salt is bad. Coffee is good. Coffee is bad. Don't drink. Have a glass of wine a day. It changes. It changes with media. It changes with who's got the money, who's got the research, who's got the advertising…I think that has a lot to do with that (Stella, 43, white, BMI 30.9).

In sum, respondents like Stella, Kirk, and Jamie condemn the universal government mandate. Their perspectives on health have strong implications for body work. All three respondents consciously reject the desire to lose weight and accept or resign themselves to their bodies.

Self-Perception of Healthiness

Given how respondents expanded and/or redefined health, it is not surprising that many considered themselves healthy. In fact, only eight of 42 (19.0%) respondents acknowledged that they were not healthy and/or put themselves closer on the "poor health" end of a health continuum than the "ideal/good health" end.[3] Specifically, these

[3] The original interview schedule did not ask respondents to quantify their self-perceptions of health. Several respondents asked if they could and, as interviews progressed, this became such a common practice that I

respondents assigned themselves a 5 or less when asked to rate their health on a scale of 10 (with 10 representing optimum health). Only five of these eight respondents (62.5%) were obese and only half were aware of a weight-related diagnosis. For example, Joanie (48, white, BMI, 38.9) was diagnosed with a fatty liver and admitted that she was unhealthy, giving herself a three. She assigned this number primarily because, while she does not treat her body with respect, she does not "smoke or drink to excess." Similarly, Amarika (26, African-American, BMI 36.3) considers herself unhealthy. She laughs and admits, "I'm probably, I think if I went and got medical screening, I'd probably be really, not really do very well at all." Consistent with formal health definitions, she agrees that she is in poor health even though she has not had the blood work to know this.

A majority of respondents (23 or 54.8%) placed themselves around the mid-way point or slightly above, articulating openly that they were either healthy and/or assigned a number between 5 and 7.5. They acknowledged that given their body weight, they could be healthier. Many in this mid-range category also focused on their *present* health. Their reluctance to assign a higher score stems partially from their willingness to acknowledge that weight issues might present serious health problems down the road. This is seen with Estella (28, Hispanic, BMI 45.2) who gave herself a 5 because she does not have diabetes now, but concedes that she might in the future. The words of Adele (26, African-American, BMI 28.9) are illustrative: "I'm overweight, but I'm perfectly fine. But down the road, I might not be perfectly fine, you know what I mean? Because with developing hypertension,

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started asking respondents to rate their health on a 10-point scale. While the validity of this health scale would be strengthened if I had a comparison group of "normal" BMI respondents, the narratives nevertheless support a clear qualitative distinction between those who rated themselves high from those who rated themselves low on this scale.

developing diabetes, it doesn't happen overnight. It's like a process." Others who did not believe they were in poor health also rated themselves healthy because of redefinitions, including, the aforementioned theme of "feeling good." For example, Jocelyn (46, African-American, BMI 31.8) considered herself healthy because she relied on an unofficial measure of health: "I put myself at a seven because I feel real good. I'm not sick, really. You know, I don't feel like some people are, sick. I feel good."

The remaining quarter (11 or 26.1%) placed themselves in categories higher than 8, partly because, like Jocelyn, they did not rely on official measures. Recall Jamie (27, African-American, BMI 33.0) and Denzel (27, African-American, BMI 27.7) who were both critical of the BMI. They evaluated themselves as 9 and 8, respectively, saying that their scores would have been higher if they were not tobacco users. And Johnavon, despite being on the cusp of obesity (BMI 29.5), said he was a 10 explaining that his cultural measures of health are different from "white man's society." Pragmatic measures of health also influenced self-interpretations of healthiness. Alesha (34, African-American, BMI 26.3) measured her health by her ability to do her job as a correctional sergeant in a prison. When I asked why she considers herself healthy, she emphasizes how health is measurable through actions:

> Because I'm, I know that if, say, for instance I'm at one side of the unit and two inmates are fighting on the other side of the unit and I need to respond and I need to run, when I get there I'm huffing and puffing. So in that I'm a get there. Some people can't even get there. So from point A to point B, I'll get there on time. So I consider myself being healthy in the sense that I can get my butt up and run [laughs]. I might be out of breath but I can get there, so, you know. That's why I say a 7 or 8 (Alesha, 34, African-American, BMI 26.3).

Finally, other respondents stated they were healthy and/or gave themselves a high score on health because they had made lifestyle changes that led them to conclude that they were

healthier. Obese respondents like Rhonda (40, white, BMI 38.1) and Jack (37, white, BMI 39.4) were both diagnosed with diabetes and made radical life changes. Both made dietary changes and had now incorporated walking into their routines. This is especially noteworthy for Jack who had lost several toes to the disease. Subsequently, both had lost a significant amount of weight (50 and 40 lbs respectively) and stated that they were 8 on the healthy scale because they were healthier compared to their previous physiological states.

Health Motivations and Body Work

How respondents process health meanings not only has important implications for self-perception of healthiness, but it also has implications for body work. Specifically, it is connected to body work motivation, although not necessarily to the success of body work and measurable outcomes such as actual pounds lost. That is, how individuals process health meanings influences in part their health-based motivation for bodily change. This is especially the case for respondents who harshly criticized the government mandate. The data suggest that respondents can be categorized into four different types (conformists, co-opters, apathetics, and rebels) based on two dimensions: (1) full acceptance of the health mandate and its universal principles, and (2) motivation specifically from this health mandate. This typology of health motivation is not meant to be a rigid classification scheme, but instead, presents several ideal types that can be used for comparison and illustrative purposes.

The Conformists

The majority of respondents were conformists. Thirty-one (73.8%) respondents not only agreed with the government dictate, but were also motivated by it. This is not surprising given that the health frame is authoritative. Thus when asked why they wanted to

lose weight, conformists indicated that health concerns were influential. While some conformists considered themselves healthy because they adopted a broad definition of health, the health mandate was nevertheless impetus for weight loss. Conformists worried about and feared medical problems and, in turn, were motivated by these concerns.

Rhonda's situation is typical. The government's health message reverberates throughout the narrative of this 40-year old divorced mother who works as a teaching assistant:

> Yeah, I remember the first time the doctors put on the record that I was obese, it crushed me. 'What! What do you mean?' But, you know, it's a national problem. I think that by saying, 'okay, yes, I'm obese, I'm working on it, and get[ting] healthier,' I'm setting a good example for the kids around me that are on their way to a sedate, overweight lifestyle.…I think it's important to accept the label and [that] you do have these problems that are associated with weight. So if you can change that you can become healthier and get rid of those risks (Rhonda, 40, white, BMI 38.1).

Recurring themes among conformists include fears of early death or developing heart disease, along with an awareness that diabetes or some other health concern "runs in the family" – an oft-mentioned phrase. Like a public service spokeswoman, Susan (44, white, BMI 26.5) cites that "heart disease [is] the number one killer of women in this country." There were also specific concerns about having to take medication for the rest of their lives. In sum, conformists heeded the health message and it provided impetus for behavioral changes. Like Rhonda, who was diagnosed with diabetes, a handful of conformists were motivated by some kind of formal diagnosis. Eleven of 31 (35.5%) were told by doctors that

they had "abnormal" blood work or conditions such as high cholesterol, diabetes, or a fatty liver.[4]

Whether conformists were successful at losing weight was an entirely different matter. While the presence of motivation does not guarantee that weight loss behaviors will be initiated, an absence of motivation virtually guarantees that these behaviors will not. Thus, in order to understand the eventual decision to lose weight, it is first necessary to understand from where the desire to lose weight emerges. While conformists such as Rhonda were able to successfully change their diets and implement exercise regimens, respondents provided a host of reasons for not performing body work and only doing "mental body work," the ongoing psychological determination to change one's body and consciousness about it. Despite the fear of disease or death, many admitted to being lazy or too tired after a long day of work. The Arizona heat was frequently cited as an inhibitor to exercise. Conformists also provided structural justifications for not converting mindset into action, citing time and money issues. "Life gets in the way" said Ramone (25, Hispanic, BMI 32.9). Fast food, they reminded me, is quick, cheap, and easy while fresh and healthy foods are expensive. Moreover, exercising takes time and gym memberships, even if desired, were not affordable for this group of primarily working-class, lower SES respondents.

The Co-Opters

From the government's perspective, conformists such as Rhonda are ideal citizens. They agree with the health frame are motivated by it. Yet, the remaining 26.2% percent were either critical of the health mandate and/or not motivated by it. A second category of

[4] This is a conservative estimate. Respondents openly admitted that they did not visit the doctor regularly and, if they did, that they were uncertain their blood work would indicate "normal" levels.

respondents that I label co-opters (6 or 14.3%) expressed some dissent with the health mandate, especially with the blanket applicability of single health standards. However, despite critique, they are nevertheless motivated to lose weight for health reasons. This suggests an incomplete rejection of authoritative knowledge. Shawntea (36, African-American, BMI 44.4) who earlier spoke of her reservations about the universal standards nevertheless concedes that she is motivated by health:

> My dad had a heart attack…I think it really set in that a major concern is that you really do need to exercise and that you do not need to be out of a certain weight to avoid that. And you could be perfectly fit and still have the same issues. To me, if you're where you need to be, it prolongs [life] a little more I think. Well, then my mom, she had the gastro by-pass. But she doesn't have to take blood pressure medicine. And I'm going to be 40, years to come, but I want to be a healthy 40. I want to do things in my life (Shawntea, 36, African-American, BMI 44.4).

She admits, however tentatively, that being obese has serious health implications that she needs to address if she wants to live a long life. Co-opters such as Shawntea and Jeanette (35, white, BMI 46.3) both focused on finding a health and diet plan that were suited to their personal needs. Recall that Jeanette experienced much frustration with doctors for giving her generic advice and, as she put it, for being "didactic, looking at the charts that sort of thing." In light of her dissatisfaction, she opts to create her own health and diet plan. "It's taking me many years to come to the point where now I'm doing something that works because not all people are the same…I had to change it around to fit me." Her program includes minimal exercise and two snack meals a day. Despite critique, co-opters were still highly motivated to attain better health. They did so, on their own terms.

The Apathetics

The apathetics were a very small group of respondents who did not express dissent about the government's universal health mandate. Yet, somewhat surprisingly, they were not motivated by it. Indeed, those who fall into this category might be considered extraordinary cases that defy logic. Acceptance of the health mandate would rationally imply health motivation. This was not the case for two respondents. Both respondents were placed in this category that required explicit agreement with the universal health mandate and explicit statement of no health motivation. So while Matthew (31, white, BMI 25.1) and Joanie (31, white, BMI 38.9) both understood and conceded the health risks of being overweight, they expressly claimed that they were concerned about these risks and that it did not motivate them. Matthew states forthrightly: "No, I don't care about being healthy." He explains that he only eats healthy foods because his wife would not permit him to eat otherwise. He justifies his apathy by comparing himself to his grandfather who ate whatever he wanted and "hasn't had any problems since he had the bypass." Matthew admits to, in his words, having a "false sense of invincibility."

Joanie is a nurse and therefore clearly understands the health risks of being obese. Yet she is not motivated by health. Joanie is in an abusive marital relationship and eats to "stuff her emotions." While she is concerned about her obese daughter's health, she is not concerned about her own. She suffers from depression and is too apathetic about her health to care. She believes that, just like smoking or alcohol, if she was really concerned with the accompanying health issues she would simply stop binge eating. When asked how she reconciles her personal ambivalence to health and her health worries for her daughter, she admits that she is in denial about her bodily state:

> Well, it's kind of like the fact that I don't look in the mirror anymore. I don't know what term I want to use [pause]. When I don't look in the mirror, I am not recognizing what I've done. It's the same thing as the other. As long as I don't look in the mirror, I'm not the person in the mirror. So, I would say I just don't dwell on it. I think that's what it is. I avoid it (Joanie, 48, white, BMI 38.9).

With both Matthew and Joanie, a psychological mechanism is at work that makes them ambivalent to health. Matthew feels he is invincible and Joanie is depressed and in denial. In Chapter 5, I return to Joanie's case in more depth because, while she is not motivated by health, somewhat surprisingly, she was highly motivated to change her body for other reasons.

The Rebels

As seen earlier, the most vocal critique of the government's universal health mandate came from Kirk (26, white, BMI 37.7), Jamie (27, African-American, BMI 33.0), and Stella (43, white, BMI 30.9). I label them rebels because their critique was vocal and also accompanied by little to desire to lose weight. That is, rebels were not motivated to do body work. Kirk's story is illustrative. First, he admits the diabetic factor does not motivate him. He feels he's "at a loss, really, when it comes to losing weight. So it's like at this point what can I do?" He therefore accepts his body and, in reference to diabetes, "just to be comfortable with the fact that this is where this is going." However, his situation is unlike Joanie's. He is not depressed; his decision is active and conscious. So after previous struggles with diets and attempts to conform to health and social standards, Kirk, like the other rebels, chooses to disengage from the health discourse.

Given the downplaying of living long lives, rebels focus instead on living well and happily. Jamie, who clearly stated that he does not want to live to 80 or 90, lives in the

present moment, focusing on his academic and career goals for himself and his daughter. A strong theme for the rebels is self-acceptance. Unlike in the past, they no longer struggled with their bodies, or at least struggled less with them, coming to a place where they were more or less at peace. Stella used therapy sessions in part to come to terms with her body. She is also a born again Christian and this newfound ideology affects how she now deals with her body:

> I'm a baby Christian. And a lot has changed, my spirituality, and I know a lot of Christian women who hate their bodies. So, but for me, it was really learning that God loves us no matter what. We don't have to do anything we don't have to be anything. It doesn't matter to Him what we eat or drink, or what size we wear. Or what, how our hair is done or makeup or jewel[ery]. It doesn't matter to Him (Stella, 43, white, BMI 30.9).

God accepts her for who she is and so she tries to do the same. Rebels were either happy or complacent with their bodies and comfortable with who they are. As such, they have minimal desire to do body work and that they do little body work causes little anguish or consternation.

Each rebel came to reject the health frame in different ways. Stella reached this point after ongoing reflection, questioning, and therapy. She grew up with parents who worked in the beauty, i.e., hairdressing, industry and, for some time, was a member of Curves, a women's gym. She repeatedly observed the tremendous amount of dissatisfaction individuals, but mostly women, felt about their bodies. Her ongoing questioning of cultural norms, along with her decision to accept Christ, played a key role in her decision to accept her body. Kirk's lax attitude towards health and weight loss was developed after attempting various diets. Ironically, his most successful diet – one that provided a transition point to both attitudinal and behavioral changes – was unintentionally planned. Kirk describes how

he lost 60 lbs on a Ramen noodles diet "because that's what you can afford when you don't have money." The weight loss, however, did not make him happy. He says:

> I didn't feel good about myself. Even, I mean, 60 lbs gone. Huge, huge difference. I mean we're talking, that requires a wardrobe overhaul. …And it didn't make a damn bit of difference. All I knew was that I was unhappy, you know. Mealtimes were like, 'oh god, I've got to eat,' you know, kind of thing. And so it was like, 'you know what? I'm just going to let myself be the way I'm going to be and I'm going to enjoy what I'm doing (Kirk, 26, white, BMI 37.7).

Finally, while the transition point in Jamie's life is less clear, it is apparent that he does not prioritize his body. His narrative is similar to Denzel's story presented in Chapter 5. As a young single parent struggling to excel academically in order to one day go to law school, Jamie feels there are other things to worry about than his body. Life is too short and since he does not have any present health complaints, high blood pressure, or cholesterol, he is not presently motivated by health issues. In fact, he is not motivated by either the health or beauty frames. His focus is on enjoying his life, advancing his school and career, and improving his economic situation.

For the rebels, their broader understanding of health cannot be separated from the ideals of happiness and inner peace. A quote from Kirk captures well the rebel perspective: "I think the key is being happy. If you're happy with the way you are, then screw everybody else." Notably, like the majority of co-opters, rebels were all in the higher weight category. Vocal critique of the government's position and definitions thus strongly correlates with higher body mass indexes.

Discussion and Conclusion

The medical community warns that obesity is a health epidemic. In response, it sends out a powerful and authoritative public message: individuals with a BMI greater than twenty-five put themselves at risk of serious medical problems. They should therefore lose weight, following a universal formula comprised of regular physical activity and a "proper" diet.

Culture is a tool kit or repertoire of habits, skills, and styles from which individuals construct strategies of action and the self. Individuals, as savvy cultural negotiators, draw on various components of culture and use it to define, guide, and interpret desired action and to reinforce or create a sense of self. Confirming Swidler's identity model, respondents actively use health information, in ways that they think are consistent with who they believe they are or want to be. That is, they use elite health knowledge and bend it in ways to help them interpret and understand their lives. While some respondents wholly accepted the health message and used it to motivate lifestyle changes, others redefine it in light of their life situations. They considered themselves healthy because they were spiritually, mentally, or emotionally healthy. Or, they were healthy because they were able to perform their jobs and carry out everyday tasks. Respondents also partially or wholly rejected health knowledge because it did not fit with their life experiences and the way they think of the world. Rebels, in particular, were critical of the BMI and the health frame because it did not mesh with how they thought of happiness. Their personal experiences also led them to reject the main tenets of the health frame. In other words, respondents used authoritative health knowledge in multiple ways – some by accepting, others by redefining, and still others by rejecting this information.

The varying uses of the health frame are important as they are related in part to self perceptions of healthiness. Not surprisingly, and consistent with previous research, an expanded definition of health produces higher self-ratings (Idler, Hudson and Leventhal 1999). The various uses of the health knowledge also illuminate the potential centrality of lay person's beliefs and understandings of their health situation. As Popay et al. (1998) acknowledge, lay persons' understandings of health provide a vital connection between the relationship between social context and the experience of health and illness. In many ways, respondents' knowledge constitutes informal knowledge, knowledge that ordinary individuals develop to deal with their daily lives (Geertz 1983; Gramsci 1971). This subjective knowledge can potentially challenge elite authoritative knowledge. Like feminist standpoint theories (Hartsock 1983; Smith 1987) that argue that women are uniquely situated in a gender-stratified society and therefore provide a particularly advantageous vantage point, so too do overweight individuals in a body-stratified society. Their specific standpoint or epistemology comes directly from their grounded experiences and possession of a body that does not conform to the health mandate. These understandings not only highlight the disjunction between the strict indicators of health adopted by the medical field and a socio-cultural understanding of health (Kellert 1976), but they can also provide insight into the creation of sound public health policy. Government health messages about proper dietary and exercise habits are potentially lost if they ignore how individuals process these meanings and apply them to their daily lives.

Four classification types emerged from the data based on two axes: acceptance of the government's health dictate and body work motivation. These categories are ideal types and it is possible that individuals, over time, move from one category to another. While there are

many reasons why individuals may fall into one category more so than another, it is notable that all but one co-opter was obese and, with one exception, they were all minorities. Ethnicity not only mediates what is in an individual's cultural tool kit, but how s/he might put these tools to use. This is seen in Shawntea's case. She is obese and African-American and admits that she gleans health information from African-American media sources such as BET (Black Entertainment Television). Shawntea discusses at length the influence of African-American women such as Kelly Price, Monique, and Star Jones. With Johnavon, I observed how his ethnic background informs his critique of the dominant health discourse. At times he rejects the dominant health knowledge, claiming that he is healthy because he has a harmonious relationship with nature, self, and others. Other times he acknowledges that he must make lifestyle changes if he is to live as long as his grandfather. In other words, ethnicity provides an interpretive tool for understanding and using health messages. Co-opters, while motivated by health, used health knowledge in ways they felt were consistent with their own understandings of the world and themselves.

Similarly, rebels use culture to construct the self. They draw on health messages and explicit challenge it, thus eschewing it as impetus for body work. Rejected by a body-conscious society, many respondents (not just rebels) reported pasts that were filled with on-and-off dieting, struggles with weight loss, and the desire for social acceptance. Yet rebels somehow reached a point of self acceptance. For Stella, while the precise point of change is unclear, it is closely tied to her self-reflection and Christian rebirth. Interestingly, while none of the rebels were familiar with the fat acceptance movement, their perspectives resonate with the tenets of fat acceptance activists and the social justice frame. As we saw in Chapter 3, members of NAAFA critique the government tenet that overweight or obese

automatically signify unhealthy. Fat acceptance activists are also critical of the government's patrolling of weight, focusing instead on fitness at any size, happiness, and the tearing down of social barriers and stigma associated with larger body sizes. Central to the rebels' sense of self are self-acceptance, peace, and happiness. As such, rebels use the health frame very differently than the conformists. Because these internal states are more important to them than physiological health, combined with their personal experiences, they are able to reject the dominant health frame and free themselves from both the health and aesthetic mandates of society.

CHAPTER 5

BODY IMAGE, BODY CONSCIOUSNESS, AND BODY MANAGEMENT: THE BEAUTY MYTH REVISITED

This chapter focuses on the lived experiences of men and women and their relationship to the beauty frame. The thin beauty ideal is pervasive in western culture and the thin body is a visible cultural symbol that signifies competence, success, and desirability. How do individuals, especially those who do not measure up to the cultural aesthetic ideal, use this frame? Moreover, how does this frame surface in every day interactions? How do those who do not conform negotiate their bodies in a body-conscious culture? To address these questions, I turn to the in-depth interviews with forty-two overweight and obese respondents. However, before turning to this qualitative data, I begin by examining the general resonance of the beauty frame. I do this by turning to the survey data (n=456) on the population from which the interview sample is drawn.

The Beauty Frame and Beauty as Status

Media images in Western culture emphasize an aesthetic ideal of thinness, especially for women (Bordo 1993). This ideal is not only omnipresent, but has intensified over the years. Playboy centerfolds' bust and hip measurements have decreased over time while the Body Mass Indexes (BMI) of the Miss U.S.A. pageant winners show a significant decline (Garner et al. 1980; Rubinstein and Caballero 2000; Wiseman et al. 1992). Similarly, male Playgirl centerfolds and action figures have become increasingly "dense" and muscular throughout the decades (Leit, Gray, and Pope 2001; Pope et al. 1999). Today, images of an extremely thin ideal for women and a muscular ideal for men abound in print and visual

media. In both forms, fat is eschewed. In western culture, the overweight or obese body is considered aesthetically displeasing, unattractive, or even ugly.

These beauty ideals have been exposed as unrealistic. The probability of attaining Barbie's measurements in real life is under 1 in 100,000 while Ken's measurements are only attainable for 1 in 50 men (Norton et al. 1996). They are nevertheless coveted. Women strive to be thinner while men are conditioned to strive to be heavier in muscle (Furnham, Badmin, and Sneade 2002). These ideals are sought not only because depictions are pervasive, but because the lean body symbolizes self-control, success, and acceptance (Brownell 1991). The thin body brings social status and is associated with an array of positive social traits. Compared to unattractive people, attractive people are assumed to possess more socially desirable personality attributes. For example, they are expected to lead better lives, hold more prestigious occupations, and have happier marriages (Dion, Berscheid, and Walster 1972). Being thin, and beautiful more generally, creates a "halo effect" where attractive individuals are assumed by others to be good, intelligent, and well-natured, while unattractive individuals are stigmatized as mean, dishonest, and trustworthy, a "horns effect" (Katz 2001). Beautiful people are also considered to be more competent. Studies support such claim, especially when performance is below par "attractiveness matters: You may be able to get away with inferior work if you are beautiful" (Landy and Sigall 1974: 302). In other words, beauty is an important status characteristic that shapes social interactions and outcomes at various life stages and in various social settings (Puhl and Brownell 2001; Webster and Driskell 1983). Beauty is status.

Importantly, the social benefits of being thin and beautiful are not only perceived, they are real. The social effects of this status are especially salient for those who do not

possess beauty and thinness, compared to those who do. Obese individuals who visibly do not fit the cultural beauty ideal are not privy to certain social benefits and are subject to a significant amount of bias and discrimination throughout their lives (Puhl and Brownell 2001). For example, studies on hypothetical managers, job applicants, and coworkers find that overweight managers are seen as less desirable and judged more harshly (than average weight managers); there is less desire to work with obese targets (compared to thin targets); and stereotypical perceptions of obese workers as lacking self-discipline, having low supervisory potential, and having poor personal hygiene and professional appearance are prevalent (Decker 1987; Klassen, Jasper, and Harris 1993; Rothblum, Miller, and Garbutt 1988). Negative stereotypical beliefs about overweight and obese employees affects real social outcomes such as wages (Loh 1993; Register and Williams 1990). Women, especially, face a significant wage penalty for obesity and obese women are significantly more likely to hold low-paying jobs compared to thin women (Pagan and Davila 1997). Obese individuals have also reported that their weight affected termination or suspension (Rothblum et al. 1990). In educational settings, obese children are considered lease desirable as friends, ranked similarly to children with disabilities (Richardson et al. 1961). Even in young children, including preschoolers, anti-fat attitudes are documented (Counts et al. 1986; Cramer and Steinwert 1998). Studies show that obese individuals are actively discriminated in the college admission process and weight has been attributed to poor academic evaluations (Canning and Mayer 1966; Solovay 2000; Weiler and Helms 1993). On the social scene, obese individuals, and particularly obese women, are less likely to be considered as desirable sexual partners (Regan 1996). In sum, there is considerable evidence pointing to

anti-fat views. The "horns effect" is widespread, resulting in various social disadvantages for those in the upper weight categories.

Individuals covet and work towards the aesthetic cultural ideal because beauty and thinness provide status and they also come with tangible social rewards. It is also coveted because built into the ideal is the assumption that the body is infinitely malleable (Bordo 1993; Brownell 1991). Achieving the perfect body is thought to be possible with the right combination of diet and exercise. Biological variables that realistically limit individuals' body size are overlooked. The omnipresent ideal thus comes hand-in-hand with the message that we all can look this way, if we just try hard enough.

To attain this ideal, individuals resort to various forms of body work (Gimlin 2002), from aerobics to liposuction to dieting, with anorexia nervosa and bulimia at an extreme end of the dieting spectrum (Fallon 1990; Stice et al. 1994). Exercise is less about health and enjoyment than it is about changing body shape, controlling weight, and enhancing attractiveness (Cash, Novy, and Grant 1994). Dieting regimens, the use of weight-loss drugs and/or steroids are commonplace (Pope, Phillips, Olivardia 2000). Indeed the culture that glorifies this ideal also puts forth the many remedies and prescriptions that assist individuals in their relentless, albeit vain, pursuits. The fashion, weight-loss, beauty, and fitness industries have all profited generously (Fraser 1994; Seid 1989).

Body Dissatisfaction and Body Image

Not surprisingly, in this culture of thinness, body dissatisfaction is widespread. Nearly two decades since Naomi Wolf's best-selling book *The Beauty Myth* (1991), research continues to point to the increasing dissatisfaction that individuals, and especially women, have with their physical appearance (Cash and Henry 1995; Cash and Roy 1999;

Cash, Winstead, and Janda 1986; Feingold and Mazzella 1998). Women's weight is closely tied to, and often erodes, their self-worth (Rodin, Silberstein, and Striegel-Moore 1985). Pursuit of the beauty myth places women at physical risks (Saltzberg and Chrisler 1995; Sprague-Zones 1997). Barbie's measurements are not only unrealistic but dangerously thin (Turkel 1998) and many young women report that they smoke to curb their appetites (Sorensen and Pechacek 1987). Recent studies with men show similar body image disturbances (for an overview of the recent literature on male beauty ideals and male bodily concerns, see Hatoum and Belle 2004).[1] The psychological effects of the pursuit of the perfect body are well known. Preoccupation with body weight and shape is often accompanied by depression and social anxiety (Cash and Deagle 1997; Cash and Grant 1996; Cash and Pruzinsky 1990; Freedman 1986; Thompson 1996).

The tyranny of the thin ideal may not have uniform effects. While female gender is a key predictor of poor body image, race can sometimes serve as a buffer. Specifically, studies point to more flexible concepts of beauty by African-American adolescent girls when compared to their white counterparts (Parker et al. 1995). In general, studies report lower levels of body dissatisfaction and anxiety, along with a more positive body image, for African-American women (Abood and Chandler 1997; Akan and Grilo 1995; Rucker and Cash 1992). However, evidence also suggests that as minority women are increasingly assimilated into American culture, their patterns of body satisfaction may eventually resemble those of whites (Altabe and O'Garo 2002; Kawamura 2002; Thomas and James 1988). A similar prediction has been confirmed with young Latinas where ideal body image

[1] Body image refers to one's subjective experiences of, and psychological attitude toward, one's physical characteristics, primarily appearance (Cash 1990; Pruzinsky and Cash 1990). In the literature, negative body image is sometimes referred to as body image disturbance or body image distress.

is correlated with exposure to time spent in the U.S. (Lopez, Blix, and Blix 1995). Eating disorders, the extreme embodiment of the beauty myth, are no longer just a white middle- to upper-class phenomenon and research indicates that lower socio-economic status (SES) Mexican-American adolescents are just as susceptible (Joiner and Kashubeck 1996). While less research has been conducted with Asian-Americans, Hall (1995) notes in her review that inaccurate perceptions of weight among thin women and a desire for thinness are increasing in this population.

Other correlates of body satisfaction studied by researchers include sexual orientation, age, and class. Homosexual men are at higher risk for eating disorders (Rothblum 2002) and experience lower levels of body satisfaction than heterosexual men (Beren et al. 1996). While lesbian women are at lower risk of developing eating disorders, studies are equivocal on whether lesbians have better body image (Rothblum 2002). Research, does however, point to a functional aspect of beauty for lesbians where they use beauty markers, such as clothing and hair, as strategies to identify one another and to distinguish themselves from heterosexual women (Cogan 1999).

Body studies are dominated by research on adolescent girls and young women. The few research studies conducted with older cohorts suggest that body size dissatisfaction is prevalent across the life span (Hetherington 1994; Tunaley, Walsh, and Nicolson 1999). Comparative research finds that older women may not feel as dissatisfied as younger women (Hetherington and Burnett 1994), but they are still more dissatisfied with their bodies than men (Janelli 1986, 1993; Lamb et al. 1993). Qualitative research by Tunaley, Walsh, and Nicolson (1999) illuminates the subjective meaning of age on body image. Their research indicates that while cross-generational influences of a thin ideal are prevalent, older women

adopt a more laissez-faire attitude towards body size and eating, rejecting the pressures surrounding size and food.

Researchers have also examined the relationship between class and body satisfaction. In industrialized societies, thinness is sometimes seen as marker of social distinction (Bordo 1993), thus predicting increased body consciousness in higher SES individuals. Studies support this, as SES-advantaged women are more dissatisfied and concerned about their bodies than SES-disadvantaged women (Ogden and Thomas 1999; Wardle and Griffith 2001). McLaren and Kuh (2004) add to this research by studying the effects of the social class of a woman's family, along with intergenerational social mobility. Adjusting for BMI, they found that downwardly mobile women were more satisfied with their appearance than stable non-manual women. Higher educational qualifications were also found to be related to more dissatisfaction with weight and appearance.

Alongside these correlates of body satisfaction (gender, race, sexual orientation, age, and class) is the key variable of BMI. Not unexpectedly, body dissatisfaction increases with higher BMI (Hill and Williams 1998). The relationship between BMI and body image raises important questions about how overweight and obese individuals deal with this dissatisfaction. How do individuals who fail to live up to the cultural ideal negotiate their fat bodies? If the ideal constructs them as unattractive and if higher BMI is correlated with higher body dissatisfaction, how do these individuals deal with their bodies on a day to day basis? In other words, given the powerful cultural legitimacy of the beauty frame and because beauty is status, how do nonconformists use this frame in their everyday lives to navigate their world and to understand themselves?

Social psychologists have begun to look at these questions. According to Degher and Hughes (1999), overweight or obese individuals may adopt a "fat" identity that requires identity management in the form of various coping strategies. These strategies may be particularly important in situations that bring to the forefront discrepancies between an individual's actual body and desired ideal, especially if the individual is highly invested in his/her appearance (Cash 1995, 1996, 1997; Cash and Grant 1996; Cash and Roy 1999). Degher and Hughes identify five strategies including *avoidance* of situations where fat is problematic, e.g., not looking in mirrors; *reaction formation*, e.g., responding to negative input by eating more; *compensation*, e.g., overachieving in other areas such as school; *(stereotype or face) compliance*, e.g., minimizing negative responses and maximizing acceptance by complying with one or more social stereotypes of fat people or agreeing to diet; and *accounts* (*fat or eating stories*), e.g., using excuses or justifications for one's weight. While some overweight or obese individuals use these coping strategies and neutralization techniques – essentially, psychological techniques that enable an individual to justify a certain act/behavior or, in the case of obesity, a bodily state – others actively resist the deviant identity. Resistance may come in the form of *exemplars* that reject deviance, e.g., asserting that "I am not unattractive"; *continuums* that distance the self from deviance, e.g., "At least I'm not as fast as she is"; and *loopholes that excuse the deviance*, e.g., "but I was sick or I have different genetics" (Cordell and Rambo Ronai 1999). "Fighting back" also occurs through expressing anger or seething internally; verbal assertion; physical aggression; displays of flamboyance; participating in fat activism; self-acceptance and enlightenment of one's condition; and focusing on the positive aspects of weight (Joanisse and Synnott 1999).

In sum, an overview of the research literature points to high rates of dissatisfaction, primarily among women, and an array of resistance and neutralization techniques for those who do not conform to society's ideal. While the former conclusion is drawn primarily from the social psychological literature and involves mostly quantitative survey data analyses on college age samples with women, the latter involves qualitative data in the form of in-depth interviews and ethnography, again usually with women. While these qualitative studies illuminate some of the key mechanisms of identity negotiation, there is still a dearth of studies on the lived experiences of overweight individuals and how they negotiate their bodies in a day-to-day situation. A recent study by Paquette and Raine (2004) details the socio-cultural context of women's body image and body image as a static construct that fluctuates as women encounter new experiences and re-interpret old ones. They note that despite the plethora of studies on body image, "[s]tudies have yet to explore body image from women's perspectives, through their life experiences, as expressed in their voices" (Paquette and Raine 2004: 1048). I contribute to this literature by turning specifically to survey and interview data with both men and women.

Survey Data: Body Satisfaction and Psychological Correlates

Table 5.1 presents descriptive statistics indicating that body image is important. Nearly two-thirds of the sample (71.1%) expressed agreement in some form that body image is salient, with 52.4% selecting the modal category of agree. Moreover, over half (52.5%) of respondents expressed a desire to be thinner. Yet, despite this finding, respondents tend not to adopt the self-labels of overweight or obese as 65.6% disagreed that they were overweight and 89.4% disagreed that they were obese. Recall, that using government standards, 35.3%

of the sample were overweight (BMI greater than 25) with 12.5% falling in to the obese category (BMI greater than 30).

Table 5.1: Beauty Variables: Descriptive Statistics

	Strongly Disagree	Disagree	Neutral/ No Opinion	Agree	Strongly Agree	N
Body image is very important to me.	.7%	10.7%	17.6%	52.4%*	18.7%	450
I wish I were thinner.	12.5%	21.1%	13.7%	39.2%*	13.3%	451
I am satisfied with my body weight	5.1%	34.6%*	13.7%	33.7%	12.9%	451
I consider myself overweight.	32.0%	33.6%*	6.4%	24.0%	4.0%	450
I consider myself obese.	59.6%*	29.8%	5.6%	3.8%	1.3%	450
Fat is beautiful.	20.6%	31.9%	35.8%*	10.0%	1.8%	452
Fat is ugly.	8.4%	21.6%	39.1%*	22.1%	8.8%	453

Note: Row totals do not always sum to 100.0% because of rounding error; *=modal category.

The cultural ideal that thin is beautiful resonates, to some extent, in the data. Half the sample (52.5%) disagreed with the statement that fat is beautiful. At the same time, 35.8% expressed neutral or no opinion on this statement. Similarly, and perhaps reflecting a social desirability bias, respondents' opinion on the statement "fat is ugly" did not side with either disagreement or agreement. Again, like the statement "fat is beautiful," about one-third fell in the modal category of neutral/no opinion.

Despite the fact that nearly half the sample expressed that they wished they were thinner, response to the statement "I am satisfied with my body weight" was less polarized. While the modal category for body satisfaction was disagree (34.6%), a total of 46.6% indicated that they were satisfied with their body weight, while a total of 39.7% indicated that they were not. Various demographic variables were also significantly related to body satisfaction.

Table 5.2 presents the results of a logistic regression analysis that regresses BMI and other independent variables on the dependent variable body satisfaction. A recoded dichotomous dependent variable is used instead of the continuous Likert scale item as the

assumption of equidistance between Likert scale responses (strongly disagree, disagree, neutral/no opinion, agree, and disagree) does not necessarily hold. Specifically, agreement and strong agreement are coded as 1, while all other categories are coded as 0.

All race variables included in the regression analyses are dummy variables where whites are the reference category. The Other race category is a combination of three categories all of which have a small number of observations (Native/Indian American, Hawaiian/Pacific Islander, and Other). Income (measured in thousands) uses the midpoint of a household income category while married, college degree, parental status (having any children versus none), and employment (referring to fulltime employment) are all dummy variables. I tested for theoretically driven interaction effects for black and BMI; black and sex; Hispanic and BMI; Hispanic and sex; sex and parental status; and sex and BMI. I included the only significant interaction term (male * BMI) in Model 4 and Model 5.

The results of the regression confirm the key findings in the current literature. BMI is significantly and negatively related to body satisfaction, even after controlling for an array of demographic variables. The odds of satisfaction decreases as BMI increases. Model 2 and Model 3 show that gender is a strong predictor of body dissatisfaction, where men are more satisfied. However, this effect reverses in Models 4 and 5. This is because of the interaction term. The significant interaction term male * BMI indicates that as BMI increases, women will be less likely to be satisfied with their bodies. Furthermore, consistent with the literature is a buffer effect of body dissatisfaction for African-Americans; being black increases the odds of body satisfaction by nearly ten times (9.189). The analyses also point to a significant relationship between parental status and marital status. Having children decreases the odds of body satisfaction by .427 while marriage increases the odds of

body satisfaction by 2.557. The significant findings for race (black) and parental status also holds for the dichotomous dependent variable "wish I was thinner." Specifically, blacks are significantly less likely to wish they were thinner, while respondents with children are significantly more likely to wish that they were thinner.

Table 5.2: Logistic Regression Analyses: Satisfaction with Body Weight

	Model 1		Model 2		Model 3		Model 4		Model 5	
BMI	-.154	***	-.181	***	-.203	***	-.330	***	-.327	***
	(.027)		(.032)		(.035)		(.062)		(.063)	
Age			-.021		-.017		-.019		-.023	
			(.016)		(.016)		(.017)		(.019)	
Male			1.256	***	1.315	***	-3.606	*	-3.481	*
			(.246)		(.254)		(1.691)		(1.696)	
Parental Status			-.437		-.694		-.641		-.850	*
			(.361)		(.377)		(.386)		(.414)	
Black					2.070	**	2.345	**	2.218	**
					(.714)		(.798)		(.809)	
Asian					-.200		-.188		-.194	
					(.560)		(.561)		(.567)	
Mixed Race					-.304		-.234		-.280	
					(.332)		(.337)		(.342)	
Hispanic					.262		.203		.227	
					(.303)		(.306)		(.315)	
Other Race					.100		.192		.060	
					(.773)		(.794)		(.823)	
Male * BMI							.210	**	.208	**
							(.073)		(.073)	
Income									-.006	
									(.004)	
Married									.939	*
									(.438)	
College Degree									-.363	
									(.351)	
Employment									-.019	
									(.250)	
Constant	3.550	***	4.191	***	4.555	***	7.406	***	7.639	***
	(.658)		(.763)		(.807)		(1.393)		(1.425)	
χ^2 (df)	41.636	***	76.905	***	88.457	***	97.716	***	105.078	***
	(1)		(4)		(9)		(10)		(14)	

Notes: N=380, standard errors in parentheses.
* p <.05; ** p <.01; ***p<.001 (two-tailed tests).

Is body satisfaction related to psychological correlates such as confidence, esteem, and happiness? Table 5.3 presents the results of three regression analyses.

Table 5.3: Logistic Regression Analyses: Body Satisfaction and Psychological Variables

	Self-Esteem		Confidence		Happiness	
Body Satisfaction	1.333	***	1.283	***	1.203	***
	(.283)		(.313)		(.343)	
BMI	-.034		-.018		.006	
	(.030)		(.031)		(.034)	
Black	.184		.404		.770	
	(.708)		(.769)		(1.094)	
Asian	-1.422	*	-.675		1.159	
	(.569)		(.611)		(1.070)	
Mixed	.046		-.325		-.243	
	(.345)		(.355)		(.373)	
Hispanic	-.564		.133		.054	
	(.318)		(.369)		(.390)	
Other Race	-1.016		-.021		-.615	
	(.701)		(.762)		(.741)	
Age	-.028		.001		-.001	
	(.016)		(.018)		(.019)	
Male	-2.651	*	-2.182		.486	
	(1.316)		(1.563)		(1.463)	
Household Income	-.001		-001		-.003	
	(.004)		(.004)		(.004)	
Married	.373		.345		-.233	
	(.427)		(.468)		(.469)	
College Degree	.555		.709		.224	
	(.348)		(.399)		(.398)	
Parental Status	-.021		-.612		.376	
	(.359)		(.381)		(.443)	
Fulltime Employment	.674	**	.621	*	.594	
	(.255)		(.281)		(.305)	
Male * BMI	.166	*	.108		-.012	
	(.051)		(.062)		(.056)	
Constant	1.456		.750		.753	
	(.831)		(.861)		(.951)	
χ^2 (df)	60.065	***	49.125	***	27.599	*
	(15)		(15)		(15)	
Observations	379		380		378	

Notes: Standard errors in parentheses.
* p <.05; ** p <.01; ***p<.001 (two-tailed tests).

While variables were entered into the analysis in blocks based on theoretical significance, I did not observe suppression effects. Body satisfaction, along with all three outcome variables, is measured dichotomously where 1 represents agreement in any form (strongly agree or agree), while all other categories were coded 0. Again, I tested for theoretically driven interaction effects for black and BMI; black and sex; Hispanic and BMI;

Hispanic and sex; sex and parental status (for the predicted variable happiness); and sex and BMI. I include the only significant interaction term (male * BMI) in the final models.

The logistic regression models point to a key finding. Body satisfaction predicts all three psychological outcomes: self-esteem, confidence, and happiness. Specifically, reported body satisfaction significantly increases the odds of higher self-esteem, confidence, and happiness by over three times (3.792, 3.607, and 3.33, respectively). Note that these are self-report measures that are not based on third person assessment using a psychological instrument or scale. Even so, this finding is not surprising given the body consciousness of western societies. Other findings include a negative effect of self-identified race as Asian, along with male gender on self-esteem. Full-time employment is positively and significantly related to both self-esteem and confidence. The significant interaction term male * BMI also indicates that as BMI increases, women will be less likely to report high self-esteem.

Interview Data: Responses to the Beauty Ideal

The statistical data point to the overall salience of body image and confirm several other key findings in the current literature. The survey data show that African-Americans are generally more satisfied with their bodies than other races and that BMI has a negative effect on BMI, especially for women. Moreover, body satisfaction is an important correlate of self-reported psychological measures such as self-esteem, confidence, and happiness. While these data speak to the general views held by a sample of individuals of various body types, it is only by turning to qualitative data that it is possible to flesh out the specific processes involved with body dissatisfaction. In a body-conscious society where body image is considered extremely important, body dissatisfaction manifests itself in very tangible ways. I begin first by discussing how respondents approach the cultural ideal of thinness (by either

rejecting it or accepting it) and the views of four respondents (Jeanette, Denzel, Janice, and Susanna) whose narratives illustrate recurring themes in both categories. Second, I examine how, despite rejection or acceptance of the cultural ideal, the majority of respondents use the cultural ideal to motivate weight-loss behavior. Finally, I turn to how respondents, primarily women, manifest a body or weight consciousness that involves the ongoing emotional and physical management of their bodies.

Rejecting the Ideal

Respondents approached the cultural beauty ideal in two main ways, either by rejecting or accepting it. The majority of respondents openly criticized the ideal, exposed it as an airbrushed media fiction, and articulated that it is unattainable and dangerously unhealthy. Respondents, especially parents, also spoke of concerns for the younger generation of girls. For example, Jeanette is 35, white, and, based on the government's classification schema, she is extremely obese (BMI 46.3). She is remarried with two children. Previously a clerk, she is now going to school full-time so she can eventually pursue a career in journalism. Her household income is below $30,000. When asked about media images, Jeanette responds:

> I think it's biased. It's not healthy for our society. …They're not portraying society in a realistic way. And these girls grow up seeing people like Kate Moss thinking I should look like that. I could be a super model. It's a really unrealistic goal. You know, as far as the images…they need to show people being real more often. …Parents really need to sit down and say 'this isn't real. You need to know this isn't real. And this is what a real person looks like. Look around you.' Really be able to tell their kids what's real and what's not real (Jeanette, 35, white, BMI 46.3).

She goes so far as to liken Barbie to a cartoon:

> I don't think they…people should be held by those standards. Like I hate Barbie dolls. I liked to play with them while I was a kid but I look at them and, ugh [laughs]. And they're so unrealistic. And my kids have Barbies only because their grandparents give them to them. But I've sat down and said, 'this is not what a real woman looks like.' And they know it's pretend. It's like a cartoon. You have a little cartoon in your hand. And they understand it. They can see cartoons aren't real and things on TV are always not true, very few times actually (Jeanette, 35, white, BMI 46.3).

Jeanette exposes the cultural ideal for what it is – a creation such as a cartoon – and she ensures that her children understand this. She continues to express that the thin ideal is dangerous for one's health and even as unhealthy as being overweight or obese:

> I've heard that, really, people who are really too thin for their body can have a heart attack and stroke. There are two ends to the spectrum. You can have your grossly overweight and grossly underweight and they both have health problems. And a lot of people don't see that that these people that are super skinny, they don't ovulate. They can't have kids. Their breasts go away. They have more issues. They have osteoporosis more often. These people are sick, as sick as overweight people, if not sicker because overweight people can be healthier longer than a skinny person (Jeanette, 35, white, BMI 46.3).

Jeanette's critique of the thin media ideal comes hand in hand with praise for media images that portray larger women in positive light. She voiced appreciation for the film *My Big Fat Greek Wedding* and its portrayal of "real, bigger people," along with the magazine Mode (that features plus-size models),[2] noting however that the models' faces are still airbrushed. She also spoke about how during certain historical period, sculptures of women, as she learned in her art history class, had "big breasts, bellies, and big wide hips" and, again, voiced

[2] Interestingly, Mode magazine, launched in 1987, was the first and only high fashion monthly targeted to full-figured American women. It stopped publishing in 2001 despite a circulation of 600,000 and approximately 3.5 million readers. A company statement cited an inability to attract beauty advertisers as a key reason for the magazine's demise.

appreciation for these depictions. She is unable to relate to the thin ideal and therefore desires an ideal that is more realistic and representative of bigger women like herself. In general, respondents discussed how they were "hardwired for curves" and that bigger individuals were in fact more attractive than rail-like models. As such, they desired to see more "thick" and "heavier" models and cited models such as Queen Latifah as an attractive ideal. This is, I show shortly, remarkably different from Janice's perspective.

Critique of the cultural beauty ideal was often accompanied by a more general critique about our body obsessed culture. Respondents voiced that the cultural ideal is one that focuses on material beauty. Indeed, claims that the beauty ideal is shallow and superficial is one means respondents used to reject the ideal. Beauty, they repeatedly said, is about inner beauty, happiness, self-acceptance, and confidence. For example, Denzel is 27, African-American, gay, and overweight (BMI 27.7). He works as a full-time cook and goes to school full-time. He comments on our body culture and what he considers beautiful. For Denzel, beauty is about self-acceptance, self-assurance, and internal beauty:

> I like people who like themselves. You know, if you're not satisfied with your body. That's up to you. That doesn't mean I don't like you. But if I have a guy who works out everyday at the gym and I have a guy who sits at home and drinks a six-pack every day after work, if he's happy with himself, I want to hang out with this guy more than the guy who spends every day at the gym. Because he's living his life the way he wants to live it. He's happy with his body. He's happy with his surroundings. …A lot of people are confused. And like people see me checking guys out. And they're like, you're so gross. And I'm like why? Because he's big, because he's beautiful, because he's walking down the street with his head held up high? (Denzel, 27, African-American, BMI 27.7)

Denzel later explicitly criticizes our body culture:

> To me there are more important things out there. That's what gets me really frustrated about this country. Now everybody's focus is on looking younger, looking thinner, stapling this gut, stapling that gut, Botoxing this eye, and all this kinda crap, trying to shed 20 years off your life, whatever. You know, we come and we go. We have to die one day. You're going to get older. You might as well just accept that. That's what makes you beautiful. When you try to fight that and reverse that. You're only lying to yourself (Denzel, 27, African-American, BMI 27.7).

According to Denzel, individual and societal priorities are misguided. As he says, there are more important issues, primarily social issues, to tackle. The government's priorities should lie elsewhere. As he puts it: "We're destroying our country right now, as we speak, over oil. That's the big picture. But, yeah, right now is the six-pack and looking young. So I think the government should really reevaluate what is important in life." For Denzel, appropriate priorities include helping the needy and providing relief for Hurricane Katrina victims. When asked why he adopts such a perspective and the source of it, he tells me first and foremost that he is happy and that weight loss is not necessarily going to make someone happier:

> I live my life that I live to know it. And Tom, Dick, and Jane can do everything society tells them to do. They can lose the weight. That doesn't mean they're still going to be happy the way I'm living my own life. I don't really have the extra baggage or whatever, but I'm happy. I wake up every day and I'm satisfied. Blah, blah this, blah, blah that. These guys are going through hell and hot water trying to lose weight and they're still not happy (Denzel, 27, African-American, BMI 27.7).

He then links his worldview to his upbringing, life experiences, and personal struggles:

> I think it depends on your family values. It definitely depends on how you were raised as a child. I have been through a lot in my life to be 27-years old. For someone to tell me this is

> what you should be like or look like to be happy, I just know that's just dumb. It just depends on what you've been through in your life (Denzel, 27, African-American, BMI 27.7).

Denzel's life story sheds light on his worldview. He grew up in Memphis, Tennessee where his parents separated when he was eight. He was raised by his grandmother and a mother who worked her way up from the laundry department to the computer department at a local hospital. As he grew up, he watched his mom work several jobs, as he says, "just to keep the roof over [our] head and clothes on our family's back and food on the table." His father also worked in various jobs, but had a life changing event when he was shot by a fellow worker. He describes his family as hard working where "nothing was really given to us on a silver platter. I mean, I know work, that's my life. …I grew up in a household, work, work, work, work, work." His first job at age thirteen was as a dishwasher where he was paid under the table since he was too young to be legally employed. This job was followed by a string of odd jobs, including working at a concession stand and in fast food. Currently, Denzel lives below poverty line. However, as he tells me, "that's why I'm working full-time and going to school full-time so I can get to the better place and one day maybe help my family to succeed to get into the better place." He stresses that he is happy and that there are individuals who are in worse financial situations.

Just like Denzel, respondents who criticized the thin beauty ideal and our body culture focused on inner beauty. By denigrating the cultural ideal, respondents were able to resist it. A recurring theme throughout the narratives was that the cultural ideal was a material ideal and that inner beauty was really what matters. Time and time again, respondents articulated that beauty is "whatever you're comfortable with," "something in

your heart, your soul, your mind," "in the eyes of the beholder," "a natural look, a natural beauty," "how you carry yourself and feel about yourself" and "[something] without limits."

The majority of respondents, like Jeanette and Denzel, consciously and actively rejected the cultural ideal as something that was unrealistic, dangerous, and undesirable, focusing instead on inner beauty or attainable standards of beauty. Many parents like Jeanette made an especial point of ensuring that daughters knew about this beauty myth. Denzel's rejection of the body culture is especially remarkable, as he is gay. Even while the gay subculture, with its emphasis on body image, increases gay men's dissatisfaction (Rothblum 2002), Denzel, like the majority of respondents, was still able to resist the ideal. This rejection may be common because of the fact that this is primarily an older, working class sample, confirming previous studies documenting the inverse relationship between body satisfaction and SES. Denzel's narrative was exemplary and echoed other stories where efforts to attain a good education and good paying job were central. Some of the older respondents noted that a more mature perspective on beauty came with age, shifting the focus from physical to inner beauty. In sum, among this group of working class and lower SES respondents, beauty ideals were heavily criticized as an airbrushed media fiction. The ideal and its accompanying body culture of thinness were rejected. It does not eventually bring true happiness.

Accepting the Ideal

While the majority of respondents criticized the thin ideal and/or its accompanying body culture, a minority of respondents accepted it. These respondents described the beauty ideal as a source of incentive or inspiration. Janice's perspective is illustrative. She is 44, Hispanic, and a single mother. She works as a full-time kindergarten aide while going to

school part-time studying art history and religion. With a BMI of 34.2, she is considered obese. Her household income is in the $20,000s. First, unlike rejecters who described the cultural ideal as an unattractive and sickly extreme, Janice explains that runway models are in fact beautiful:

> As an aesthetic, I do recognize that while it's noble to think that 170 lb woman at 5'10" is beautiful, that's great. But the reality is that Prada outfit is not going to look as good on her as it does on a woman who's 5'10" and maybe 120 lbs. It's just not going to be the same. ...That is beautiful. That 110, you know (Janice, 44, Hispanic, BMI 34.2).

Contrary to Jeanette, Janice also feels that the larger body ideal during the Renaissance was revered only because it signified a higher class status. According to Janice, skinnier women were actually the ones considered beautiful. Thrice in her narrative she apologizes for her perspective, explaining how she feels it is "shallow" or "horrible" for her to think this way and recognizing in part that it is an unconventional perspective for someone who is obese. So while the cultural beauty ideal is exalted as an important and desirable social status, it is (as seen earlier in the rejecters' comments) simultaneously denigrated as shallow. Specifically, it is considered material and superficial. Unlike Denzel who redefines beauty as internal beauty (thereby resisting the aesthetic frame), Janice accepts the beauty frame and concedes her "materialistic" perspective. When I ask if she feels influenced by the popular cultural thin ideal, she responds:

> I would hope so. I would hope so [laughs]. It sounds horrible, but yes, I am, because … I don't believe that we can deny that it is an ideal. It really is. Any more than the ideal back during maybe the 1300's or, actually probably more like, around the Renaissance and a little bit later that the paintings of chubby women with their cellulite and that was because everybody was thin from famine. It wasn't because, oh, these women are beautiful. It was a

> way of showing that these women have money, and this is the upper class. And I still believe even back then that thin women were still probably revered as more beautiful than these chubby things that we see in the paintings. Clothes just look better (Janice, 44, Hispanic, BMI 34.2).

Janice, despite being obese, finds the thin body to be inherently beautiful. When questioned if the ideal is oppressive at all, she responds definitively: "No. No, it's encouraging. I see it as encouraging." In fact, this is a key distinction between the rejecters and accepters. The former do not necessarily see the ideal as attractive and they also see it as damaging to the psyche. The latter do not see it as problematic and detrimental to their esteem. Janice continues to critique the magazine *More* which features women who are forty or older:

> And god, there's this magazine called More that I read also. Oh, it's just awful. They have these women in there in their 40s and that's great, but they're chunky. And every time I look at this thing I'm appalled. And I have to write in that they need thinner people in there because the clothes don't look good. It does an injustice to the clothes. But they want 'real people' (Janice, 44, Hispanic, BMI 34.2).

Her level of concern for the younger generation is remarkably different from Jeanette's:

> We look at magazines to look at beautiful things. It's all about looking. So I just don't think that it's a bad thing if you have a good foundation. And the girls that look at it, no, I don't think it's bad for them. [Thank you for sharing your perspective.] Do a lot of people say, 'Oh no, it's horrible?' Oh no, I think it's wonderful. …As someone who is very visual, I want to look at men who are beautiful. Also, when I hear that Abercrombie & Fitch is being sued because they wouldn't hire some short, little, stocky, pudgy guy, I say, 'Go Abercrombie & Fitch.' You stand up for what is the most important thing. …You know, and get rid of the pudgy little guy who wants to be there. It's too bad, you know. Dye your hair and lose some weight (Janice, 44, Hispanic, BMI 34.2).

Notably, the racial minority women who accepted the ideal made a conscious effort to do so. For example, Susanna who is 34, single, Hispanic, and overweight (BMI 26.7). She is a part-time student who worked previously in the field of international marketing and her household income is less than $20,000. Susanna rejects what she refers to as the Mexican-American ideal. She believes that, because she left Arizona at age 12 and moved to Arkansas and was not around her family year round, she developed a different set of ideals than her Hispanic family. She explicit pinpoints the source of her ideal as American fashion magazines:

> So I got to develop my own beliefs, my own belief system apart from theirs, sort of. I got to know what theirs was but I was able to develop my own as well. …I guess maybe from looking at the typical fashion magazines or the typical idea of what beauty is in the American society, as opposed to what it is in the Mexican-American society. You know, they're two different things there (Susanna, 34, Hispanic, BMI 26.7).

Later in her interview, but unlike those who explicitly critique the ideal, Susanna carries on to say that she uses the aesthetic ideal as an incentive:

> I think the ideal, if I didn't hold on to the ideal, I might just let go of it completely, you know. Even though I don't ascribe to being as skinny as those models are, if I didn't have some, for me, if I didn't have some way of holding on to what I feel like my body should be. At least, you know, in that way, I would just let myself go. …I think that I could easily become very overweight. Because that is what is sort of hereditary in my family and is just easy to get to with the foods that we eat. So I think that's the only thing that holds me grounded to anything that can be even a smidgeon healthy. You know, it's either for me, you know, I'd rather be a little bit healthy and not, you know, and not as overweight as I know that I would be. You know, I guess it's just a weird way of holding onto what I know

> that I have to do [laughs]. I don't know, it just keeps pulling me in, sucks me in (Susanna, 34, Hispanic, BMI 26.7).

Susanna essentially uses the beauty ideal, in part, to reach her health goals. When I ask her if holding onto the cultural beauty ideal makes her unhappy, she responds: "No, it doesn't make me unhappy, because I know that I don't take it to the extreme. I don't take it to where I know that it shouldn't be." In sum, unlike those who reject and criticize the ideal, a smaller group of respondents accepted the ideal and saw it as something positive that provided them with incentive and inspiration. For them, the beauty ideal was not experienced as a source of oppression or anguish.

Internalization: Desiring Weight-Loss

Whether respondents rejected or accepted the ideal, it is notable that the majority of respondents voiced a desire to be thinner in order to change their appearance. In other words, regardless of whether they thought the ideal was unrealistic and damaging or inspiring and encouraging, respondents desired weight loss. Consequently, they would use the cultural beauty ideal as a motivator for body work. The three "rebels" discussed in Chapter 4 are exceptional. These three respondents questioned both the legitimacy and meaningfulness of the health and beauty frames. They consciously embraced their obese bodies, vowing not to worry about the thin ideal or health concerns. Regardless of these exceptions, similar to Joanisse and Synott's observations, the majority of respondents "agree with the norms of the majority culture and constantly engage in weight loss attempts" (1999: 60). Most respondents, then, internalized the beauty norm. It carries cultural legitimacy.

While this is not surprising for respondents who internalized or accepted the ideal, it seems somewhat surprising for those, like Denzel, who criticize the ideal. A striking

observation is that criticism of the ideal does not necessarily come hand-in-hand with abandonment of the desire to look thinner. Respondents, like Alena (33, white, BMI 25.4), who critique the ideal but are nevertheless used it as motivation, sometimes experience much frustration and anguish. Alena articulates a desire to be thinner and to fit the beauty ideal, but feels conflicted as she admits to being a progressive thinker. As a feminist, she says "I think even if you're a critical thinker, it doesn't make you immune to it, you know." She jokingly articulates her desire to both tear out the Victoria's Secret ad and to order the bra. Alena waivers from a desire to lose 10 lbs to a desire to accept her overweight body. It is a daily struggle between love and hate. Critique is therefore not a buffer or a protector for desiring cultural norms.

While it may seem like both rejecters and accepters are cultural dupes that passively absorb the cultural ideal, narratives suggest respondents are not passive in their desires for weight-loss. First, they actively pursued weight loss, not because they felt a pressure to conform to beauty ideals, but because they hoped to reap some kind of benefit. Throughout the narratives, multiple reasons for desiring weight surfaced, including health, psychological, and social benefits. Respondents were especially cognizant that beauty is a status characteristic that is accompanied by social rewards. Second, even while respondents desired weight loss, they were not attempting to achieve an extreme and unrealistic ideal. At most, they were hoping to lose some weight, but not to be model-thin.

First, as I discussed in Chapter 4, respondents widely acknowledge the health benefits of weight loss. Respondents articulated concerns about diabetes, heart disease, and other conditions associated with heavier weight categories. These concerns were sometimes brought to their attention by medical professional, while other times, they were simply aware

that health problems were imminent if they did not make lifestyle changes and lost weight. As this is the subject of Chapter 4, I provide only two further examples here:

> I would really like to drop the weight to get rid of the sleep apnea. That one kinda scares me a little bit. Just the fact that I could wake up dead. Yeah, that one worries me a little bit. That stress test at the heart hospital wasn't nothing nice. And that had a lot to do with weight and lack of cardio (John, 36, mixed race, BMI 37.7).

> But then seeing those numbers on the scale and them saying, 'you've got a fatty liver or sclerosis of the liver. Uh-oh! Okay, it's time to do something now' (Jay, 37, Hispanic, BMI 39.9).

While respondents, regardless of race or gender, cited health concerns as a key motivating force for weight loss, women also articulated psychological motivations. Fewer concerns expressed by men about the psychological benefits of weight loss confirms previous research showing that women's psychological wellbeing is tied more closely to their body image than men's. When I asked female respondents why they wanted to lose weight, they replied:

> One would be to feel better about myself (Kelly, 37, white BMI 46.0).

> Because I want to feel better about me. I think being a black, I'm black in case you haven't noticed. I'm single. I have three kids. Sometimes I think women in general don't always feel good about themselves unless you're like thin. …I have my level of confidence and it's high about a lot of things and then some things it's kind of, you know, a little bit sad. And I don't want those feelings. Practically all my girlfriends are all overweight and that's not like big girls sit together. It's not anything like that. It's just, you know, I want to feel better about myself. And I noticed that even when we're talking about amongst ourselves our one qualm is that … if lost 10 lbs or if I lost 50 lbs or if I lost 100 lbs. It's always our conversations, losing weight… I just want life to be beautiful for me. …I want to feel good

> about me. I want to be governor of Arizona. I want to look cute in my suit. I want to have that nice smile (Shawntea, 36, African-American, BMI 44.4).
>
> I think it's very important for me to feel good about myself. Especially, I've been always this weight. I wonder how I'd look if I lost a little more weight. Would I look prettier? I would definitely feel good about myself (Marisa, 24, Hispanic, BMI 27.3).

> I just feel like if I lost the weight then I wouldn't think about it so much and I would just be more comfortable with myself (Sandy, 25, white, BMI 25.1).

While men did reference "feeling better" or "feeling good," it was often in relation to something more instrumental, opposed to building self-esteem and a sense of worth. For example, feeling better for men meant being able to put on a pair of pants or wear certain clothing items (Javier, 43, Hispanic, BMI 31.8; Malaki, 33, mixed race, BMI 29.4; and Terrence, 36, white, BMI 26.5) or being able to play sports better (Alberto, 34, Hispanic, BMI 30.0).

Finally, respondents recognized that weight loss would bring about an array of social benefits. Beauty brings social status and social rewards. Respondents actively strove for the aesthetic ideal and used it as a motivator because they recognized that thinness is a valued trait that comes with social perks. For example, single respondents like Meena were acutely aware that it mattered on the dating market and, as such, were motivated to lose weight to find a significant other. Unemployed respondents like Benny, who also has a 10-year old criminal conviction, acknowledged that weight matters on the job market:

> I go out with my friends and we go out for drinks. You know, and I just cannot stand it when guys pay more attention to my friends and just ignore me. So I'm trying to look good and that's why I'm trying to lose weight. …Because I'm in my early thirties and I want to… it's about time for me to settle down. So, I mean, a guy's not going to go for a fat girl, you

> know, because of what the media has established. So I just want to be attractive enough to get a man (Meena, 42, South Asian, BMI 29.8).

> I mean for me it's a health issue number one. But also because of my age and I have so many strikes against me…I want to look as good as possible when I go for a job. I don't want to look … I don't want there to be any question. I want them to see me and want to hire me. So that's my reason for getting back in shape. I just want to make it easier to get a job (Benny, 49, white, BMI 33.5).

In addition, respondents recognized that not only does the thin ideal come with social rewards, but it also averts social stigma, isolation, and poor treatment. In Chapter 4, we saw how the obese nurse Joanie was too depressed to care about the state of her health despite being told that she has a fatty liver. However, she nevertheless articulated a desire to lose weight, but not for health reasons, but to avoid the social stigma that comes with being fat. In her words:

> I'm more motivated by aesthetic issues…I think what I really miss is the feeling of being healthy, the self-esteem that I had, the clothes that I could wear, the different value people put on me when I was smaller. All of that. I miss that. And, in some ways it makes me angry. It's just like anything else, you know? The way you dress, people judge you. And the way you look, people judge you…Yeah, I think the stigma that comes with it is very frustrating (Joanie, 48, white, BMI 38.9).

The desire for respect and social dignity that she once had is evident throughout her narrative. Joanie used to be in the military and when she was stationed in Germany spent countless hours at the gym. It was not unusual for her to workout five or more days a week. She considered herself physically fit and was within military regulation. She attributes her substantial weight gain to the downfall of her marriage, her husband's alcoholism and abuse,

and accompanying depression. With the depression came comfort eating, eating as punishment, and eating to "stuff her feelings," a pattern often triggered by her husband's actions or words.

Joanie's experiences ring true for other obese and extremely obese respondents, confirming a major claim of the fat acceptance movement that overweight and obese individuals are treated poorly. Many reported being treated differently in public and social settings, often in the form of being ignored, stared at, or insulted. These incidents occurred in chain clothing stores such as Victoria's Secret, but also in larger stores such as the Home Depot. Melanie describes her experience in one store:

> I went into Banana Republic and I was a size 16 and I walk in and I was like 'hi, could you help me?' And they didn't even look at me. And I, so I went over and I found something and I found a sweater and I was like 'hi do you have this in my size?' Didn't look at me. … So it's been difficult. But I'm, because I've started to lose weight and my self image is improving. I'm starting to fit into my old clothes again. I'm feeling better about myself. It's starting. I'm starting to feel like I'm human being again. But I really do, I think that there's this awful, awful stigma. And, I don't know if it's against, I don' know if it's against men, because I've never been a fat guy. But I have been a very fat girl and there's definitely this awful, awful stigma. And it's so hurtful because it's like, 'why are you judging me based on that?' (Melanie, 27, white, BMI 32.0).

The majority of respondents who were overweight as a child were teased and insulted by schoolmates and a handful were severely taunted by family members on an ongoing basis. Joanie was heavier as a child and her mother neither showed deep affection to her nor wanted to be seen with her in public because, as she says, "she was ashamed of me." Melanie's mother treated her in a similar manner to the point where she finally confronted

her and asked: "It's like what's wrong with me the way I am? Why, why would I be better if I was in that size jean as opposed to this size jean? What's the big deal? And I asked her at one point, I was like mom, do you measure my value by the size of my butt?"

Joanie also felt that she experienced discrimination on her job in the military. In her words:

> If you are fat, it doesn't matter how smart you are or how competent you are or any of that. All they [the military] see is the fat. It's true. Yeah, you lose your job. If you're within regulation weight then you're recognized for all those things, the good things that you do. But if you're not in regulation weight, let's put it this way: I won a national award given to me in Washington, D.C., for volunteerism. They did not want to send me because I was fat. I didn't deserve it. They didn't want anybody to see that this Air Force person was fat. [Did you end up going?] I went but it was a big fight. It was a big fight amongst the higher ups. Someone stood up for me and said 'she did the work.' You know, who are you going to send to receive the award, someone else? Is that who you're going to send? I did go, but let me tell you, there was a big fight. They didn't want me to get the award at all because I was fat (Joanie, 48, white, BMI 38.9).

She was eventually removed from superintendent back to clinic supervisor. To cope, she gained more weight, rejected all forms of body work, and spiraled into a deeper depression:

> So I coped by being angry, resentful, getting fatter, depression, just retreating into myself, not talking to people. I don't know, it's kind of like I wanted to disappear but I couldn't. How can you disappear when you're a big fat slob? [laughs] I don't know. Maintenance of myself went down. I wasn't exercising. I wasn't taking care of any part of me. My hair, my skin. I wasn't using make-up anymore. The only thing I could say is, you know, I put on clean clothes and I bathed every day. That's about all I could say. I didn't take any pride in the way I looked. It's kind of like a feeling of failure to thrive. A failure to thrive. That's it (Joanie, 48, white, BMI 38.9).

Obese women like Joanie experience the social stigma of weight first hand on a daily basis. While for many it was a source of frustration, anger, and sadness, for some it also provided motivation for weight loss, even sometimes stronger than the desire for good health. Even the second apathetic (discussed in Chapter 4), Matthew (31, white, BMI 25.1), while not caring about being healthy, was strongly motivated to lose his abdominal weight in order, he states, to look nice for his wife. Because beauty is a visible social status characteristic that is tied to social rewards and eschews social derision, it is a strong motivator for weight loss, sometimes even more so than health, as Joanie's case confirms.

The beauty and health ideals are inseparable. Excluding the rebels, the majority of respondents were motivated by both health and beauty.[3] Not surprisingly, just as rebels were disengaged with the health frame, they too were disengaged with the beauty frame. The abandonment of one often comes with abandonment of the other. Beauty and health are so connected that many respondents actually conflate the two. For example, both Marisa (24, Hispanic, BMI 27.3) and Meena (31, South Asian, BMI 29.8) define health first and foremost as being thin (weighing less and not having rolls of fat), while for Benny (49, white, BMI 33.5) and Egor (32, White, BMI 28.7), the aesthetic ideal is not just a beautiful ideal, it is about being "healthy looking." Referencing shows like ABC's *Grey's Anatomy*, Egor says "the people on the shows look healthy." And when I ask him about the cultural standard of beauty, Malaki (33, mixed-race, BMI 29.4) claims that "the idea is health, in a big regards, you know. And, you know, the people you see in magazines and TV, for the most part, are

[3] Jay (37, Hispanic, BMI 39.9) is an exception. Jay said he was only motivated by health (and a diagnosis of a fatty liver) and not by beauty. The reason for this is precisely the transpose of Joanie's situation. He claims that beauty does not motivate him because he is in denial about his appearance. Similar to Joanie, Jay never looks in mirrors. He says: "I don't have the concept that I'm overweight, that I'm fat." So like Joanie who is in denial about health, Jay is in denial that he does not meet the cultural beauty standard. As such, the beauty ideal provides little incentive for weight loss.

very healthy." Finally, we observed earlier how Susanna (34, Hispanic, BMI 26.7) embraces the beauty ideal and openly admits that she holds onto the ideal because it provides her with an incentive to be healthy. In sum, the two dominant frames about the overweight body (the beauty and health frames) combine to provide powerful motivation for weight loss behavior.

It is noteworthy that respondents approached the aesthetic ideal in moderation, mainly citing lifestyle changes, healthier eating, and more exercise. Only four respondents were currently taking diet pills and appetite suppressants to achieve weight loss while several were open to the possibility (one respondent was doing personal research on various drugs, and two respondents said they would take weight loss drugs if they could afford it). The remaining respondents saw weight loss drugs as "cheating" or were scared of their effects and feared potential dependency. Many had tried these remedies when they were younger and had experienced adverse side effects such as problems concentrating and a racing heart. Furthermore, no respondent expected to achieve the cultural ideal and desired merely to attain a body that they felt more comfortable with. As Susanna mentioned, the media images are not problematic because she does not take her desire for weight loss to an extreme. Overall, respondents approached weight loss in a reasonable and balanced manner. Repeatedly, they cited that they were making lifestyle changes to achieve their weight loss goals.

Gender, Body Consciousness, and Body Privilege: Navigating Private and Public Spaces

The general desire for weight loss is one way the beauty frame manifests itself in the lives of overweight and obese individuals. However, the ideal also manifests itself in more

subtle, indirect, and gendered ways. While the majority of respondents hoped to lose weight, there is a distinct difference in how the fat body is experienced by men and women. First, while men desire weight loss, it rarely becomes a preoccupation. Second, while men are aware of their bodies, women experience an elevated degree of body awareness. This "body consciousness" means that women are constantly engaging in body management, both physically and emotionally, in both private and public spaces. Compared to men, women feel more of a need to conceal, neutralize, and manage their fat bodies.

First, body issues are more salient for female respondents. Unlike the men interviewed, women often think of body issues. The desire to lose weight and knowing that they possessed a body that did not conform to society's ideals are at the forefront of women's minds. For example, when I asked respondents if weight was something they think about today (compared to when they were younger), female respondents often replied that food, dieting, and/or weight loss are things they are preoccupied with daily:

> When I wake up in the morning, actually the first thing on my mind. How am I going to eat today?... Every day that I wake up, that's on my mind. The minute I wake up, if my stomach's hungry or whatever, the way I start off…that's always the first thing on my mind. What's my food going to be like today? (Joanie, 48, white, BMI 38.9)

> I think I wake up and get to sleep thinking I need to lose weight (Adele, 36, African-American, BMI 28.9).

> Yeah. Just about everyday (Melanie, 27, white, BMI 32.0).

> Oh, very much. All the time (Susan, 44, white, BMI 26.5).

These responses contrast Matthew's (31, white, BMI 25.1) forthright response that echoes most of the men: "Like do I wake up in the morning and go, omigod. No. Oh no." While this gendered response to the beauty ideal may be partly a social desirability effect elicited by me as the interviewer, two men, Ramone and Terrence, admitted that weight and body issues are something they consider quite important. Ramone recognizes that his perspective on weight is rather unique for his gender and he likens himself to a woman:

> I'm like, 'I want to lose weight! I want to lose weight! I want to lose weight!' Honestly, I'm like a woman. You know what I mean [laughs]? Women are like this. Women can be thin and be, like, 'oh my god, I look, you know.' And sometimes I do it, like, 'oh I've got to lose weight. I got to lose weight. Oh, I'm going to lose weight.' So I've been doing well, you know, but still I want more and more and more (Ramone, 25, Hispanic, BMI 32.9).

> I know that some people are totally obsessive. But I am very aware of it (Terrence, 36, white, BMI 26.5).

For several women, body issues are so salient that they color their worldview. That is, weight is so important that it acts as a lens filtering other life experiences. For example, Susan (44, white, BMI 26.5) explains the degree to which her self-esteem is tied to weight: "Very much so. If I'm at my ideal weight, it seems like, and I know this is stupid, everything else seems better. Because hey you look good, you feel good, you feel as good as you could feel."

Second, women's preoccupation with body issues and the need to lose weight come together with a heightened awareness of their "deviant" bodies. In other words, overweight women are much more conscious than men that their bodies do not conform to the cultural ideal. This awareness of one's body, or body consciousness, results in the ongoing

management of the body and its display. This management may be physical, involving attempts to conceal one's body or to "pass" as a "normal" sized woman (Goffman 1963). Physical body management involves physically manipulating one's body or available props (such as clothing) or changing one's actual behavior to physically avoid a potentially body anxious situation (such as a mirror or public setting). Management can also be emotional, involving an internal conversation that includes reassuring oneself of one's self worth. Emotional body management is psychological work. Just like physical management, emotional management allows overweight and obese women to muster through difficult situations. These acts of management are similar to the techniques of neutralization, justifications, accounts, exemplars, continuums, and loopholes (discussed earlier) that overweight individuals use to manage their deviance and help them understand, accept, and feel more comfortable with their bodies (Degher and Hughes 1999; Cordell and Ronai 1999; Lyman and Scott 1970; Sykes and Matza 1957). However, the acts of body management I observe are different from these previously documented mechanisms insofar as they are more than just verbal justifications or accounts. Instead, they also include very overt physical behavioral changes and emotional work that allow an overweight woman to negotiate a stressful situation.

Body consciousness and body management are gendered. It is observed in only a handful of men and only in moderate degrees. While it does takes place on a continual basis, it is often elicited by some trigger. Triggers make respondents hyperconscious of their bodies and the need to manage their appearance. These triggers include mirrors, clothing, physical structures, other individuals, and public settings in general. As Paquette and Raine (2004) observe, body image is not a static concept. Women must negotiate situations in

order to survive them with their self-esteem and sense of worth intact. Overweight and obese women are constantly presented with situations, individuals, and objects that make them aware of their bodies.

Not unexpectedly, mirrors are a major trigger to body consciousness. As gateways to respondents' physical sense of self, mirrors are a blatant reminder that respondents deviate from the cultural ideal.[4] While respondents like Melanie dealt with mirrors by reassuring and reminding themselves that they are "okay" and "alright," the most common strategy was avoidance (see also Degher and Hughes 1999). Outright avoidance of mirrors allows respondents to avoid the need for body management altogether. Several respondents, including one male respondent, spoke about their experiences with mirrors:

> As long as I don't look in the mirror, I'm okay. I cannot stand mirrors. I hardly like to look into those, especially the full-length ones (Margee, 42, white, BMI 29.2).

> Usually I look away from the mirror for one. I actually, I have a big problem with mirrors. I usually don't even look at them. I'll look down or I'll do the quick flash. Like, okay, alright, doesn't look bad, okay. And so when I have one of the times when, okay, wow, you're unattractive, it's almost like I need to go find a nice quiet place for a while and just think. It's like okay, okay. You're alright (Melanie, 27, white BMI 32.0).

> Well, it's kind of like the fact that I don't look in the mirror anymore. I don't know what term I want to use [pause]. When I don't look in the mirror, I am not recognizing what I've done. It's the same thing as the other. As long as I don't look in the mirror, I'm not the

[4] Scales did not elicit similar reactions. Instead, for most respondents, scales were avoided because they did not want to become obsessive about weight loss or they feared disappointment. Scales were also used practically. That is, to provide a status check on weight loss efforts.

> person in the mirror. So, I would say I just don't dwell on it. I think that's what it is. I avoid it (Joanie, 48, white, BMI 38.9).

> I've been watching *The Biggest Loser* ever since it came out. And when I'm looking at all these people, I'm like, 'Man, they're fat.' I say, 'Wow, they lost that many lbs?' And so then my wife would, you know, she would say something. And I said, 'I'm not as big as those people are.' [His wife replies:] 'Do you look in the mirror?' I don't look at mirrors. So, you know, I know I'm losing weight, but I don't have the concept that I'm overweight, that I'm fat or anything. It's just not there. [How do you deal with mirrors in the changing room?] What mirrors [laughs]? I don't look at them until I'm all the way dressed (Jay, 37, Hispanic, BMI 39.9).

Clothing does something similar. Whether it is during a clothes shopping excursion or when they put on clothes for the day, clothing reminds respondents that their bodies do not conform. However, unlike mirrors that can be avoided, clothing cannot be avoided and elicits a different response. Laticia and Susanna discuss how clothing acts as a trigger that works in both direct and subconscious ways:

> I find myself buying bigger stuff because I don't like tight…you know, showing my weight, my size. So I usually buy a lot of bigger clothes that hang (Laticia, 43, African-American, BMI 34.2).

> Oh my gosh, I've just gained those, you know, I'm back up to 147 lbs. Maybe in those days that I'm going to school I'm not necessarily consciously thinking about it. But I'm more aware of the clothes that I have to wear or the clothes that I can't wear, the clothes that I need to wear to make my body appear different. Or, you know, to hide. You know, wear more loose clothing or whatever it may be. So in that sense, yeah, I think I have to sort of

> be more aware at those points of what I'm wearing and what I can't wear (Susanna, 34, Hispanic, BMI 26.7).

As Laticia and Susanna voice, the clothing they wear cannot be taken for granted. They often feel compelled to conceal or hide their bodies. Loose clothing is used to minimize fat. Even in professional settings, this awareness and management continues. Alena teaches English as a Second Language (ESL) classes:

> But, you know, when I'm teaching, that definitely, I'm like, 'okay, I'm not going to wear this when I teach, because it makes me look a little chubby,' or, you know, 'is my ass jiggling when I'm writing on the board?' (Alena, 33, white, BMI 25.4)

Terrence was one of the few men who manipulated his body and clothing in public settings. When I asked him about body consciousness, he responds:

> I'm aware of it when I dress. I'm aware of at least two different things. One is that I'm fatter than I want to be. The other is that, okay, I'm fatter than I want to be. I'm out of shape in that I'm weaker than I want to be and so forth. And I have a constant level of tension which I feel all the time. And so in those three ways, I'm kind of always aware of my body. But then, also, once I'm dressed and everything like that I pick things that I can wear that I'm not going to look too bad in. Lots of shirts are fitted. Forget that [laughs]. That's not going to happen. So I wear boxier stuff and I tend to wear, I'll wear a T-shirt with some kind of button shirt over it, like unbuttoned, just to obscure my silhouette. In that way, I'm kind of always aware. Is my shirt open too much? All this kind of stuff and this kind of adjusting. If I sit this way, does that make me look slouchy? Whatever. If I bend over, to pick this up, in front of this person, will they get a complete view of how wide my back actually is? You know, so, I'm aware of my body pretty much all of the time in the ways I wish it was different (Terrence, 36, white, BMI 26.5).

Not unexpectedly, despite the desire to swim because of the Southwest heat, respondents often avoided the pool. Swimsuits evoked especial anguish as they provide little opportunity or means for body management and concealment.

Physical structures such as desks and tables also prompted body consciousness and management. As overweight and obese individuals navigate public spaces, they are often reminded that the world was not designed for larger individuals. Rhonda discuses her body awareness when she is on a plane or at the theater:

> When you're on a bus or you're in an airplane, I'm self-conscious about making sure I'm in my own space. Because there's so much about heavy people going on airplanes, whether they should buy two seats so they could fit. In a movie theater, I go to the ballet and stuff. I get self-conscious about where my arm is and stuff, make sure I'm not in the other person's space. Because I don't want them to say, 'you're heavy, you're taking up my space'….So it just makes me aware that I'm not the skinniest thing so I don't want people glaring at me like that. They think that I'm taking their space (Rhonda, 40, white, BMI 38.1).

Similarly, public bathrooms and school desks are triggers that may lead to some physical adjustment and/or emotional management. Jeanette shares her experiences about returning to school:

> The first day of class awful because they had these evil little chairs that I couldn't fit into. And desks that are connected, I hate that. So I had the, what do you call that, the handicapped tables and chair which was kind of embarrassing. It was the first day and now it's like 'this is my table, don't touch it [laughs].' It's my spot now (Jeanette, 35, white, BMI 46.3).

While she was initially embarrassed, eventually Jeanette was able to manage the stigma and feel comfortable claiming the handicapped chair as her own. She later continues to discuss other triggers:

> Let's see, bathroom stalls are made for smaller people. It's all very subtle. It's all telling you in a way, you shouldn't be that big. If you can't get into the bathroom stall, you should do something about it. I'm afraid of first being looked at. I mean, I'll use the handicapped stall. It's bigger. Every now and then I'll come across a person in a wheel chair that gives me an evil look, like 'what are you doing in there? You can walk.' But in a way, being overweight, big, is a handicap. You can't fit into things. You go to a restaurant, I hate booths. They're made for smaller people. You know, even though they're trying to feed you. You can't do that (Jeanette, 35, white, BMI 46.3).

In these public situations, Jeanette becomes highly aware of her obese body. Using the handicap bathroom makes her uncomfortable as she feels that individuals will judge her. She likens being obese to being handicapped and this allows her to manage emotionally these situations. In similar vein, Amarika and Jay discuss their experiences with smaller desks and chairs. However, unlike Jeanette, they are less welling to adopt the handicap label, thus creating the need for further management. While Amarika attempts to disassociate herself from the trigger and the accompanying awareness that she is too fat to fit into the desk, Jay must get to the classroom early to ensure that he can claim the only desk in which he can fit. When asked about how she feels during these experiences, Amarika replies:

> Really huge [laughs]. Like I'm a whale. I feel self-conscious because, you know, the big desk is usually reserved for somebody who has a disability or is much heavier. So to have to know that I have to sit in the big desk makes me feel like, 'wow, I'm that person.' I really disassociate myself with being fat until I'm actually, like, I actually am confronted with it (Amarika, 26, African-American, BMI 36.3).

> And at school, if I am in the right classroom, I want to be there early so I can get the fat person desk. Because I will not fit comfortably in the rest of the desks. And I don't want to sit at the handicapped table [laughs] (Jay, 37, Hispanic, BMI 39.9).

Physical structures work as triggers that remind overweight and obese respondents that they are different and this reminder must be psychologically neutralized or physically managed by, say, going to class early.

Interactions with other individuals also serve as subtle reminders.[5] For example, significant others, even while providing unconditional support, were often experienced as triggers. Body consciousness for women often meant that they did not feel comfortable undressing in front of their partners. As such, these situations needed to be managed through lighting or avoidance. For example, Margee admits:

> When I was married I wouldn't get undressed in the light. I always got dressed in the dark for the longest time too…I don't think it bothers me, I just know that it's weird. I don't know if it bothers them [previous partners] because I never said anything, but I know that they noticed (Margee, 42, white, BMI 29.2).

The experience is the same for some lesbian women like Ayleah who admits that:

> I'm starting to become more aware because I feel myself and that feels uncomfortable. And I know what I think intimately with my partner, like, you know, I don't want them to feel me, that I have a stomach or my thighs are big. So that I guess makes me aware when I'm with my partner when we're in the same space (Ayleah, 32, African-American, BMI 29.3).

Intimacy cannot be taken for granted. She continues:

> I couldn't be physical with anybody. I didn't, I never felt good about myself. I felt like nobody would like me because I felt like I was fat. But I didn't feel fat the way other people

[5] This section does not deal with how overweight and obese respondents are subject to teasing, taunts, and insults. Here the focus is on subtle interactions that make respondents aware of their body and thus the need for body management, physical or emotional.

> might have felt fat. I just felt insecure about my body. And looking at people and seeing different sizes that I like, it might have been, they could have been the same size, they just had a different body. I felt fat (Ayleah, 32, African-American, BMI 29.3).

Eventually, she was able to get beyond her body consciousness to engage in sexual relations. Like Margee, this meant managing the room lighting or in Ayleah's case, also being with someone who was bigger than her. Ayleah continues:

> Yeah, it had to be dark or the person had to be bigger than me. You know I wasn't thinking those things at that time consciously. I believe that that was in the back of my mind (Ayleah, 32, African-American, BMI 29.3).

It was not only individuals such as partners that prompted body consciousness and management. Often respondents felt the watchful eyes of a generalized other in public settings. Whether it was at work, at school, or in a restaurant, respondents felt like they were constantly being watched and therefore needed to adjust their behavior or bodies accordingly. Awareness of one's body meant constant preoccupation with managing how one looks, despite reassurances from friends and partners that they look just fine. The possibility that generalized others are observing and subsequently judging prompts extensive body management and physically repositioning of the body for this audience, however imagined. Brittany discusses an outing with her boyfriend's family and a classroom scenario:

> But in public situations, yeah, I'm like really uncomfortable. I try, like, I went with my boyfriend's family and I was just, like, oh my God, you know, I'm sitting there and I had like, I had like a little skirt on and a shirt. I sat up straight and I try and keep my head up so you can't see my chin. You know what I mean? So it's always there. It's always, always there (Brittany, 24, Hispanic, BMI 30.1).

> I remember that I'd always wear a jacket and I'd never take it off the whole seventh grade year. And it, we live in [this hot southwestern city], okay, and it was like a coat, and I would never take it off. And I remember one day I was taking a math test in class and I took it off. And I could not concentrate on my test that I had to put it back on so I felt more secure or something (Brittany, 24, Hispanic, BMI 30.1).

Similarly, as Alena sits in the classroom she becomes aware of her body:

> Today I was thinking about how my ass was hanging out of the back of the chair [laughs] and what the? This is so stupid. There's a young guy that sits behind me and I'm sure he doesn't notice what, I'm sure he doesn't care about the thirty-something year old [laughs]. But I'm thinking, 'and my ass is hanging out, and that kid's going to see my ass and think I got a big fat ass' (Alena, 33, white, BMI 25.4).

When asked if this body consciousness extends in other areas of her life, Alena describes a restaurant scenario that echoes Brittany's experiences:

> Sometimes out at a restaurant, some restaurants have those kind of high stools, you know? And when you sit down at one of those, because it's normal, your stomach kind of bunches up and the style right now is kind of the low pants and stuff. Well, if you're wearing low pants, your gut will hang over them when you sit down. And so I'm very uncomfortable and self-conscious in a situation like that, where you're kind of up. And you're like, 'Oh man,' you know. I'm constantly kind of, like, pushing, pulling my shirt down and trying to sit up straight and suck in my gut. And I'm going, 'You know, I'm here to eat. Who's looking at me, and who cares?' But I still do it. I'm very uncomfortable in those kinds of situations (Alena, 33, white, BMI 25.4).

In these public spaces, female respondents would often tug, pull, twist, and straighten clothing while physically holding in body parts. Like Alena, some would question why they did it, but still continue to do it.

Manipulation of clothing to hide body parts may be partly due to the clothes that are available. In other words, the clothing that women wear contributes to making them more body conscious. Women's clothes, in general, are designed specifically to show off the body and are often neither functional nor comfortable. Overweight and obese working class women find it especially difficult to find clothing they find desirable, comfortable, and/or appropriate. This problem is then exacerbated by financial constraints. Rhonda expresses her views on clothing:

> I hate clothes shopping. I really do. You go in and there's all these cute styles and they go up to a size 16 and I'm a 20. So I have to go into the Women's section that's tucked away in some place in a corner and you have to hunt for them. And they're like old lady styles [whispers]. I'm 40 and I'm getting there, but not yet [laughs]! Yeah, it's like they don't cater to the heavier set woman. So you're out of luck if you're not, you know, like a 10-12. 14 forget it. Very limited choices, unless you can afford the higher price stores because some of the higher price stores do cater to heavier, bigger women. But if that's not in your budget, you're sort of out of luck (Rhonda, 40, white, BMI 38.1).

Body consciousness in public settings can be so strong that some women do not even want to leave their homes. Only after doing emotional management and self reaffirming talk does Melanie find the courage to continue on with her day:

> There are days where I'm like you've got a butt, a bottom, you've got a bottom the size of Brazil. You can't go out today. You know, and then, but I'll take a step back and go, 'you know what? No, it's okay. It's okay. It's okay. You're fine. Just go about your day' (Melanie, 27, white, BMI 32.0).

Similarly, Brittany's body consciousness in public setting is so pronounced that she prefers to stay within the safe confines of her home:

> Oh, I don't go out. Like at all. Really. I don't really go out and do anything. I don't go out. I don't do anything. I don't go anywhere. I don't want to. I'm fine just sitting on the couch in, like, some pajamas or clothes that are comfortable. And I don't have to worry about what other people are thinking about me or how I look in other people's eyes, you know what I mean? …Just anywhere. Like sometimes I don't even want to go out to eat at a restaurant or like go out. Even just coming to school is like really hard. You know, because I want to feel comfortable with what I'm wearing or make sure that I look okay and not look like fat or something. Anywhere. Go to a bar or go to the movies or go to the mall. Go anywhere. Go to the pool for God's sake. Like that's hard. And I love the pool. I'm a water baby. And it is too hot here to not go swimming, you know. And trying on clothes is like the worst thing in the world. I don't even go shopping. Because I don't want to deal with it, you know (Brittany, 24, Hispanic, BMI 30.1).

For Brittany, it is not only high pressure social situations like bars that she avoids. It is, as she mentions, anywhere – school, the mall, restaurants, etc. Obese women like Brittany and Melanie must do significant emotional work before they can even exit their homes.

At the same time respondents were highly body conscious and doing body management in public settings in order to feel more comfortable and to conform, they conceded that often there was, in fact, no one watching them:

> If I go out to eat, I feel like everybody is watching me. It's that paranoia. I used to be always paranoid that everybody's watching me and I'm their sole focus. And I had to talk myself out of that, that they're not watching me. And actually I learned to look around and I noticed that they're not looking at me (Jeanette, 35, white, BMI 46.3).

> It's uncomfortable. It's really uncomfortable. Like, I remember one time we left the house just to go do something real quick and so I threw on some jeans that are probably a little too tight. Your stomach hangs over or something and like a shirt and not a big T-shirt or

> anything. And then he wants to go to Applebee's and so I'm sitting there and I'm like really uncomfortable. And I kind of like look around and see who's looking or who's, and nobody is, you know. But still I just feel really uncomfortable (Brittany, 24, Hispanic, BMI 30.1).

When asked why they feel so conscious about their bodies, most of the respondents did not have strong explanations for their behavior. For example, Margee "felt she was just self-conscious that way" and was "worried that they're going to judge [her] or something." Brittany admitted that she doesn't know why she thinks people care, "like [she's] the star of the show or something, like somebody's watching [her] somewhere." Of the various responses, Alena's is most pointed. She theorizes her body consciousness candidly: "I guess it would have to be just a lifetime of, of thinking I'm fat, being told I'm fat, and knowing that you're in a situation where image is really important."

In a highly body conscious society where women's worth is closely tied to their appearance and where body issues are more salient for women, overweight and obese women often internalize these meanings. The "situation where image is really important" is, in fact, everyday life. While it may appear that these women are acting in ways that are paranoid, notably, many respondents were subjected to ongoing teasing, insults, and taunting by both family members and/or strangers when they were younger and/or as adults. Jeanette's sense that she is being watched in restaurants is not altogether unfounded given her past experiences. As an extremely obese woman, she has been the recipient of much name calling – from being snorted at to be called "fat pig." She had an employer that would often approach her desk and say that "something smells" and once, when eating at a restaurant, overheard a group of young boys say "look at her go" as she ate her dinner. These insults and experiences vary in degree of severity but the majority of women

nevertheless experienced them. These hurtful, at times even hateful, comments are then internalized and subsequently manifest themselves in the form of body consciousness in both private and public settings. This internalization then makes women their own worst enemy. Estella's discussion of body consciousness thus becomes unsurprising. She says:

> Just that you always have that feeling in the back of your mind like somebody's looking at you and judging you because you're fat, because you're overweight. But then you begin to look at the other people and you realize they're not even looking at you. You're like, they're not even looking. You yourself, I guess, are your own demon, in the sense that, you know. I guess when it comes down to it, I mean, you yourself, you always think the worst (Estella, 27, Hispanic, BMI 45.2).

Estella and the rest of the women are their worst demons only because they have been subjected to a body conscious society that is unforgiving of larger women. In a society that places extraordinarily value on their bodies, nonconformity has real consequences, whether directly (in the form of insults, teasing, and/or taunting) or indirectly (in the form of social isolation and/or more subtle forms of discriminatory treatment). Triggered by mirrors, clothing/clothing situations, physical structures, and/or specific and generalized others, fat bodies require constant management. Overweight individuals, especially overweight women, do not have body privilege and thus must continually neutralize, conceal, or manage their deviant bodies if they are to maintain their self-worth and sense of dignity.

Discussion and Conclusion

Consistent with the current literature, the quantitative data confirm the overall importance of body image for both men and women, along with the finding that men are generally more satisfied with their bodies than women and African-Americans are generally more satisfied than other races. Moreover, the survey data point to body satisfaction as an

important determinant of self-esteem, confidence, and happiness. While these quantitative data illuminate general trends and the general resonance of the beauty frame, it was only by turning to qualitative data that it was possible to detail the specific processes involved with body image and dissatisfaction. It was also through these interviews that we could observe culture at work.

In many ways, the majority of interview respondents who critiqued the beauty ideal tried to overtly exclude it from their cultural repertoires. That is, they consciously toss it out of their cultural tool kits. It neither aligns with their sense of self nor their experiences as overweight and obese individuals. They do not wish to engage it and thereby condemn it as unrealistic, unhealthy, and superficial. They attempted to resist the ideal, opting instead to redefine beauty in terms of a more realistic and heavier ideal. When they talked about beauty, they focused instead on what they felt is a deeper, more important form of beauty, namely internal beauty. They also stressed what they considered to be more profound matters and priorities in a body obsessed society. Personal struggles, financial and academic, were considered more important than something superficial and shallow such as beauty. These are all means of resistance.

At the same time these critics voiced dissent, they were nevertheless motivated by the cultural ideal. While they desired disengagement with the ideal, they were not able to entirely resist it. The majority of respondents therefore coveted weight loss, explicitly articulating that they wanted to lose weight for aesthetic reasons. Open critique of the cultural ideal can still come hand-in-hand with internalization. Culture, or at least this element of culture, is so powerful that it is nevertheless internalized and used to motivate

body work. Indeed, this is what the critics and accepters have in common. Both openly aspire to weight loss; the aesthetic ideal provides motivation.

The halo effect and notion of beauty as status can explain this internalization. The halo effect is both perceived and real and overweight and obese respondents know this. They have experienced the stigma of weight and desire to avert this horns effect. In this case, culture is drawn on because it is a powerful motivator tied closely to positive social outcomes. This is confirmed by those who both reject and accept the ideal. Interestingly, the majority of accepters (who voiced that they enjoyed and appreciated the ideal) were Latinas who explicitly rejected what is usually considered a more forgiving Hispanic ideal. They expressed that the American ideal was more attractive, used this ideal as a weight loss motivator, and, at times, as an incentive to better health. They recognized that beauty is status and, moreover, they recognized the importance of this status in western culture. It is also notable that, of the women who displayed extreme body consciousness (particularly in public settings), none were African-American. Again, race mediates how culture is used and its effects.

Culture works in gendered ways. The desire for weight loss is universal and does not vary by gender. But how body issues manifest themselves in respondents' daily lives is very gendered. Compared to men, weight issues are not only more prominent in women's minds, but they are experienced differently. Women are highly conscious of their bodies on a daily basis, whether it is in the private setting of their homes or in public settings such as restaurants. While this body consciousness is ongoing, it can sometimes be triggered by objects or other individuals. Mirrors, clothing, desks, significant others, and generalized others all play a role in heightening body consciousness. This body consciousness can be

experienced as so powerful and oppressive that women sometimes do not even desire to leave their homes. This was the case particularly for obese Latina and white women.

Heightened body consciousness leads overweight or obese women to believe that they must neutralize or conceal their bodies. Fat is experienced and treated as a form of deviance that requires more than just verbal neutralization (Degher and Hughes 1999). It requires ongoing physical and emotional management. This is, in its most basic form, culture at work. Women perform physical body management when they manipulate their bodies and/or props such as clothing to conceal themselves or body parts. They also perform it when they change their actual behavior to physically avoid a potentially body anxious situation. The avoidance of mirrors and, in some cases, all public settings is exemplary. Physical body management sometimes takes place alongside emotional management – an internal dialogue where a woman assures herself of her self worth and dignity. Both forms of body management enable overweight and obese women to negotiate difficult social situations. Like impression management (Goffman 1959), body management is not only about presenting and convincing others of a different and more socially desirable sense of self (one that is psychologically unscarred from being "deviant"), but it is also about presenting a different and more socially desirable body, a body that conforms and that is privy to myriad social benefits. Or, at the very least, it is a body that is not subjected to social sanctions.

Extreme body consciousness is observed only among women. At the same time it is possible to theorize women's preoccupation with body weight and display as their idiosyncratic obsession or paranoia, social constructivist/feminist theory and objectification theory suggests otherwise. Social constructivists and gender scholars note that the western

ideal of thinness affects women in remarkably more pronounced ways than men. This is because weight and womanhood are inseparable and "[i]deologies of weight closely parallel ideologies of womanhood" (McKinley 1999: 97). Women who covet the thin body are not only attempting to conform to cultural norms, but they are conforming to cultural meanings about gender. In other words, they are "doing gender" (West and Zimmerman 1987) in a society that defines womanhood in large part by how she appears. Women's body consciousness therefore is the least bit surprising. Women are highly aware of their bodies on an ongoing basis because "real women" conform to the beauty myth – a myth that is relentlessly reinforced by media images and thus often internalized. Overweight and obese women are doubly stigmatized. They are highly body conscious because they do not live up to the aesthetic ideal and its corresponding ideal of womanhood.

Objectification theory can also account for women's sensitivity and heightened awareness of body norms. Objectification theory points to how media produces an objectifying gaze of women's bodies and their body parts (Frederickson and Roberts 1997). The female body is often seen as an object to be looked at, particularly an object of the male gaze (Spitzack 1990). Continuous objectification by both media and others may lead to "objectified body consciousness" where women come to experience their bodies as objects (McKinley 1995). McKinley and Hyde (1996) discuss three key components of objectified body consciousness: (1) constant body surveillance where women see themselves as (they think) others see them; (2) internalization of cultural standards where women see the norm as a personal choice rather than the product of social pressure, which can lead to intense shame when they do not live up to this standard; and (3) beliefs that appearance, given enough effort, can be controlled to comply with cultural standards. Thus in a body

conscious society where women equate thinness with womanhood and where they continue to be portrayed as media objects/things to be gazed at, women like (among others) Brittany, Alena, and Jeannette begin to experience themselves as objects. Because the cultural ideal is so pervasive, these women come to see themselves as they think others (and particularly men) see them. That is, they think of themselves primarily as bodies that deviate from the aesthetic mandate. Objectified body consciousness comes with intense shame and, in both private and public settings, psyches and bodies require ongoing emotional and physical management.

Women's body consciousness is then exacerbated by real life experiences where they are punished and/or made aware of their "deviance." Through insults, teasing, and taunting or through more overt forms of discrimination, these women are reminded that they do not conform and that society is watching, patrolling, and sanctioning. This patrolling heightens body consciousness and reminds women that body management is, in fact, necessary for survival. Because beauty is status and they do not possess this status, they are reminded daily that they do not possess body privilege. Just like male and white privilege that comprise an invisible package of unearned assets that men and whites can cash in on each day without even thinking about it (McIntosh 2002), those with body privilege can take for granted that they will be treated with respect and dignity as they navigate their social world. They can assume that their bodies will not be the subject of scrutiny or criticism. Overweight and obese individuals, and particularly women, cannot make such an assumption. They do not posses body privilege are therefore compelled to do ongoing body management.

CHAPTER 6

RESONANCE OF THE MARKET CHOICE FRAME, INDIVIDUAL AND CORPORATE RESPONSIBILITY, AND THE PERVASIVENESS OF MORAL MODELS OF FATNESS

In this chapter, I turn to the market choice frame and its relationship to a main tenet of the social justice frame – derogatory views of overweight individuals. I begin by examining how the food industry shapes consumption patterns by creating a "toxic environment" and the various public responses that have emerged to induce corporate responsibility. I then assess the resonance of the food industry frame. How do individuals think about the fat body and the issue of responsibility? Are they sympathetic to industry's position that emphasizes individual responsibility? Moreover, what is the relationship between perspectives on responsibility and derogatory views of overweight individuals? I address these questions by turning to the survey data collected from respondents of various body types, along with the forty-two in-depth interviews with overweight and obese respondents.

The Toxic Environment

The food industry shapes consumption patterns and, by extension, body types in several ways. In modern societies food supplies are stable and plentiful. Since 1935, the number of U.S. farms has fallen dramatically and there has been a general trend towards large farms (Hoppe and Korb 2005). The emergence of factory farming, while posing problems to the environment and engaging in ethically questionable treatment of animals (Turner 1999), has resulted in increased specialization, efficiency, and productivity. The U.S. food supply now provides a daily average of 3,800 calories per capita, more than double

what is required by most adults (Nestle 2002). While consumers are assured access to a wide variety of affordable foods, this abundance also encourages over-consumption and an energy ratio imbalance leading to weight gain. That humans are particularly efficient fat storers facilitates this gain. Historically, food was only periodically available and the risk of famine was constant (Loos and Bouchard 2003). Humans thus evolved with an efficient ability to sustain biological functions and to store excess energy in fat tissue (Unger and Orci 2000).

Consumers not only have more opportunities to buy food, but when they buy it, portion sizes are large. Since the late 1970s, portion sizes have increased, with the largest sizes found at fast food establishments (Nielsen and Popkin 2003). Many of these foods are also energy dense. This is in part because the food industry faces an economic quandary. While globalization and the concentration of ownership have resulted in extra profits for the industry (Silverstein 1984), there are still limits to individual consumption. The industry must therefore develop innovative ways to increase its profit margin. One strategy is to increase the sale of high profit foods such as processed foods or foods made with cheap ingredients such as sugar and wheat. These energy dense foods are typically low in fiber and high in sugar, salt, fat, cholesterol, and food additives – similar to what Winson (2004) refers to as "pseudo foods." Pseudo foods provide overabundant calories and are low in nutrients such as proteins, minerals, and vitamins. Diets comprised of such foods lack bulk and consequently encourage eating more than what our body needs (Worcester 1996). Marketing of these high-fat low-fiber foods, especially to children, is seen as an effective, and thus is a widely used, industry strategy (Gamble and Cotugna 1999; Story and French 2004). Accordingly, there has been an upward shift in the energy density of consumed foods, along

with an increase in edible oil and sugar intake, in both local and global diets (Drewnoski and Popkin 1997; Popkin 2004; Popkin and Nielsen 2003).

The food industry has also been accused of supplying nutritional misinformation to consumers, using supposedly conflicting evidence, and hiding negative data in the name of profit (Chopra and Darnton-Hill 2004). In other words, critics accuse industry of creating an environment where consumers are misinformed about nutrition, thus encouraging greater consumption. These strategies are linked to industry attempts to influence public health policy more broadly (e.g., see Nestle 2002). For example, there has been an ongoing battle between the sugar industry and the World Health Organization (WHO) about dietary recommendations for sugar. In 2004, the U.S. sugar industry lobbied the Bush administration to challenge the WHO's scientific findings linking sugar to obesity and an accompanying dietary recommendation to limit sugar intake to less than 10 percent of daily calories (Barrionuevo and Becker 2005; WHO 2003). Lobby groups have also had their say about the U.S. Food Pyramid (Nestle 1993). Corporate influence on health guidelines is difficult to deny when, for example, many of the Nutrition Fact Sheets produced by the American Dietetic Association (ADA) are sponsored by food and beverage groups (e.g., ADA 2006). In sum, American society structurally provides foods that are readily and easily accessible, in large portions, and are not necessarily healthy – a problem confounded by misinformation and nutritional guidelines that, some have argued, encourages (over)consumption since they are influenced by food industry lobby groups.

Inducements to Promote Corporate Responsibility

Various responses intended to instill corporate responsibility are emerging in light of the ways industry influences consumption. Turning the spotlight away from individual

responsibility, these responses emphasize corporate responsibility and place pressure on corporations to structurally create an environment that fosters healthy lifestyles. These responses mirror strategies once used to place checks on the tobacco industry and include the use of taxes, labels, litigation, and marketing restrictions (Chopra and Darnton Hill 2004).

To limit consumption of unhealthy foods and to encourage consumption of healthy foods, health advocates such as Kelly Brownell of the Center for Science in the Public Interest (CSPI) and the Yale Center for Eating and Weight Disorders have called for special taxes and subsidies. Foods high in calories, fat, or sugar would be taxed while the costs of healthful foods such as fruits and vegetables would be subsidized. Presently, eighteen U.S. states, along with the Canadian federal government and seven provinces, levy special taxes on soft drinks, candy, and/or snack foods (Jacobson and Brownell 2000). According to advocates, these special taxes, sometimes referred to as the "Twinkie tax" or the "fat tax," generate revenue that health officials could then use to sponsor nutrition and other health promotion programs.

The CSPI has also called for the use of food labels to help consumers identify unhealthy products. The Center recently submitted a petition to the U.S. Food and Drug Administration (FDA) requiring that health messages appear on soft drinks containing high fructose corn syrup and other caloric sweeteners (CSPI 2005). The petition details the extensive health impact of soft drinks on obesity and diabetes, bones and osteoporosis, and heart disease. These labels are similar to health warnings placed on cigarette cartons and reflect a similar assumption that consumers need this information to make informed decisions.

Another strategy used to instill corporate responsibility is captured succinctly by Spurlock in his film *Super Size Me!*. As he puts it, "sue the bastards!" Liability suits, similar to earlier suits against Big Tobacco, have surfaced since 1992 when the parents of two girls in New York sued McDonald's for making their daughters "fat and unhealthy" (*Pelman v. McDonald's* 237 F.Supp, 2d 512, 543 (S.D.N.Y. 2003)). While the initial case was dismissed by the district court judge, the threat of litigation nevertheless places pressure on the food industry to reassess their marketing and sales practices. The industry is now fighting back. Lobbyists for food companies have pushed state and federal legislation to limit lawsuits seeking personal injury damages related to obesity (Warner 2005). The National Restaurant Association (NRA) has been especially vocal in the campaign to pass these "commonsense consumption laws" that are now enacted in over twenty states. At the federal level, the *Personal Responsibility in Food Consumption Act*, also known as the Cheeseburger Bill, having received House approval, awaits consideration in the Senate.

Finally, health advocates have called for restrictions on the marketing and sale of unhealthy foods to children (Prevention Institute 2002). They stress that children are exposed to over 10,000 food advertisements yearly, 95% of which are for high-profit and nutrition poor products such as candy and sugared cereals (Brownell and Ludwig 2002; Gamble and Cotugna 1999; Story and French 2004). The industry has been somewhat responsive. For example, the country's top three soft-drink companies have recently agreed to remove sweetened drinks like Coke, Pepsi, and sweetened iced teas from school vending machines (Burros and Warner 2006).

Industry Perspective: Individual Choice and Personal Responsibility

In response to accusations that it is creating this toxic environment, and in light of these inducements to instill corporate accountability, the food industry, especially through the Center for Consumer Freedom, is articulating a position on the overweight body. Because I discussed the key tenets of the market choice frame in Chapter 3, I do not elaborate on details here.

While the soft drink pullout from schools suggests that food companies are bowing to health interests, the industry's overall position is that, at bottom, individuals are responsible for what they consume (Buchholz 2003). That is, it is about personal responsibility. According to the food industry, in a democratic capitalist society, individuals have the right to consume whatever they want. The industry emphasizes the themes of choice, common sense, and personal responsibility. The defining characteristics of the market choice frame are the choice to consume and individual responsibility over what is consumed. As such, no one should be told what they can or cannot eat. Adults, the industry proclaims, are sensible enough to make their own decisions. By extension, just like food choices, body size is a personal choice.

At the same time the industry dismisses obesity as a public health crisis, it nevertheless has made adjustments to promote healthy eating. Company specific action to combat obesity and promote healthy eating choices include clear communication in labeling, packaging, and advertising; reformulating products to reduce calories, trans fat and sugars, and lower cholesterol; adding vitamins to foods; and offering smaller portion sizes (Finn 2005).

Alongside these product and marketing changes, strong emphasis is placed on the promotion of physical activity. A core industry claim is that one does not become overweight or obese just from overeating. Instead, lack of exercise is a primary contributor. Along these lines, the industry promotes solutions to the "obesity epidemic" that focus on increasing activity levels. For example, in January 2003, the American Council for Fitness and Nutrition (ACFN) was formed. This joint collaboration between food and beverage companies, trade associations, and nutrition advocates attempts to create long-lasting remedies to obesity in America (Finn 2005). The ACFN promotes healthy eating, but high on its agenda is motivating physical activity in both adults and children. To a similar end, food companies maintain websites promoting healthy active lifestyles such as Pepsi Co.'s www.healthispower.net and www.smartspot.com.

In sum, in light of recent talk about the food industry's role in contributing to an environment that promotes weight gain and in light of public measures to put checks on the industry, the food industry has articulated a frame on the overweight body. This market choice frame emphasizes agency and individual responsibility over corporate responsibility. It also emphasizes policy that focuses on a fit America, rather than industry controls. Food industry ads and publications clearly indicate the industry's negative position on special taxes and food labels. The free market, not the government, should dictate what the public eats. Restrictions on food marketing to adults, along with responsibility lawsuits, are similarly condemned. So while the CSPI calls for labels, taxes, and other measures to regulate industry in hopes of halting the "obesity epidemic," the industry calls for less government control and greater individual responsibility.

Survey and Interview Data: Perspectives on General Industry Issues

Does the market choice frame resonate? Are individuals sympathetic to industry's position? Table 6.1 presents descriptive statistics showing that survey respondents expressed some views consistent with industry claims.

Table 6.1: Perspectives on General Industry Issues and Responsibility Issues

	Strongly Disagree	Disagree	Neutral/ No Opinion	Agree	Strongly Agree	N
The food industry should sell whatever products it wants, including unhealthy products.	7.8%	20.6%	19.5%	41.9%*	10.2%	451
There should be special taxes on unhealthy foods.	20.3%	38.4%*	23.6%	12.5%	5.1%	448
Fat people should sue companies whose food contributed to their size.	58.5%*	29.3%	10.2%	1.8%	0.2%	451
Unhealthy food products should have warnings labels to indicate that they are unhealthy.	2.2%	10.7%	16.4%	48.4%*	22.2%	450
The marketing/advertising of unhealthy foods to children should be restricted.	4.4%	18.4%	26.8%	34.1%*	16.2%	451
There are too many fast food restaurants.	3.1%	9.5%	18.1%	36.9%*	32.3%	452
The food industry influences government health policy.	1.1%	8.3%	44.1%*	34.5%	12.1%	447
Fat people are responsible for their own bodies.	.2%	1.3%	5.1%	46.1%	47.2%*	451
The food industry is responsible for obesity.	19.6%	39.9%*	21.8%	15.4%	3.3%	449
The fast food industry is responsible for obesity.	19.5%	36.6%*	21.1%	15.3%	7.5%	451
The food industry is *partially* responsible for obesity.	8.4%	23.3%	23.1%	38.6%*	6.7%	451
The fast food industry is *partially* responsible for obesity.	8.4%	20.2%	16.6%	41.9%*	12.9%	451

Note: Row totals do not always sum to 100.0% because of rounding error; *=modal category.

The industry position that it should be able to sell whatever product it wants is reflected in the sample. Over half (52.1%) agreed in some form that the industry should be able to sell any product it wants, including unhealthy products. As a whole, respondents did not favor the use of taxes and lawsuits. Again, siding with industry, only 17.6% agreed that

there should be special taxes on unhealthy foods while 87.8% disagreed with the statement that fat people should sue the food industry for their weight, with 58.5% falling into the strongly disagree category.

The interviews strongly support these perspectives. The themes of personal choice and individual responsibility resound, with little differences by gender, race, or BMI. Even this group of overweight and obese respondents places much emphasis on individual choice. Capitalist sentiments were also prevalent and there was agreement that the food industry should be able to sell, more or less, what it wanted. It is then up to consumers to make their own choices. When asked if the food industry should be able to sell any product, several respondents replied:

> You can sell the pie, you can sell the, I don't care. You know, it really is, if you believe in capitalism, you've got to believe in it the whole way. [And you believe in it?] Oh, sure. Yeah [laughs]… Because why should we restrict it? If McDonald's wants to sell you a pot of grease with a gravy dip and people want to buy that, let them buy it. It's their funeral. It's their indigestion. Knock yourself out (Kirk, 26, white, BMI 37.7).

> I think they should be able to because it's our right to decide. It's our will. We are adults. We have the right to decide what kind of life we want to live. I don't think we should be forced to eat healthy food. I mean, we're America, you know. Freedom of choice here (Hillary, white, 26, BMI 29.2).

> If they want to sell me a 5 lb bucket of fries, let them put it on the menu. That doesn't mean I have to order that 5 lb bucket of fries. It's all about the individual. You still have the option wherever you want, but make it sensible. Just because they're offering it, doesn't mean they have to take it (Denzel, 27, African-American, BMI 27.7).

Denzel continues to discuss the parents of the girls who sued McDonald's for making their daughters obese. He shares a similar perspective to Meena, a 31 year-old overweight (BMI 29.8) South Asian student who works as a dental hygienist. Again, industry is not responsible for an individual's weight gain, especially since the food was not forced upon them. Individuals make their own decisions. In their words:

> These people who are suing Mickey D's a couple years ago. Now that really got under my skin, not for the fact that they were suing Mickey D's, but the reasons for they were suing Mickey D's. Oh, I ate six Big Macs and put on 100 lbs. Ronald McDonald didn't stand there with a pistol to your back and make you order six Big Macs. So now why are you going to turn around and sue this company? And for them to get away with it. That was just dumb. That was so stupid (Denzel, 27, African-American, BMI 27.7).

> Well, it's not really the fast food industry's fault. It's their fault for making the decision to choose the wrong foods. Yeah, so I just feel that it's ridiculous (Meena, 31, South-Asian, BMI 29.8).

Like the opinions expressed on lawsuits, respondents' views on taxes were similarly vocal, adamant, and negative. In general, respondents did not favor taxes. On the one hand, they were not favored because taxes as a whole were not seen as desirable. As Javier, a 43 year-old obese pastor, says:

> I think that people can make their own choices. Hopefully they're making informed choices. I don't like the idea of taxing more stuff….I'm just against taxing more across the board. I don't want them to tax baseball games. Don't tax basketball games. I'm just not in favor of any more taxes (Javier, 43, Hispanic, BMI 31.8).

On the other hand, respondents viewed taxes as an ineffective solution to preventing the consumption of unhealthy foods. Mark is white, 38 years-old, and obese. He

formerly worked in demolition but is currently unemployed. He goes so far as to compare food to drugs:

> It's like drugs. If someone wants it, they're going to get it. They'll go out and kill their own cow and make their own food. Don't make no sense. It's just another way for the government to make more money (Mark, 38, white, BMI 39.9).

The view that taxes are futile is echoed by Alesha, a 34 year old, overweight, African-American correctional sergeant. As she says:

> It wont matter. They'll still buy it. It [taxing] don't matter. Individual people, they just do what they're going to do, and this is America. This is what we do (Alehsa, 34, African-American, BMI 26.3).

Despite strong consensus that individuals are responsible for their bodies, respondents nevertheless acknowledged that choices are often hard to make. Respondents confessed that they often make poor choices, in large part because of time constraints. For example, Terrence, a 36 year-old overweight marketing consulting and father of two, was constantly struggling to find time to incorporate exercise into his daily routine. His fast-paced lifestyle made making healthy choices difficult. He resorts to fast food because of its convenience. Terrence says:

> Those people [the fast food industry] are not doing me any favors. They are not helping…You know, I said earlier, like a sandwich is enough. A sandwich is enough but you don't just want a sandwich. You want a sandwich and a thing with it, right? That's what we are … we are like entitled to and so what can you have? French fries. I mean, there should be some other thing you can get with it. So, it's not the food industry driving all this. It's the cycle between what people will buy most of the time and what's available. But I tell you, when you try to make really good choices, it's just hard. Okay, so like Boston Market you can eat. Their food's pretty good. You could take the skin off the chicken if you want to go

> that far. I don't deal with that. But it's not fried, you know. It's good. And then you can get steamed vegetables. You can't drive through and get it. It usually takes awhile to get food in line at Carl's Jr. So if I'm really in a hurry I won't go there. So there are all kinds of…there's definitely a lot of occasions where I make less healthy choice because of convenience and it's only convenient because the food industry is churning out mostly crap. The restaurant industry, the fast food industry, you get mostly crap (Terrence, 36, white, BMI 26.5).

Marisa, a 24 year-old overweight Latina, also expresses the difficulties with making healthy choices when one is a busy student. Marisa goes so far as to say that she really has no choice but to eat out. Her schedule is tight and, for her, packing a lunch is not an option. Her views are similar to Shawntea, a 36 year-old extremely obese African-American and single-mother of three boys. Shawntea works two jobs while attending school part-time. Her workweek is 52 hours:

> But the fact that we are basically always working and, you know, students are always out of their house. We have no option unless you take your food with you [laughs]. We have no option but to eat out. And that's the problem (Marisa, 24, Hispanic, BMI 27.3).

> Well, I think the reason why most of us end up eating at fast food restaurants is because you're out of time. You know, and like for me, I bought dinner last night. I didn't get home until past 7 o'clock. I wasn't going to cook. I was doing more errands after work and we could have probably gotten salad or something but the treat was the burgers. And I had it and I'm actually trying not to buy more out, even for my kids. There is just some times where there isn't enough time (Shawntea, 36, African-American, BMI 44.4).

Strong resonance of the food industry frame was not seen across all the variables. Despite the emphasis on personal choice and opposition to taxes and industry lawsuits, over

two-thirds (70.6%) of respondents conceded that there should be warning labels on unhealthy foods. Two respondents succinctly capture competing perspectives on warning labels: John is pro-labels because they might stop him from eating things that he felt he should not, while Alberto expressed opposition to warning labels because he feels they are futile:

> That might not be a bad idea. The only reason why I say that is because for someone who does have a weight problem, it might guilt me into not eating, not taking the bite or whatever. Yeah, I could go for that I guess. It'd be kind of a humorous read [laughs] (John, 36, mixed-race, BMI 37.7).

> What are you going to put on there? How exactly would you word that, you know? They would have to do that for their whole menu. If I'm going to eat a bag of gummy bears, I'm going to eat a bag of gummy bears. I smoke cigarettes, the warning on the label don't mean nothing. …See, what it all comes down to, nobody's going to tell me what I can or cannot do. Once you start telling people that, more times than not they're going to do what you told them not to do (Alberto, 34, Hispanic, BMI 30.0).

Those against labels felt, like Rhonda, a 40 year-old teacher's assistant, that current nutritional labels (indicating the content and calorie breakdown) are sufficient. In her opinion:

> Warning labels, huh? I think it would be nice if the information on the calories and stuff, maybe if that was put on the package for the quarter pounder with cheese or your Kentucky Fried Chicken. I think if people knew how many calories were in there and how much fat was in there, or salt, that they would, it would blow their mind. Like whoa, I've been eating this? I think if the information was more readily available. I don't think you need a warning label, but like [sarcastically says] 'Warning: This has 1000 calories. Do you know you're only supposed to eat 1200 a day!' [laughs] But if it had some of the nutritional information on

> the package when they hand it to you, then you could read it, then you would realize. Then I think people would be able to make healthier choices. But ignorance is bliss and they don't know so they don't worry about it [laughs] (Rhonda, 40, white, BMI 38.1).

Finally, there was some recognition that children may be in need of special protection from corporations. Half (50.3%) the survey sample indicated that there should be restrictions on the marketing of unhealthy foods children. In general (69.2%), most respondents felt that there were too many fast food restaurants. However, they were less opinionated about the industry's influence on health policy. Forty-four percent were neutral suggesting that there was not strong polarization on this issue.

Survey and Interview Data: Perspectives on Responsibility

To assess perspectives on responsibility, I asked survey respondents to indicate who they felt was responsible for obesity. I present these results in Table 6.1. Of all the variables, "individual responsibility" has the strongest level of agreement. The majority of respondents (93.3%) believe that people who are fat are responsible for their own bodies. Only 1.5% expressed any form of dissent – a finding that points to strong resonance of a key tenet of the market choice frame. In other words, survey respondents strongly believe that individuals are responsible for their bodies.

In general, there was disagreement that either the food industry or the fast food industry is responsible for obesity. Nearly two thirds, 59.5% and 56.1%, disagreed that the food industry or the fast food industry, respectively, is responsible. Modes for both statements were disagree – 39.9% and 36.6%, respectively. Yet, interestingly, when faced with more lax statements about the industry, respondents conceded industry responsibility. Specifically, two less stringent statements (the food industry is *partially* responsible for

obesity and the fast food industry is *partially* responsible for obesity) lead to very different results. The modes switch to agree where 38.6% and 41.9%, respectively, expressed agreement that the industry is partially responsibility. Total disagreement is halved and drops to 31.7% (for the food industry) and to 28.6% (for the fast food industry). Jeanette's lengthy narrative captures well this middle-ground position. She is 35, white, and extremely obese. While siding adamantly with individual responsibility, she concedes that corporations are still responsible in some way:

> Hmm, on the one hand, you don't have to go there. On the other hand, you don't know what the food is made of. There's responsibility on both sides. There are people that are hard liners and say they don't have to go in there. They don't have to eat that food. So they shouldn't sue them. And that's true to an extent. On the other hand, they're going out to eat. They don't know what's in it. They're making bad choices, but they're not thinking about it. They're just eating the food because they're hungry. So it's not really a conscious thought. I think that there's responsibility on both sides. So maybe there could be some legislation. Because there's definitely all kinds of false sense going on. There's a symptom there, they need to solve the problem underneath it. If they inform people better then there won't be any lawsuits. I don't want to ban lawsuits because that's going to help drive people to think. You see this, 'oh, that's awful.' Somebody else might say, 'hmm, that's bad food, maybe I shouldn't eat there anymore'…I don't think we should limit legislation at all. Education I guess is a better word (Jeanette, 35, white, BMI 46.3).

So even though consumers have the decision of not eating at chains that offer unhealthy foods, Jeanette notes that corporations still need to provide information and ensure that consumers are educated about their products. As she forthrightly states, there is responsibility on both sides.

Interestingly, respondents could be grouped into two categories in terms of how responsive they feel industry currently is to public health demands. I label these two groups believers and skeptics. The majority of respondents were believers as they felt that the fast food industry is adjusting to changing times and providing healthier options. To the contrary, the handful of skeptics adopted a more critical eye to these so-called "healthy options" and questioned industry's overall motives. Kirk is an example of a believer:

> I'm a little bit frightened that McDonald's is the health food leader right now. I mean that kind of screws with my head a little bit. 'We have salads and fruit cups and yogurt.' Wow, leading the health charge is McDonald's, followed closely by Wendy's (Kirk, 26, white, BMI 37.7).

Similarly, Alesha is a believer. She notes that the industry provides healthy choices and goes so far as to say that people need to choose them:

> I believe that you had a choice to go in there and spend your money. Because it's not like the fast foods don't offer the healthy menu items. Fast food places have healthy items as well and when you go in there and you ignore those healthy items and you go and you purchase the unhealthy items and then you want to bring in legalities because you do. I don't think that's right (Alehsa, 34, African-American BMI 26.3).

Estella is also a believer. However, she notes that the choices we make and the products that industry offers are closely tied. That is, they are mutually reinforcing. As she says, "so yeah, I mean, they can sell whatever they want, but when we start getting healthier, they're going to start getting healthier. Because they're going to be like, they're going to sell what we want, because we buy what they sell. So in reality it comes back to us." In other words, individual choice and structure come hand-in-hand.

In contrast to the believers, skeptics like Ayleah question the extent to which the healthy foods offered are, in fact, healthy. They also question the sincerity of the food industry. When I asked her what she believes is the relationship between the food industry and obesity, she responds:

> I think it has a big role. It's fast food, you know. And it tastes good for the majority. Even like the healthy stuff, you might not be eating meat, but what's in your salad dressing? How much, you know? If it's really good, it's probably not that good for you. I think that fast food industry has a big part. I think more people have become aware of that and maybe changing the way that they intake, but it seems like they don't care. You know, even when they show that they care by putting something different on the menu, it's just about money and taking advantage of people who don't really know (Ayleah, 32, African-American, BMI 29.3).

Regardless of whether they were a believer or skeptic, respondents placed strong emphasis on choice. In sum, both the quantitative and qualitative data point to general support for industry's position. Even if the food and fast food industry produce unhealthy items in abundance, they are not to be held wholly responsible for what is, ultimately, a consumer's decision.

Survey Data: Social Justice and Anti-Fat Views

Views about responsibility are important because they reveal how individuals think about blame which, in turn, has implications for social justice. This is because when obese individuals are seen as responsible for their condition, they are more likely to be evaluated negatively (DeJong 1980, 1993; Weiner, Perry, and Magnusson 1988). This claim stems from the basic premise of attribution theory.

Attribution theory assumes that in interactions, individuals often attempt to make sense of other people's behaviors or social outcomes by looking at the causes of the behavior or outcome (Heider 1958; Weiner 1986). According to Weiner (1986), there are three causal dimensions of attribution theory: locus of control (internal versus external); stability (whether the cause is stable or changes over time); and controllability (the extent to which a cause is controllable). Internal controls are said to stem from the individual, e.g., intelligence, while external controls stem from outside forces, e.g., the weather or luck. Attribution theory provides one avenue for accounting for social outcomes and their success or failure. For example, individuals often attribute academic success to internal causes such as innate ability and attribute failure to external and uncontrollable causes such as poor instruction by teachers.

Attribution theory has also been extended to explain reactions to various social stigma (Weiner, Perry and Magnusson 1988). Specifically, Crandall and his colleagues (Crandall 2000; Crandall et al. 2001; Crandall and Schiffhauer 1998) use attribution theory and its focus on causality and controllability to explain why obese individuals experience negative social treatment. According to their research, when people encounter individuals with a stigma, they search for a cause of the stigma. When the stigmatized trait, e.g., obesity, is considered to be under the individual's control (controllable), and is also thought to be due to laziness, weak will, or lack of self-restraint (internal causes), blame is assigned to the individual. Notably, in this formulation, external causes (such as the role of the food or fast food industry in creating a toxic environment) are downplayed or altogether dismissed. This type of internal and controllable attribution justifies discriminatory views or treatment of the stigmatized individuals, as often the case with overweight and obese individuals. As

Schwartz and Brownell observe, "[i]n the case of obesity, individuals have a highly stigmatized condition and are thought to be responsible for it" (2004: 44). Indeed, this is one of the myths that social activists at NAAFA are trying to debunk. They argue for external attribution: obesity is not caused by behavioral factors (internal causes) alone; genetics (which is a cause that is beyond one's control) also plays a key role. This is, notably, a key distinction between the market choice and social justice frame. While the former focuses on internal attribution in order to shift responsibility to the individual, the latter focuses on external attribution as a way of fighting discrimination.

Here I test the hypothesis that adopting the core tenet of the market choice frame – belief in individual responsibility – directly affects stereotypical thinking about, and negative perspectives of, overweight individuals by encouraging an internal and controllable attribute of blame. As attribution theory argues, those who believe that overweight or obese individuals are responsible for their condition are more likely to hold stereotypically negative views of fat individuals.

Table 6.2 presents the results of regression analyses that regress individual responsibility on two dependent variables – agreement that fat people are lazy and that they are a burden to the economy or health care system. Recoded dichotomous dependent variables are used instead of the continuous Likert scale item as the assumption of equidistance between Likert scale responses (strongly disagree, disagree, neutral/no opinion, agree, and disagree) does not necessarily hold. While strong agreement and agreement are coded 1, all other categories are coded 0.

The "other" race category is a combination of three categories all which have a small number of observations (Native/Indian American, Hawaiian/Pacific Islander, and Other).

All race variables included in the regression analyses are dummy variables where whites are the reference category. Individual responsibility is coded as a continuous variable ranging from 1 (strongly disagree) through 5 (strongly agree). Income (measured in thousands) uses the midpoint household income while married and college degree are both dummy variables. I found the interaction effect for race and BMI to be non-significant and therefore excluded it from the final models.

Table 6.2: Logistic Regression Analyses: Fat Individuals are Lazy and a Burden to Society

	Lazy		Burden to Economy or Health Care System	
Individual Responsibility	.869	***	.469	**
	(.204)		(.180)	
Respondent's BMI	-.049		-.029	
	(.027)		(.024)	
Black	.299		-.154	
	(.634)		(.558)	
Asian	1.352	*	-.404	
	(.588)		(.554)	
Mixed Race	.393		-.026	
	(.321)		(.301)	
Hispanic	-..054		-.379	
	(.297)		(.286)	
Other Race	.501		-2.155	*
	(.706)		(1.073)	
Age	-.048	*	.033	*
	(.020)		(.015)	
Male	.246		.047	
	(.235)		(.222)	
Income	-.001		.005	
	(.004)		(.004)	
Married	-.719		.099	
	(.446)		(.369)	
College Degree	.205		.816	**
	(.327)		(.301)	
Constant	-2.316		-2.703	*
	(1.185)		(1.061)	
χ^2 (df)	53.983	***	38.180	***
	(12)		(12)	
Observations	384		384	

Notes: Standardized coefficients; standard errors in parentheses.
* p <.05; ** p <.01; ***p<.001 (two-tailed tests).

The most striking observation from the regression analysis is that there is significant effect for individual responsibility in both models. In other words, holding fat individuals responsible for their bodies increases the likelihood in the belief that fat people are lazy or a burden to the economy/health care system, even when other variables are held constant. Specifically, increased agreement in individual responsibility doubles the odds of believing that overweight people are lazy (2.385). It also increases the odds of believing that overweight people are a burden to society by 1.599 times. The control variables also suggest that Asians (compared to other races) are more likely to agree that fat people are lazy (odds are 3.865 more likely). This finding may partially reflect stronger indoctrination by model minorities of the American ideology of individualism that is often embedded in the assumption that overweight individuals are lazy. While respondents' BMI has a negative relationship to both dependent variables, BMI is notably insignificant in both models. Interestingly, the influence of age is significant. However, the direction of the age effect is not consistent across models. While age decreases the likelihood of agreement that fat individuals are lazy (odds of .953), it increases the likelihood of agreement that fat individuals are a burden to society (odds of 1.034). A positive effect is also observed with those who have completed a college degree (associates/bachelors degree or higher). Survey respondents with a college degree are more likely to believe that fat individuals are a burden to society by a factor of 2.261.

Discussion and Conclusion

General resonance of the market choice frame likely reflects the broader acceptance of "American" values. Endorsement of a free-market capitalistic ideology probably accounts for as much of the disdain for the use of taxes and litigation in and of itself, as it

does for the disapproval of these strategies to control industry. This is consistent with the literature. Social movement scholars have noted that the more a frame resonates with familiar cultural themes, the more likely it will be accepted as a natural way to interpret reality. Embrace of a free-market ideal is closely tied to the "master frame" of American individualism – the belief that just by pulling ourselves up by our bootstraps we can achieve infinite goals, whether it is making a million dollars or redesigning our bodies as we desire. In this way, the market choice frame resonates and is accepted as a natural way of thinking about the overweight body. It seems appropriate or normal, then, not to hold corporations, but individuals, responsible. It is therefore unsurprising that the majority of individuals feel that overweight individuals are responsible for their own bodies and that neither the food nor the fast food industry is entirely responsible.

It is somewhat remarkable that even overweight and obese interview respondents admit that they themselves are responsible for their overweight bodies. This is testimony to the power of the master frame. Unlike the health and beauty frames that come up against some resistance and reformulation, the market choice frame in its original form successfully penetrates respondents' cultural repertoires. At the same time it does, it creates little internal dissonance and is met with little resistance. Although some obese interview respondents did not use the term obese as a self-label, all interview respondents admitted that they were overweight. I was informed that there is "truth in advertising." As a whole, respondents openly conceded that they were overweight and candidly declared that they alone were to blame for their bodies. While respondents did not explicitly connect this perspective to body work motivation, the assumption of individual responsibility nevertheless framed their

narratives. Cultural messages that resonate with familiar cultural themes such as American capitalism and the ideology of individual are extremely powerful.

Yet while capitalistic ideals seem ubiquitous, there is simultaneously some willingness among respondents to acknowledge that unfettered corporatism is undesirable. They consider less intrusive public health measures, such as labeling unhealthy products or placing restrictions on the marketing of unhealthy foods to vulnerable populations such as children, desirable. Moreover, the belief that industry is *partially* responsible for obesity, coupled with the sentiment that there are simply too many fast food restaurants, indicate that the assertion that fat individuals are solely responsible for their bodies is far from conclusive. There is some, however tentative, concession that corporations are, in part, responsible. Lawrence notes that "[a]s claims about an unhealthy food and activity environment have increased, the role of personal responsibility for one's health has been strongly articulated in response" (2004: 69). The battle over who is responsible is far from over.

The focus on individual responsibility reflects the stranglehold of "moral models of fatness" that emphasize fatness as "bad, sinful, and ugly" and suggest that "fat people are responsible for their condition" (Sobal 1995: 69). These moral models of fatness have significant implications for social justice, the primary concern of the social justice frame. Fat acceptance activist highlight the discriminatory treatment that overweight and obese individuals experience and, as discussed in Chapter 5, the impact of not possessing body privilege. Not only do the quantitative and qualitative data show that individuals of various body sizes stress individual responsibility for body issues, but they point to a significant relationship between these views on individual responsibility and anti-fat views. Confirming attribution theory, the data indicate that holding fat individuals responsible for their bodies

increases the belief that they are lazy and a burden to society. Given the prevalence of bias, prejudice, and discrimination against larger individuals, effective public policy aimed at addressing and eradicating size-based discrimination should not disregard how individuals frame the issue of responsibility in the first place. So even in the face of recent talk about the toxic environment and our fast food nation, it appears that the belief in American hegemonic ideals and individual responsibility remains prevalent.

CHAPTER 7

CONCLUSION

Overview of Main Empirical Findings

At the start of my project, I identified four key cultural frames about the overweight body. I then asked two general research questions about these frames. First, how do cultural producers who have a direct interest in defining fat frame obesity? Second, what is the relationship between competing frames and cultural consumers or agents? To address the first question, I conducted content/frame analysis and examined how cultural meanings are produced and played out among three cultural producers: government medical researchers, social movement activists, and food industry representatives. To address the second question, I surveyed a sample of individuals of various body sizes (n=456) and conducted interviews with individuals who are overweight or obese (n=42). While the results of the frame analysis provide the descriptive backdrop of the dissertation, the survey and interview data analyses provide a more in-depth look at cultural frame resonance, the uses of culture, and culture in action.

After describing my research design, methods, and data in Chapter 2, I presented the results of the frame analysis in Chapter 3. I documented the signature elements of the health, social justice, and market choice frames. The CDC's health frame constructs obesity as a growing health epidemic. The CDC, and the medical community that endorses this frame, considers obesity a growing health epidemic with major health and economic consequences. Using the BMI, the government warns individuals with a BMI higher than twenty-five of the increased health risks associated with being overweight. These include the

increased risk of type 2 diabetes, coronary heart disease, and stroke. The CDC relies on mainstream medical research to support its frame and it is assumed a sensible person will adopt it.

In contrast, NAAFA's social justice frame focuses, not on public health, but on discrimination. NAAFA members challenge the CDC's core medical claim that links obesity to disease, stress that fat individuals can still be healthy, and point to the dangers of yo-yo dieting. They also condemn weight loss drugs and weight loss surgeries that they consider ineffective at controlling weight. According to the social justice frame, sensible action means remaining active and avoiding obsessive dieting and preoccupation with weight loss. NAAFA members call attention to discriminatory practices that make it difficult for overweight individuals to be healthy. The stigma of fat makes it hard for overweight individuals to participate in physical activity in public settings and they are deterred from seeking medical assistance, often fearing and experiencing poor treatment.

The food industry has also chimed in and put forth a cultural frame on the overweight body. It too challenges the CDC's health claims, including the obesity-disease link, and questions whether there is in fact an obesity "epidemic." Given its economic interest, food industry lobby groups such as the CCF downplay the role of overeating and pin weight gain on lack of exercise. Industry representatives urge individuals to make their own decisions about what to eat and drink. By extension, individuals are entitled to possess whatever body size they desire. This market choice frame argues that the free market should dictate. Not unexpectedly, the industry adamantly opposes food regulation as a means of curtailing increasing obesity rates.

All three frames have a different relationship to the cultural and social structure. The medical frame works within the existing cultural structure of the thin beauty ideal. Even though public health documents do not engage debates about cultural standards of beauty, the government's health message nevertheless reinforces the thin body ideal. If fat is undesirable because it is unhealthy, then thin is necessarily good. The health imperative implores individuals to change their bodies and to lose weight. On the other hand, NAAFA's overall philosophy challenges the cultural structure that stigmatizes fat bodies as ugly and deviant. Wann's fat acceptance manifesto is, at bottom, about reclaiming the fat body and overturning the narrow beauty ideal that has created psychological anguish, particularly for overweight women. Finally, the food industry's position poses few challenges to the current social and cultural structure. In fact, the industry is part of, and thrives off of, the capitalist economic system. Its interests are not ideological, but economic. It makes no claims about what bodies are acceptable or preferable. All bodies are tolerated, so long as they consume.

Each frame points to various responses to the issue of fat based in part on its perspective on the causes of obesity. The health frame, even when suggesting that obesity has multiple causes, places responsibility on the individual, focusing on internal and controllable causes of weight gain such as individual exercise and eating habits. Individuals are told to follow proper dietary and exercise guidelines set forth by the federal government. The health frame thus has the potential to continue legitimizing social inequality and size-based discrimination while reinforcing stereotypes. By focusing primarily on individual changes, and by implicitly supporting the thin ideal, the health frame can be used to

stigmatize fat bodies and to deny the possibility that fat individuals can still be healthy and fit. In contrast, by rejecting hegemonic body ideals and exposing myriad causes of obesity, the social justice frame endeavors to promote a more tolerant perspective on the overweight body. By focusing on both internal and external attribution (and not just the former) and also uncontrollable genetic causes, NAAFA challenges the key source of discrimination – the belief that individuals alone cause their condition because of laziness, weak will, and/or lack of self-control. These are prevalent stereotypes that NAAFA members work to debunk. The social justice frame promotes responsible research, public tolerance of body-diversity, and sensible health defined outside the narrowly constructed fiction of the thin aesthetic. Finally, the market-choice frame promotes a laissez faire approach to the fat body. While the food industry challenges the claims of the medical frame, it does so only for the sake of generating sales. It expresses little interest in creating a more egalitarian society. Given its emphasis on lack of exercise as a primary cause, food industry lobby groups focus on increasing activity levels among the American public. They vocally protest food industry regulation.

With this descriptive understanding of frames laid out, I proceeded to examine the relationship between cultural frames and agents. In Chapter 4, I reported findings from the interview data. I discussed how the government's health frame is considered authoritative and I documented how individuals respond to this authoritative knowledge. Specifically, I focused on how respondents use this knowledge to motivate weight loss. Despite observing that a majority of respondents accept this authoritative knowledge, I found that respondents also redefine and reject culture based on their personal experiences. The interviews highlight

three different, but interrelated, mechanisms respondents use to redefine health. First, respondents redefine health by focusing on spiritual or mental health. Second, they redefine health by focusing on pragmatic measures of health by, for example, gauging health through their ability to accomplish every day tasks. Finally, respondents individualize health by rejecting the universality of government standards. While many respondents redefine the government's health frame by bending its tenets, some overtly reject the health frame. They critique the health frame's main measure, the BMI, along with claims such as obesity is linked to disease, disability, and premature death.

These redefinitions of health are important because they affect how respondents assess their level of healthiness. Redefinitions lead many respondents to consider themselves healthy. They are also important because they have implications for weight loss motivation. From the interview data, I categorized respondents into four types based on their acceptance of the health frame and their health-based motivation. Conformists accept the major tenets of the health frame and are, in turn, motivated by it. Co-opters express some critique of the health frame, but like conformists, they nevertheless concede that there are health benefits of weight loss and, as such, co-opters too were motivated to lose weight for health reasons. The apathetics, despite agreeing that being overweight is unhealthy, were apathetic about their health and unmotivated to improve it. Finally, rebels were a small group of respondents who both rejected the universal health mandate and were not motivated to lose weight because of health concerns.

In Chapter 5, I examined the resonance of the beauty frame. Consistent with the current literature, the survey data confirm the overall importance of body image for both

men and women, but especially women, along with the finding that African-Americans are generally more satisfied with their bodies than individuals of other races. As BMI increases, satisfaction is less likely, especially for women. The survey data also point to body satisfaction as an important determinant of self-esteem, confidence, and happiness.

In Chapter 5 I also looked at how the beauty ideal surfaces in the lives of individuals who do not conform. Similar to the previous chapter on health motivation, I examined how respondents use culture to motivate action. In a body-conscious society where body image is considered extremely important, body dissatisfaction manifests itself in very tangible ways. First, respondents either openly critique or accept the cultural ideal. Notably, only a handful of respondents accept the ideal, claim it is beautiful, and consciously use it as an incentive for weight loss. The majority of respondents reject the ideal, voicing that it is unattractive, dangerously unhealthy, and an airbrushed myth that needs to be debunked. They also place minimal stress on body issues. In this group of primarily working class and lower SES respondents, completing one's education and obtaining a good job are considered top priorities. External beauty and weight loss are not. As a form of resistance, respondents focus on internal beauty, citing our body-obsessed culture as materialistic and superficial.

Despite claims that the beauty ideal is unattractive, unhealthy, and a cultural fiction, nearly all respondents internalize the ideal and aspire to lose weight. As such, the beauty ideal is a motivator for weight loss. In this way, open critique of culture provides little buffer to desiring cultural norms. However, the data show that in their attempts at weight loss, most respondents are level-headed, are against taking weight loss drugs, and acknowledge that they would never achieve the ideal. Similarly, they commonly discuss lifestyle changes

and oppose quick-fix diets. They aspired to target weights that would enable them to feel healthier and more comfortable with their bodies.

The interview data also highlight the interconnection between two dominant frames, indicating that motivation for weight loss often stems in part from the health frame but, at times, even more from the beauty frame. This is because the social rewards associated with the thin ideal are often more prominent, immediate, and tangible then the benefits associated with the health ideal. Beauty is a social status that opens up doors in multiple arenas – from the dating market to the job market. Moreover, those who do not possess this status are, not only subtly excluded from these social rewards, but they are also overtly subjected to an array of social injuries – form social isolation to lower wages. As fat acceptance activists stress, as previous research studies support, and as my interview data confirm, overweight and obese individuals experience a significant amount of social stigma and weight-based discriminatory treatment. The desire for body privilege and the reduction of this stigma therefore provides strong incentive for weight loss, sometimes stronger than the desire for good health.

Interviews also show how the beauty frame manifests itself in gendered ways. Culture works in different ways for men and women. While the desire for weight loss cuts across gender, race, and age lines, how overweight and obese women and men negotiate their daily lives differ. Compared to men, women are much more preoccupied with weight issues. Women are highly conscious of their bodies on a daily basis, whether it is in the private setting of their homes or in public settings such as restaurants. While this body consciousness is ongoing, it can be triggered by objects or other individuals. Mirrors,

clothing, desks, significant others, and generalized others all play a role in heightening body consciousness. This body consciousness can be so powerful that obese women sometimes do not desire to leave their homes. In Chapter 5, I theorize this gendered body consciousness and management using feminist and objectification theory. Extreme body consciousness and body management are prevalent among women primarily because ideal womanhood and ideal weight are closely tied. Body consciousness and body management are also functions of constant media objectification. These social psychological processes are then compounded by concrete life experiences that repeatedly remind obese women that their bodies do not conform. Through insults, teasing, and taunting or through more overt forms of formal discrimination such as employment discrimination, these women learn that they deviate from the cultural ideal and that society is watching, patrolling, and sanctioning. Body management becomes a survival technique that enables overweight women to leave certain private and public situations with their self-esteem, sense of worth, and dignity intact.

In the last empirical chapter, I examined the market choice frame and its relationship to the social discriminatory views that fat acceptance activists underscore. In Chapter 6, I examined the debate over responsibility (individual versus corporate) and the resonance of the market choice frame. As a whole, both the survey and interview data point to strong resonance of industry views and a strong belief in individual responsibility. General support for perspectives consistent with an industry point of view likely reflects the larger acceptance of the master frame of free-market capitalism.

In Chapter 6, I also turned to the relationship between views on responsibility and anti-fat perspectives. Attribution theory argues that individuals often feel that biased or

discriminatory treatment against obese people is justifiable since they are seen as the cause of their own stigma. Survey data analysis confirms the basic tenets of attribution theory, showing a significant and positive relationship between views on individual responsibility and anti-fat perspectives. Specifically, holding fat individuals responsible for their bodies increases the likelihood that respondents believe they are lazy and a burden to society.

Theoretical Contributions

The dissertation makes several theoretical contributions. Specifically, the research speaks to the general relationship between culture and agents. Swidler argues that culture is a tool kit or repertoire of habits, skills, and styles from which individuals construct strategies of action and the self. Individuals, as cultural negotiators, actively draw on various components of culture and use it to define, guide, and interpret desired action and to reinforce or create a sense of self. They are not merely passive recipients of larger cultural forces. As a whole, the empirical results confirm Swidler's identity model. Respondents actively use health information, in ways that they think are consistent with who they believe they are or want to be. For some, health knowledge is fully accepted. Their experiences, including recent diagnoses, bodily changes, and/or the general aging process, encourage them to accept this authoritative knowledge. But for others, health claims are bent in ways that are more congruous with daily experiences and their worldview. For example, in busy lives where work surfaces prominently, health is gauged by one's ability to perform their job. Or, when repeated diets based on recommended health guidelines fail, it is not surprising that this information is reframed and, as such, health is individualized. Others also overtly reject all or parts of the health frame. In the case of the rebels, government health

knowledge does not resonate with their personal experiences and it creates internal conflict. Consequently, it is dismissed from their repertoires. Regardless of whether culture is accepted, redefined, or rejected, they are all grounded in experience. They are contingent upon individual experiences, personal locales, and views of self and world.

Importantly, race and ethnicity mediate how culture is used. Racial/ethnic communities and racial/ethnic identity provide alternative meanings systems that individuals draw on to confirm, or to challenge, dominant meaning systems. Redefinitions of health by minority respondents show that often times even when there are competing meanings that conflict, they are still reconcilable. Minority respondents who redefine health are unwilling to reject entirely a conventional understanding of health because they partly recognize its benefits. By navigating different meaning systems, individuals draw on the best of both worlds. The mediating effect of racial identity is also apparent in how minority respondents approach the beauty frame. Notably, Latinas were prominent among the few respondents who openly accepted the cultural beauty ideal. They did not experience the ideal as oppressive but, instead, actively sought it, hoping that it would provide social rewards. From competing meaning systems, individuals select desired elements of culture that are consistent with their experiences and also who they aspire to be.

At the same that culture is actively used by individuals, it can also be seen at work in very subtle and important ways. The phenomena of body consciousness and body management expose how culture creates privilege and, moreover, how the unprivileged must manage their subordinate status. Abstract cultural ideals are therefore manifested tangibly in everyday lives in mundane but extraordinarily invasive ways. In the case of the beauty ideal,

it significantly impacts how overweight women negotiate daily interactions. Thus when cultural messages are pervasive, powerful, and especially when they are reinforced by powerful sanctioning systems, culture can manifest itself in ways that agents find undesirable and unwanted. Accordingly, they must finds was to manage its impact.

The disconnection between how individuals critique culture and what they do with it also suggests that culture and social structure interact to determine how culture is put to use. It is rational to expect that respondents who openly critique the cultural beauty ideal would also reject any desire to conform to the ideal. However, culture works within cultural and social structural boundaries. For body issues, it works within the social hierarchy that privileges thin bodies and dismisses or subordinates fat bodies. Because beauty is status and because this social status hierarchy is enforced, both formally (e.g., through formal discrimination in various realms of social life) and informally (e.g., through disadvantageous individual-level treatment on a daily basis throughout the life course), individuals can simultaneously reject and internalize the cultural beauty ideal. They reject it because it does not comport with their understanding of the world and self. At the same time, it is internalized (and weight loss is desired) because they are aware that they live a body-stratified world. Their personal experiences confirm this. They are highly aware that they live in a society that structurally privileges the thin body. So despite openly rejecting this element of culture, they still use it. In this way, the use of culture is contingent upon social structure.

Policy Implications

The study's empirical findings suggest various policy implications. The redefining of health by overweight and obese individuals points to the centrality of laypersons' definitions.

While most respondents expressed that they are motivated to lose weight for health reasons, this motivation may not necessarily be sufficient if it comes hand in hand with the belief that one is healthy or relatively fit. Effective public health efforts to halt increasing overweight and obesity rates must take into consideration this disconnection between how the government measures healthiness and how individuals process health meanings.

Redefinitions of health also point to the overall importance of the experiences and knowledge of overweight and obese individuals, especially as a form of "situated knowledge" (Haraway 1991). While the health frame is considered authoritative, it has nevertheless failed at curtailing increasing obesity rates and improving health among this group of individuals. This inability is attributed in part to the dominant frame's failure to acknowledge the important role that situated or subjugated knowledges play in understanding this public issue. Public health policy must first begin by turning to how overweight and obese individuals experience their bodies, approach health, and think about their health-based motivations for weight loss. In a body-stratified and body-conscious society, their specific standpoint can help shed new light on how to improve their health and how to combat size-based discrimination.

Importantly, when discussing barriers to effective weight loss, respondents cited both individual behavioral variables and social structural variables. The latter include lack of time and insufficient funds. So even when conformists desired weight loss, many felt it was difficult given time and financial constraints associated with hectic working class lifestyles. Effective public health policy should intervene at this structural level. For example, public funds should be used to provide public gym facilities, parks, and recreation centers that

allow lower SES individuals to adopt healthier patterns. These facilities must be affordable and accommodate the timetables of individuals who often work two jobs while attending school. They should also have accommodations for younger children, as parents often cited children's supervision as a deterrent to exercise. Moreover, these facilities must encourage, through a welcoming environment, individuals of all body sizes to participate.

The data also point to a need for access to affordable healthy foods. Fast food, respondents claim, is cheap, convenient, and accommodating of their busy lifestyles. When inexpensive healthy alternatives are not accessible, it is not surprising that individuals turn to unhealthy foods that are easily and readily available. In short, public policy targeted at creating a healthier citizenry must go beyond providing health information. It must provide structural supports that enable individuals to translate knowledge into action.

The study also points to the prevalence and important role of size-based discrimination. Not only do overweight individuals want the social rewards that come with thinner bodies, they are trying to avoid the social stigma that accompanies being fat. Size-based bias, social stigma, and discrimination continue in part because the public feels that body weight is controllable and that fat people are responsible for their stigmatized condition. As the interviews demonstrate, this is a claim that even overweight and obese individuals believe. Efforts to address social injustice and combat increasing rates of overweight and obesity must begin by acknowledging the social structural environment that fosters unhealthy consumption patterns. Efforts must also debunk the myth that obesity is caused by internal, individual, or behavioral factors alone; genetics and the social environment also play key roles. Public education aimed at increasing understanding of the

myriad causes of weight gain may in turn help reduce size-based stigma. Given the gendered nature of the body ideal, special effort must also be made to ensure that women who do not possess body privilege are able to navigate public spaces comfortably.

Extensions and Additional Questions

The dissertation data permit several research questions to be addressed that are not reported here. First, the data provide for analysis on a range of questions that have not been reported here. Specifically, I do not detail general resonance of the health frame in the dissertation. While I observed the redefining of health among a smaller sample of overweight and obese individuals, how do individuals with a range of body types respond to the health frame? Future research will report the overall resonance of the health frame, including specific details about respondents' health knowledge and what they believe are the causes of obesity. Similarly, the dissertation does not report systematically the general resonance of the social justice frame. While I discuss resonance of the social justice frame indirectly (in the sections on the beauty and market choice frames), both the survey and interview data provide for a more pointed discussion of the social justice frame's overall resonance. Does the fat acceptance movement resonate among individuals with various body sizes? The dissertation clearly documents discrimination (a major tenet of the movement), but do individuals agree with statements such as "body weight should be a protected legal category" and "society should be more accepting of all body sizes"? Future research will detail the overall resonance of the fat acceptance movement including these more specific tenets. Preliminary interview data analysis suggests that interview respondents are not only unaware of this movement, but that they disagree with its propositions. This is

not surprising, given the strong support for the food industry's position and the belief in individual responsibility, a claim that fat acceptance activists challenge.

Second, the dissertation points to a number of additional research questions for future research. Redefinitions of health suggest that researchers should explore more thoroughly the sources and reasons for these redefinitions and, moreover, how they play into self-definitions. If overweight and obese individuals define themselves as healthy, do they adopt the labels such as overweight and obese? Moreover, what are the medical and social psychological implications of the rejection or acceptance of these labels? Given the redefining of health along more psychological lines, researchers should further explore alternative approaches to health and their relationship to other outcomes. For example, what is the relationship between religiosity/spirituality and body image? How do these health redefinitions mediate the relationship between body image and social-psychological variables such as self-esteem, confidence, and happiness?

The importance of body image, along with the prevalence of social stigma and discriminatory treatment, particularly for larger women, also points to the need for future research on the gendered nature of the beauty ideal, especially in public spaces. Moreover, how do other status characteristics affect how the body is experienced on a daily basis? While status characteristics such as gender, race, and BMI are important, researchers should examine the role of other visible physical features. For example, how do facial features, visible handicap, and/or height intervene and influence the experience of beauty privilege or non-privilege? Body mass is only one visible status characteristic that intersects with other characteristics influencing social treatment and how the self is experienced and constructed.

There is a need to document the personal narratives surrounding body privilege that take into account these intersections.

Findings about the food industry also raise questions for future research. While there is overwhelming support for the food industry's position and the belief in individual responsibility, there are a handful of skeptics who are critical of the industry's intentions. What separates the skeptics from the believers? To what extent is the industry accommodating the health needs of its consumers? Additionally, to what extent do individuals believe that that industry is changing and accommodating their needs? What are the social and health implications of these beliefs?

Finally, while I consider four key cultural frames about the overweight body, other frames or sub-frames exist. Within the health frame, for example, given the medicalization of obesity, how do pharmaceutical companies and bariatric surgeons approach this issue? Within the beauty frames, how have the diet, cosmetics, and fitness industries responded to competing frames as public discourse over the fat body increases? What other competing and complementary frames exist and what are their implications for individuals whose bodies do not conform to the health and aesthetic ideals?

Culture is an elusive concept that does not parcel out neatly for empirical study. However, as identifiable and measurable elements of culture, cultural frames provide one way to tap into cultural meanings and the relationship between culture and agents. By studying both framing competitions and the relationship between frames and agents, my dissertation sheds light on competing motivations for weight loss behavior, how cultural processes surface in daily lives, perspectives on responsibility, and the prevalence and

processes around size-based discrimination. In sum, the dissertation produces an in-depth understanding of cultural frame competitions and the relationship between frames and agents – an understanding that will hopefully lead to sound public health policy and to greater social equality. ☺

APPENDIX A: SURVEY INSTRUMENT

Contested Meanings about Body, Health, and Weight:
A Research Study

Introduction
You are invited to participate in a study conducted by a Ph.D. candidate in the Department of Sociology at the University of Arizona. The study is completely voluntary and you may decline to participate or withdraw from participating at any time. The study examines cultural messages about weight and strategies of health action.

Instructions
Please fill in or check ☑ the most appropriate response. If multiple answers apply, select the most appropriate answer unless otherwise indicated.

1. How old are you? _____

2. What is your sex?
   - Female ☐
   - Male ☐

3. Which of the following best describes your current marital status?
   - Never married ☐
   - Married ☐
   - Separated ☐
   - Divorced ☐
   - Widowed ☐
   - Other ☐
     Specify: _____

4. Are you currently dating or seeing someone?
   - Yes ☐
   - No ☐

5. If you answered "No" please continue to Question 6. If you answered "Yes" please answer Question 5(a).

    a. How long have you been dating or with the person you are currently seeing?

    _____

6. What is the highest level of education you have received?

Some high school	☐	Associate's degree	☐
High school graduate	☐	Bachelor's degree	☐
GED	☐	Master's degree	☐
Some college	☐	Other	☐
		Specify: _____	

7. Which of these **racial** categories best describes you?

White alone	☐
Black or African-American alone	☐
American Indian or Alaska Native alone	☐
Asian alone	☐
Native Hawaiian or other Pacific Islander alone	☐
Other race alone	☐
Specify: _____	
Two or more races	☐
Specify: _____	

8. Are you of Hispanic or Latino **ethnic origin**?

Yes	☐
No	☐

9. What is your household income before taxes?

Less than $19,999	☐	$60,000 to $69,999	☐
$20,000 to 29,999	☐	$70,000 to $79,999	☐
$30,000 to 39,999	☐	$80,000 to $89,999	☐
$40,000 to 49,999	☐	$90,000 to $99,999	☐
$50,000 to 59,999	☐	More than $100,000	☐

10. Are you currently working?

Yes	☐
No	☐

11. If you answered "No" please continue to Question 12. If you answered "Yes" please answer Questions 11(a) and 11(b).

    a. What is your job? _____

    b. How many hours a week do you work? _____ Hours a week

12. How many children or stepchildren do you have in preschool and grades K-12 that live with you?

    _____ **Preschool** children or stepchildren

    _____ **Grades K-12** children or stepchildren

13. What type of work do your mother and father do?

	Father	Mother
Professional and technical (e.g., doctor, teacher, engineer, artist, accountant)	☐	☐
Administrative and managerial (e.g., banker, executive in big business, high government official, union official)	☐	☐
Clerical (e.g., clerk, office manager, secretary, bookkeeper)	☐	☐
Sales (e.g., sales manager, shop owner, shop assistant, buyer, insurance agent)	☐	☐
Service (e.g., restaurant owner, policeman, barber, janitor)	☐	☐
Skilled worker (e.g., foreman, mechanic, printer, seamstress, electrician)	☐	☐
Semi-skilled worker (e.g., bricklayer, bus driver, carpenter, sheet or metal worker, baker)	☐	☐
Unskilled worker (e.g., laborer, porter, unskilled factory worker)	☐	☐
Farm (e.g., farmer, farm laborer, tractor driver)	☐	☐
Do not have a father/mother or father/mother does not work	☐	☐
Other Specify: _____ (Father) Specify: _____ (Mother)	☐	☐

14. Where do you get most of your health information from? Check all that apply.

Doctor(s)	☐
Professor(s)/teacher(s)	☐
News media (paper, television, radio, internet)	☐
Academic books and journals	☐
Popular books and magazines	☐
Government publications and advertisements	☐
Internet	
Private websites	☐
Government websites	☐
Other	☐
Specify: _____	

15. What causes someone to be overweight or obese? Take no more than a minute and **list everything** you think causes someone to be overweight or obese.

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

16. What percent of the U.S. population do you think is overweight and obese?

    _____ Percent (%) **overweight** _____ Percent (%) **obese**

17. To reduce the risk of chronic disease in adulthood, how many times a week should an adult get (at least) **30-minutes of moderate-intensity** continuous physical activity? Examples of such activity are brisk walking, raking leaves, or moderate bicycling (about 6 miles per hour).

    _____ Times a week

18. To reduce the risk of chronic disease in adulthood, how many times a week should an adult get (at least) **20-minutes of vigorous** continuous physical activity? Examples of such activity are jogging, aerobics, or vigorous bicycling (more than 10 miles per hour).

    _____ Times a week

19. Have you heard of the Body Mass Index (BMI)?
    - Yes ☐
    - No ☐

20. If you answered "No" please continue to Question 21. If you answered "Yes," please answer Question 20(a).

    a. The Body Mass Index (BMI) is a good indicator of health.
       - Strongly disagree ☐
       - Disagree ☐
       - Neutral/no opinion ☐
       - Agree ☐
       - Strongly agree ☐

21. A healthy adult diet consists of how many servings of fruit and vegetables in a day? (A serving is about ½ cup.)

    _____ Servings of **fruit** per day _____ Servings of **vegetables** per day

22. For a healthy diet, **total fat intake** should comprise no more than what percent of an adult's total daily calorie intake?

    _____ Percent (%)

For questions 23 through 33, please indicate **your opinion** using the options provided.

	Strongly Disagree	Disagree	Neutral/No Opinion	Agree	Strongly Agree
23. Being obese can shorten your life span.	☐	☐	☐	☐	☐
24. Being obese increases your risk of hypertension, diabetes, and stroke.	☐	☐	☐	☐	☐
25. Obesity rates in America are increasing.	☐	☐	☐	☐	☐
26. Obese people are a burden to the economy or the health care system.	☐	☐	☐	☐	☐
27. Obesity is a health epidemic.	☐	☐	☐	☐	☐
28. Medical research stating that obesity is linked to death, disease, and disability is truthful.	☐	☐	☐	☐	☐
29. The government should spend more money combating obesity.	☐	☐	☐	☐	☐
30. Obesity is a medical disease.	☐	☐	☐	☐	☐
31. An obese person should seek medical help.	☐	☐	☐	☐	☐
32. Bariatric surgery, e.g., stomach stapling, is a safe procedure.	☐	☐	☐	☐	☐
33. Body weight is controllable.	☐	☐	☐	☐	☐

For questions 34 through 59, please indicate **your opinion** using the options provided.

	Strongly Disagree	Disagree	Neutral/No Opinion	Agree	Strongly Agree
34. Fat people are generally lazy.	☐	☐	☐	☐	☐
35. I would date a fat person.	☐	☐	☐	☐	☐
36. Fat people experience discrimination.	☐	☐	☐	☐	☐
37. A middle-aged adult who is **25** pounds overweight can be healthy.	☐	☐	☐	☐	☐
38. A middle-aged adult who is **50** pounds overweight can be healthy.	☐	☐	☐	☐	☐
39. Fat people could lose weight if they just tried.	☐	☐	☐	☐	☐
40. Fat is beautiful.	☐	☐	☐	☐	☐
41. Fat people who take up two airline seats should pay for two seats.	☐	☐	☐	☐	☐
42. Fat people should lose weight.	☐	☐	☐	☐	☐
43. Most weight-loss drugs are safe.	☐	☐	☐	☐	☐
44. Fat is ugly.	☐	☐	☐	☐	☐
45. An individual can be both fat and healthy.	☐	☐	☐	☐	☐
46. Body size should be a protected legal category like race, gender, and religion.	☐	☐	☐	☐	☐
47. We should not judge people for what they eat.	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neutral/No Opinion	Agree	Strongly Agree
48. People should have the right to be as fat as they want.	☐	☐	☐	☐	☐
49. Obesity researchers are economically motivated.	☐	☐	☐	☐	☐
50. There should be more depictions of fat people in the media, e.g., movies, television, magazines, etc.	☐	☐	☐	☐	☐
51. Fat people are fat because they do not have **time** to **exercise**.	☐	☐	☐	☐	☐
52. Fat people are fat because they do not have **money** to **exercise**.	☐	☐	☐	☐	☐
53. Fat people are fat because they are uneducated.	☐	☐	☐	☐	☐
54. Genetics plays a role in determining body weight.	☐	☐	☐	☐	☐
55. Fat people are fat because they overeat.	☐	☐	☐	☐	☐
56. Fat people are fat because they do not exercise.	☐	☐	☐	☐	☐
57. Fat people are fat because they do not have **time** to **eat healthily**.	☐	☐	☐	☐	☐
58. Fat people are fat because they do not have **money** to **eat healthily.**	☐	☐	☐	☐	☐
59. Adults are sensible enough to make their own decisions about what foods to eat.	☐	☐	☐	☐	☐

60. Approximately how many cans of regular and diet soda do you usually drink in a day?

_____ Cans of **regular** soda a day _____ Cans of **diet** soda a day

61. How many times a week do you usually engage in physical activity at a gym, health club, sports facility, recreation center, park, or around the neighborhood?

    _____ Times a week

62. In the last year have you tried, or are you currently trying, to lose weight?
    - Yes ☐
    - No ☐

63. If you answered "No" please continue to Question 64. If you answered "Yes" please answer Question 63(a).

    a. Why were, or are, you trying to lose weight? Check all that apply.
    - To be healthy ☐
    - To be thinner ☐
    - To gain muscle mass ☐
    - To feel good ☐
    - To comply with doctor's recommendation ☐
    - To be beautiful ☐
    - For an event, e.g., a wedding, party ☐
    - For a person, e.g., significant other ☐
    - For self esteem/confidence ☐
    - Other ☐
      Specify: _____

64. Approximately how many hours a week do you usually play video games?

    _____ Hours a week

65. In a day how many cigarettes do you usually smoke?

    _____ Cigarettes a day

For questions 66 through 77, please indicate **your opinion** using the options provided.

	Strongly Disagree	Disagree	Neutral/No Opinion	Agree	Strongly Agree
66. The food industry should sell whatever products it wants, including unhealthy products.	☐	☐	☐	☐	☐
67. Unhealthy food products should have warnings labels to indicate that they are unhealthy.	☐	☐	☐	☐	☐
68. There should be special taxes on unhealthy foods.	☐	☐	☐	☐	☐
69. There are too many fast food restaurants.	☐	☐	☐	☐	☐
70. The **food industry** is responsible for obesity.	☐	☐	☐	☐	☐
71. The **fast food industry** is responsible for obesity.	☐	☐	☐	☐	☐
72. Fat people should sue companies whose food contributed to their size.	☐	☐	☐	☐	☐
73. Fat people are responsible for their own bodies.	☐	☐	☐	☐	☐
74. The marketing/advertising of unhealthy foods to children should be restricted.	☐	☐	☐	☐	☐
75. The food industry influences government health policy.	☐	☐	☐	☐	☐
76. The **food industry** is partially responsible for obesity.	☐	☐	☐	☐	☐
77. The **fast food industry** is partially responsible for obesity.	☐	☐	☐	☐	☐

78. How many times a week do you usually do (at least) **30-minutes of moderate-intensity** continuous physical activity? Examples of such activity are brisk walking, raking leaves, or moderate bicycling (about 6 miles per hour).

_____ Times a week

79. How many times a week do you usually do (at least) **20-minutes of vigorous** continuous physical activity? Examples of such activity are jogging, aerobics, or vigorous bicycling (more than 10 miles per hour).

_____ Times a week

80. If you answered "0 times a week" to either Question 78 or 79 please continue to Question 81. If you answered "1 or more times a week" to either of these questions please answer Question 80(a).

    a. Why do you exercise? Check all that apply.

- To be healthy ☐
- To lose weight ☐
- To gain muscle mass ☐
- To feel good ☐
- To comply with doctor's recommendation ☐
- To be beautiful ☐
- To socialize ☐
- For enjoyment ☐
- For self-esteem/confidence ☐
- Other ☐

  Specify: _____

81. Approximately how many times a week do you usually purchase fast food such as McDonald's, Taco Bell, or Domino's Pizza?

_____ Times a week

82. Have you heard of the National Association to Advance Fat Acceptance (NAAFA) or the concept of "fat acceptance activism"?

- Yes ☐
- No ☐

83. Have you heard of the Center for Consumer Freedom?

- Yes ☐
- No ☐

For questions 84 through 97, please indicate **your opinion** using the options provided.

	Strongly Disagree	Disagree	Neutral/No Opinion	Agree	Strongly Agree
84. I am physically fit.	☐	☐	☐	☐	☐
85. Body image is very important to me.	☐	☐	☐	☐	☐
86. I consider myself beautiful.	☐	☐	☐	☐	☐
87. I wish I were thinner.	☐	☐	☐	☐	☐
88. I am very muscular.	☐	☐	☐	☐	☐
89. I am happy.	☐	☐	☐	☐	☐
90. If money was not an issue, I would have weight-loss surgery.	☐	☐	☐	☐	☐
91. I am satisfied with my body weight.	☐	☐	☐	☐	☐
92. I consider myself overweight.	☐	☐	☐	☐	☐
93. I consider myself obese.	☐	☐	☐	☐	☐
94. I live a healthy lifestyle.	☐	☐	☐	☐	☐
95. I have high self-esteem.	☐	☐	☐	☐	☐
96. I am a confident person.	☐	☐	☐	☐	☐
97. I am pretty or handsome.	☐	☐	☐	☐	☐

98. How much do you weigh? _____ ☐ Pounds ☐ Kilograms

99. How tall are you? _____ ☐ Feet/Inches ☐ Centimeters

100. Would you be willing to participate in a paid follow-up interview? Respondents who are chosen for the follow-up study will be compensated for their time and interviews will last between one and two hours.

No ☐
Yes ☐

If you answered "No" the survey is now over. Thank you for your time. If you have any questions or comments about this survey, please use the space below to comment.

If you answered "Yes" then please fill out the information on the next page. If you have any questions or comments about this survey, please use the space below to comment.

Questions or Comments:

Thank you for participating in this research. If you have any further questions or comments, please do not hesitate to contact the principal investigator, Samantha Kwan. She can be reached at skwan@u.arizona.edu or at (520) 622-1430.

Only if you are willing to participate in a paid follow-up interview should you fill out the following information. If you are chosen to participate in the follow-up study, the researcher will contact you using this information.

Name _____

Phone number _____

Email address _____

Address _____

_____

_____

_____

APPENDIX B: INTERVIEW INSTRUMENT

Contested Meanings about Body, Health, and Weight:
A Research Study

This is a study about culture and body. I'm asking different people to tell me how they feel and deal with certain cultural messages. It isn't a study where there are right or wrong answers or where I am testing some scientific theory. I'm just interested in what you think and your stories.

Autobiographical – Cultural History

Introduction

1. What do you do for a living? How long have you been doing that?

2. How many hours a week do you work?

3. So you're currently in college? What's your major? When will you be done?

4. Are you married?
   a. What does your husband or wife do?
   b. What is his/her highest level of education?

5. Do you have any children? How old are they? What do they do?

6. Is there anything unusual happening in your life or would you say that things are quite normal right now? Normal in what way?

7. What would you say are your priorities in life?

8. What is a typical weekday like? What is your typical weekend like?

Family and Childhood

1. Where did you grow up? What was your childhood like?

2. Can you tell me a little bit about your family? Brothers and sisters? Parents? What do they do? Highest level of education?

3. How would you describe your family's class background when you were growing up? How would you describe your class background now?

4. What kinds of food did your family eat while you were growing up? How healthy would you say you all ate?

5. Thinking back, how physically active was your family? What did they do?

6. When you were younger, how did you feel about your body? Do you remember when you first starting thinking about your weight?

    a. Was your body weight really important to you? Did you try to lose weight? Why? How?

    b. What kind of feedback (if any) did your family or friends give you about your body? How did this make you feel? Did anyone pressure you to lose weight?

    c. Are there any particular moments or experiences about your weight that stand out in your childhood?

    d. Walk respondent through time-line of experiences with body.

Body Every Day/Routine Experiences

1. Can you share with me some of your experiences about the following? Does your body weight affect these experiences? How aware are you of your body on a daily basis? When you do these things?

a. School or work?

b. Dating/relationship experiences?

c. Clothes shopping? Eating out?

d. Spare time/leisure activities?

Body and Weight (Cultural Frames)

Aesthetics (Current Perspectives and Actions)

1. Can you tell me a bit about your current thoughts about your body? What is your relationship to your body?

    a. First, is your weight something that is very important to you today? Something you care about or think a lot about? When did it become important to you as an adult?

    b. How do you feel about your weight? Are you satisfied with your body weight? Gauge satisfaction (scale 1 to 10). Is it important for yourself, your partner, for others, or for other reasons?

    c. Why are you dissatisfied or satisfied?

    d. How have your views about your body changed over time?

    e. How does your age affect your views? Your class? Your race? Your sex? Sexual orientation? How?

2. Do you think your childhood experiences about body, eating, and exercise impact your views today about these issues?

3. Do you feel any pressure to lose weight? If so, why? Where does this pressure come from? Are you currently trying to lose weight? How much are you trying to lose?

    a. Why are you trying to lose weight? (Health v. beauty v. other?) Was it recommended by a doctor?

b. How are you trying to lose weight? Are you on a diet program? Do you take diet pills? Have you ever thought about having weight loss, stomach stapling, or cosmetic surgery? Have you tried to lose weight in the past?

c. How are you feeling about the weight loss process? Success? Do you check the scale often? Why has it been difficult?

d. Do you feel you have a support system?

4. If applicable: You mentioned that you have a child (or several children). Did your relationship to your body change after pregnancy? How did you feel about your body after you gave birth? Did you gain weight? Have you lost the weight? How? Have your feelings about your body changed since you became a mother?

Strategies of Health Action

Food Consumption Patterns

1. What is your relationship to food? How would you describe your eating habits? Where do you think you get these habits from?

2. Are you content with your eating habits? If you could change anything about your eating habits, what would it be? Why has it been difficult for you to change your eating habits?

3. Do you take multivitamins or nutritional supplements? How often and why?

4. Do you read labels when you purchase foods? What do you look for? Do you find these labels informative or helpful? Why do you look at these labels?

5. What is your relationship to fast food or junk foods? How often do you eat fast food in a week? How much money do you spend on fast food in a week? Why?

6. Who does the food shopping and food preparation in your home? When you prepare meals, what is your primary goal? How often do you prepare meals at home? Eat out?

7. Do you smoke? Do you drink? How often?

8. How would you say your stress level is?

Physical Activity Patterns

1. What is your relationship to exercise? How would you describe your exercise habits? Where do you get these habits from?

2. Are you content with your exercise habits? If you could change anything about your exercise habits what would it be? Why has it been difficult for you to change your exercise habits?

    a. How often do you do exercise? What do you do? Are you a member of a gym, recreation center, or sports facility? Are you physically active in some other way?

    b. Do you usually exercise alone or with someone else?

    c. Do you enjoy exercising?

    d. How long have you been exercising?

    e. Do you play video games?

Health and Health Knowledge

1. What does healthy mean to you? What does it mean to be healthy? What constitutes a healthy lifestyle? What makes someone healthy? What makes someone unhealthy?

2. Do you think you have a lot of health knowledge? Where do you get most of your health information from?

    a. Do you know what calories are? What is it? Do you count them? Why?

    b. Have you heard of the Body Mass Index (BMI)? What is it? If so, do you think it is a good measure of health? Why do you think that?

3. As a whole, do you consider yourself healthy? Why do you say that?

    a. How would you rate your healthiness? On a scale of 1 to 10, with 10 being very healthy, what would you say you are?

    b. Are there times when you feel healthier? Less healthy?

    c. How do you feel about that? How do you deal with it?

4. Do you think you make health a priority in your life? Are you health conscious? Why or why not?

5. What causes someone to be fat? Why do you think you are overweight or obese?

    a. What do you think is the role of genetics?

    b. Do you think of your weight as something you can control? Do you see yourself as responsible for your own body?

6. How often do you go to the doctor? What have your experiences been with doctors and other medical personnel? +/-/neutral experience? Are you personally concerned about any weight-related health issues?

7. Do you think you can be both overweight and healthy? What about obese and healthy?

8. Do you think that being overweight can shorten your lifespan? Do you think that it is linked to disease and disability?

9. Do you think the government should invest more, less, or about the same amount of time, money, and energy combating obesity? How? Why do you say that?

Labels and Self Perception

1. Do you consider or label yourself overweight or obese? Why or why not? How do you feel about these terms? What about the term fat?

2. In a few sentences, how would you describe yourself? I am…? Complete with what you think are the defining characteristics of you…

3. What makes someone beautiful/attractive? How would you describe a beautiful/ attractive person?

    a. What makes someone unattractive/ugly?

    b. Has this changed over time?

    c. Do you think fat or fat people are unattractive/ugly? Why do you say this? Has this changed over time? Would you date a fat person? Why or why not?

4. As a whole, do you consider yourself beautiful/attractive? Why do you say that?

    a. How would you rate your attractiveness? On a scale of 1 to 10 with 10 being very attractive, what would you say you are?

    b. Are there times where you feel more attractive? Less attractive?

    c. How do you feel about that? How do you deal with it?

5. Do you think you have high self-esteem and confidence? Why do you say this?

    a. How does your weight affect your self-esteem?

    b. Are there times when you feel more confident or have higher self-esteem? Less?

    c. How do you feel about that? How do you deal with it?

6. Do you consider yourself a feminist? If so, how do you think your feminist viewpoint affects your body image? Your views on body issues?

7. What is happiness? What does happiness mean to you? Do you consider yourself a happy person? Why or why not?

Popular Culture/Beauty Ideals

1. On a scale of 1 to 10, with 1 being low and 10 being high, how would you rate your media consumption? Why do you rate yourself as that?

2. Do you read any magazines? Which ones? Do you watch television? How much television do you watch in an average day? What do you usually watch? Are you a movie-goer? Internet usage? What do you like about them?

3. How do you feel about the beauty ideal presented in the media (say, in popular fashion magazines)? What do you think of these images? How important are these images and this ideal to you? How important are society's expectations of you?

Fat Acceptance, Discrimination, and Body Diversity: Society's Treatment

1. Have you ever been treated differently because of your body weight? Think about school, health care, leisurely activities, shopping, dating, employment experiences, etc.

    a. How have people treated you differently? Can you provide some specific examples? How do you respond to this?

    b. Do you ever feel socially stigmatized or isolated because of your body weight (like you don't fit in)? How does it make you feel? How do you respond to this?

    c. Have others ever made any assumptions about your health or fitness level? Ability?

2. How do you think our society views people who are not thin? What assumptions do you think are made about fat people? Can you provide some specific examples?

    a. Do you feel it is just thin people who treat overweight people differently or hold prejudice? How do you feel about thin people?

    b. Do you think it's different for men or women?

c. Do you think you are personally prejudiced against overweight people? How do you feel about overweight people?

3. Do you think that weight should be a protected legal category like race, gender, or religion? (Explain protected legal category if necessary.)

4. Have you heard of "fat acceptance activism"? If yes, what do you think about this perspective? If no, explain and then ask for opinion.

Food Industry

1. What role, if any, do you think the fast food or food industry plays in American obesity?

    a. Do you think that the food industry should be able to sell all types of products, including products that are unhealthy? Why or why not?

    b. Do you think "unhealthy" products should have special warnings labels as unhealthy? Why or why not?

    c. Do you think there should be special taxes on unhealthy foods? Why or why not?

    d. Do you think obese individuals should sue restaurants whose food contributing to their obesity? Why or why not?

    e. Do you think that adults are sensible enough to eat and drink whatever they want?

    f. Are children different? Should there be restrictions on the marketing of unhealthy foods to children?

Vignette I – Health Frame

Christina is 5'6" and weighs 220 pounds. Her BMI is 36 which means that, according to government standards, she is "obese." During her last check-up, Christina's doctor tells her that she must lose 80 pounds to be in the "normal" category. Because Christina is considered "obese," her doctor suggests that she be put on a weight-loss and exercise program. He tells her that losing this weight will significantly decrease her chances of premature death, type 2 diabetes, heart disease, hypertension, and stroke. If she is not able to lose this weight, he says she should consider bariatric surgery (also known as stomach-stapling).

1. What do you think about Christina's situation? What should Christina do?

2. Do you think Christina should go on a diet to lose the 80 pounds?

3. Do you think Christina should consider this surgery?

Vignette II – Social Justice Frame

Bill is 5'9" and weighs 200 pounds. His BMI is 29.5 which means that he is "overweight." Bill has a gym membership and, despite a busy schedule, he usually exercises three times a week for at least 30-minutes. He also watches his cholesterol and fat intake and ensures that on most days, he eats three healthy meals. Bill is a non-smoker and a social drinker. Although his doctor has told Bill that he is "overweight," Bill considers himself a healthy and happy individual. One day when Bill attempts to get life insurance, he is told that his premiums would be lower if he lost weight. He is medically defined as "overweight" and, as such, is formally defined as a health risk.

1. What do you think about Bill's situation? What should Bill do?

2. The doctor says Bill is "overweight." Do you think he should lose weight because his doctor says he is "overweight"? Do you think Bill is healthy?

3. Do you think it is fair that he must pay higher premiums because he is "overweight"?

4. Do you think he should lose weight to get the lower premiums?

Vignette III – Industry Frame

Mike is 6'0" and 230 pounds. His BMI is 31 which means that he is "obese." Mike believes that he should eat better and exercise more often, but unfortunately he works long hours at a very tiring job. He is often exhausted when he leaves work. It is convenient for him to pick up fast food or take-out on his way home and spend the evening watching television. One day at work Mike suffers a heart-attack.

1. What do you think about Mike's situation? What should Mike do?

2. Do you think Mike is to blame for his heart attack?

3. Should Mike lose weight?

Vignette IV – Beauty Frame

Maria is 5'3" and weighs 130 pounds. Her BMI is 23 which means that she has a "normal" BMI. Maria is constantly dieting trying to lose 15 pounds so that she can look beautiful for her wedding day. She has recently started taking weight loss drugs to accomplish this goal.

1. What do you think about Maria's situation?

2. Do you think Maria should lose weight?

Demographic Questions

1. Age _____

2. Height _____

3. Weight _____

4. Race _____

5. Are you of Hispanic or Latino **ethnic origin**? Yes ☐ No ☐

6. What is your **household** income before taxes?

Less than $19,999	☐	$60,000 to $69,999	☐
$20,000 to 29,999	☐	$70,000 to $79,999	☐
$30,000 to 39,999	☐	$80,000 to $89,999	☐
$40,000 to 49,999	☐	$90,000 to $99,999	☐
$50,000 to 59,999	☐	More than $100,000	☐

Conclusion

Is there anything else you think I should know or that you would like to share with, or ask, me? Thank you!

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