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SEVEN

Weapons of Mass Distraction in Teaching Fat Studies: "But Aren't They Unhealthy? And Why Can't They Just Lose Weight?"

Esther D. Rothblum

As co-editor of *The Fat Studies Reader* and editor of *Fat Studies: An Interdisciplinary Journal of Body Weight and Society*, I include fat studies as a topic in all my university courses in women's studies, psychology, and LGBT studies. In addition, my colleagues often invite me to speak about fat studies in their classes. The good news is that a few universities now offer specific fat studies or Health At Every Size courses (see Watkins, Farrell, & Hugmeyer, 2012). In my own lectures, I focus on control of women's appearance in general; the history of fat; media focus on weight; the "war on obesity"; weight and capitalism; the intersection of weight with gender, race, and sexual orientation; weight stigma in employment; weight anti-discrimination laws; and the creation of fat studies. Yet I have found that it is impossible to talk about fat oppression without being asked about the health risks of fat and why fat people can't just lose weight. These two questions are so often the focus of students that I have termed them "weapons of mass distraction." This chapter focuses on how to deal with these issues in a manner that doesn't distract from the substantive content of fat pedagogy.

Placing Weight Obsession Into Historical and Cultural Focus

In my teaching, I begin by examining appearance norms across time and culture, and emphasize that women in particular have always been told how to look. Susan Brownmiller (1984) offers an excellent review of the ways in which women's appearance is controlled and manipulated in her book *Femininity*; I list some of her points on slides in my teaching as follows:

- Women are expected to look and dress in ways that immobilize them;
- These constricting norms are thought to be the invention of women themselves;
- Without conformity to these norms, women are considered ugly or immoral by men;
- Without conformity to these norms, women cannot marry or function in society;
- These norms exaggerate the smallness of a feature that is already smaller in women than in men;
- These norms are considered trivial when in fact non-conformity to this fashion has vital consequences for women;
- The constricted body part or article of clothing is considered highly erotic by men;
- The medical establishment endorses the practice as health promoting while at the same time treating large numbers of women for medical complications resulting from this practice.

To illustrate these factors, I use the examples of women wearing tight corsets made of whalebone in Western cultures and the practice of binding girls' feet in China; both practices symbolized women's beauty and wealth in recent centuries. Even though women's waists are already smaller than those of men, and so are women's feet, these practices further exaggerate the smallness of women's features. I point out that women with bound feet couldn't walk or run, and that corseted women would faint when moving quickly because the pressure of the corset impeded their lung capacity. Yet women who didn't engage in these practices couldn't marry, and physicians at the time viewed corsets as a healthy method for strengthening women's spines.

In my experience, describing outdated appearance norms provides students some distance from these topics and thus allows students to understand the role of cultural and social control. Students often express shock when I describe some of the details of these practices. I then ask how the current obsession with weight fits into Brownmiller's criteria, and students are able to describe some of the parallels. They point out that women generally weigh less than men, yet women experience greater pressure to be thin than men. They state that thinness is a major criterion for women's beauty and marriageability. Sometimes students add that weight loss programs make women feel weak and tired—a form of immobilization. They may also mention that the medical profession focuses on "ideal" weights yet treat numbers of young women for eating disorders or fatalities from extreme weight loss programs.

Next I define the term *fat* and delve into the history of fat, including presenting slides of "Venus figures" from as far back as 40,000 years ago. I discuss Laura Fraser's (2009) chapter "The Inner Corset: A Brief History of Fat in the United States" from *The Fat Studies Reader*, in which she states,

> Once upon a time, a man with a thick gold watch swaying from a big, round paunch was the very picture of American prosperity and vigor. A hundred years ago, a beautiful woman had plump cheeks and arms, and she wore a corset and even a bustle to emphasize her full, substantial hips. Women were *sexy* if they were heavy. In those days, Americans knew that a layer of fat was a sign that you could afford to eat well and that you stood a better chance of fighting off infectious diseases than most people. If you were a woman, having that extra adipose blanket also meant you were probably fertile, and warm to cuddle up next to on chilly nights. (p. 11; emphasis in original)

Fraser focuses on how the image of "fat as good" prior to the 1880s in the United States changed to "fat as bad" by the 1920s. I ask students what could account for this change, and focus on three of Fraser's points: food production increased so that fatness was no longer a sign of wealth, weight became associated with morality, and there was a wave of immigrants into the United States during that period so that people of northern European descent "wanted to distinguish themselves, physically and racially, from stockier immigrants" (2009, p. 12).

As part of the history of fat, I end this section by describing the formation of the National Association to Advance Fat Acceptance (NAAFA), the Fat Underground, and the *Fat Liberation Manifesto* (Freespirit & Aldebaran, 1973). I describe that Surgeon General C. Everett Koop declared "war on obesity" in 1995 as part of the *Shape Up America Campaign* with over $1 million in funding from Weight Watchers, Jenny Craig, and Slimfast (Lyons, 2009). In this way, I also draw an association between weight and profit in capitalist societies.

Linking Weight to Income

It is imperative for an understanding of weight and health to discuss economic factors. I tell students that research in "developed" nations finds that poor people are fat and rich people are thin, and that this association is particularly pronounced for women. I ask students why they think that weight is inversely correlated with income. Nearly always (well, always, really), students believe that poor people are fat because of their inability to afford nutritious food or memberships in fitness clubs. They point out that poorer people have lower levels of education and therefore may not know which foods are high in carbohydrates, calories, or sugar. And poor people might work several jobs, they add, and so have no time to exercise. In other words, they assume that poverty causes fatness. First you are poor, and due to poverty (poor nutrition, less exercise), one becomes fat.

In fact, my research on employment discrimination and that of others has shown that there is stronger evidence for the opposite direction of causality—fatness leads to poverty due to discrimination and downward social mobility. A large body of research has shown that fat people, especially girls and women, are negatively evaluated by children, adolescents, and adults, as well as by physicians, medical students, and nutritionists, and even landlords discriminate against heavier renters (see Wann, 2009). Heavier applicants are less likely to be accepted into elite universities (Canning & Mayer, 1966), and less likely to receive financial support for college from their parents (Crandall, 1991, 1995). In the work setting, fat people are less likely to be hired, perceived as having undesirable traits, more harshly disciplined on the job, given inferior assignments, paid less, viewed as liabilities for employee health benefits, and fired for not losing weight (see Fikkan & Rothblum, 2005). Additionally, fat women are more adversely impacted by employment discrimination than fat men, including in hiring, promotion, performance evaluation, and salary (see Fikkan & Rothblum, 2012). In sum, as Paul Ernsberger (2009) has written: "While there is evidence that poverty is fattening, a stronger case can be made for the converse: fatness is impoverishing" (p. 26).

Furthermore, in the case of heterosexual women, thinner women tend to marry wealthier men (see Fikkan & Rothblum, 2012). In contrast, men are considered "marriageable" based on economic success rather than appearance. I tell students that if I had two sisters, one thinner and the other fatter than I am, my thinner sister would be more likely to get accepted to

an elite university, get her tuition paid by our parents, marry a more successful man, and have greater success in her career.

It is also important to mention the intersection of race, ethnicity, and income in the United States. Given the strong relationship between weight and income, Paul Campos (2004) has argued that fat prejudice is a subtle way to discriminate against poor people (and thus also people of color) without being viewed as overtly racist and classist. Media depictions of fat children and adults often use words that are "code" for race or ethnicity. Natalie Boero (2009, p. 116) describes how media chastise mothers who give their children "pan dulce" (Mexican sweet bread) or "collard greens smothered in fatback" (part of traditional African American southern cooking).

Finally, it is vital to mention that a multibillion-dollar weight loss industry has a lot to lose (no pun intended!) if people become satisfied with their weight. The diet food, diet soda, diet book, diet cookbook, cosmetic surgery, bariatric surgery, diet spa and retreat, and fitness club mega-industries are quick to voice their objections in the media whenever a study shows that weight is unrelated to health or that diets don't work. A major contradiction common in the media, possibly driven by media's ties to industry, is to report on a research study that indicates diets don't work or "obesity" is genetic and then to imply (usually in the last paragraph) that all that is needed is a stricter diet, better self-control, or other variables that blame the individual for the weight. In other words, the body of the article is indicating that weight is not under personal control, whereas the ending advocates for personal weight loss. For example, the *Washington Post* (Squires, 1994) reported on the "obesity gene," confirming that "obesity" is genetic. Yet a textbox in this cover story is entitled "setting a goal for weight loss gets harder with age" and focuses on the weight loss progress of one man who wanted to lose weight in time for his fiftieth birthday.

Exposing Methodological Flaws in the "But Aren't They Unhealthy" Myth

I begin this section by pointing out that there are plenty of media stories about "the obesity epidemic" but also plenty about our increasing life expectancy, yet these two topics are never presented together. For example, an article entitled "Epidemic of Obesity" in the *San Francisco Chronicle* stated, "Some 40 to 50 percent of food eaten by kids is consumed at school, and school cafeterias often offer prepackaged, unhealthy food" (2012, p. E10). Yet 6 months earlier, an article in the same newspaper entitled "Americans Are Living Longer, Need More Services" had a very different slant: "The number of Americans at least 90 years old has tripled in recent decades. ... People are living longer for a variety of reasons—with better and more available medical care and improved nutrition topping the list" (2011, p. A9). It is interesting that the same newspaper describes nutrition as poor in the first example and good in the second one.

Research on Weight and Health Does Not Control for Income

Given the strong association between weight and income, it is perplexing how rarely studies control for income. Research comparing fat and thin people is simultaneously comparing poor and rich people. Especially in the United States, where there is no national health plan,

poor people are less likely to have adequate health insurance and access to quality health care. Consequently, they may wait longer to see a health care provider and may put off preventive health care because of its high cost.

Dieting Is Associated With Health Problems, and Heavier People Are More Likely to Diet

Fat people in the United States have dieted more than thin people, and dieting (even when it's a so-called healthy diet, whatever that might be) is associated with health risks. Research on laboratory animals demonstrates that putting animals on a diet (i.e., limiting available food until they have lost a certain amount of weight and then letting them eat freely until they have regained the weight) is associated with a host of health problems, including high blood pressure, craving fat, high cholesterol, heart disease, and death (see Rothblum, 1990). Furthermore, with each subsequent "diet," it takes animals longer to lose the weight and a shorter time to regain it. The same is true of people.

Fat People Are Reluctant to Seek Medical Treatment Because of How They Are Treated in Health Care Settings

An additional factor that increases health risks is that fat people report negative experiences in medical settings and thus are more likely to avoid or delay medical care. Research has shown that medical students and physicians hold negative attitudes towards fat people (see Fikkan & Rothblum, 2012). Fat people report disrespectful treatment, embarrassment at being weighed, negative attitudes of providers, unsolicited advice to lose weight, and medical equipment that does not fit their size as reasons for avoiding visits to the doctor.

Examining Myths About Weight and Mortality

A discussion of weight and health is not complete without some focus on mortality since fat people are often told that they will die. I remind students that, unfortunately, all of us will die—the mortality rate is one per person. I show a cartoon from *The Onion* (1997) that states: "World Death Rate Holding Steady at 100%." Ernsberger (2009) has reviewed studies on weight and mortality. He reports that research that finds fat people at *lower* risk for mortality than thin people includes studies of German construction workers, San Francisco longshoremen, residents of rural Scotland, residents of Fiji, and elderly populations. Studies that find no connection between weight and mortality include research on Black people in Charleston, South Carolina, Black women insured by Kaiser Permanente; residents of rural Italy; residents of American Samoa; and Maoris in New Zealand. Finally, studies that do find fat people at high or moderate risk for mortality are those of life insurance policyholders; Harvard alumni, residents of Framingham, Massachusetts; American Cancer Society volunteers; residents of Finland; and White women in Charleston, South Carolina. Ernsberger points out that it is this last group of studies—focusing on privileged populations—that are most often cited in textbooks and in the media.

Exposing Methodological Flaws in the "But Why Can't They Just Lose Weight" Myth

For college students who are young and who have generally not experienced serious health problems, critiques of the connections made between weight and health may be less threatening than critiques about dieting. College students are typically dieting for reasons of attractiveness, not to improve health. In every classroom there will be many students who are currently dieting, and informing them that diets don't work in the long run is discouraging. In my experience, they will push back with stories of how well their own "healthy" diets are working; for that reason, in general, I don't leave much room for student discussion when I review this topic.

Weight Loss Programs Have High Attrition

It is logical to assume that the effectiveness of dieting is assessed by weighing all participants before and after a weight loss program. But in fact most weight loss studies have considerable attrition, as participants drop out of treatment, particularly if they are in the waiting list control group, don't like the treatment condition to which they are randomly assigned, or are not losing weight (see Rothblum, 1999). This means that the post-treatment and follow-up data are based on those participants who stuck with it, who were willing to attend the treatment sessions regularly and engage in the activities associated with the treatment, and who were able to lose weight.

How Is "Success" Measured?

In many areas of medical and health intervention, success is defined as change from "clinical" to "normal" levels. Take the case of smoking cessation programs. No matter how many packs of cigarettes participants are using on a daily level, the success rate of the program is defined as the percentage of smokers who quit, who don't smoke at all. Similarly, depression treatment programs admit people who have scores at the clinical level on depression scales and then measure success by the percentage who score below that level after treatment.

If weight loss programs used these criteria, none of the results could be published. People don't lose enough weight to move from Body Mass Index (BMI) scores at the "overweight" and "obese" levels into "normal weight" BMIs (for a critique of the BMI in general, see Ernsberger, 2012). Instead, "success" is defined in number of pounds lost. Imagine if smoking cessation programs counted the number of cigarettes smoked pre- and post-treatment.

People Do Not Keep Off the Weight They Lose

Commercial weight loss programs typically do not publish long-term, follow-up data, but among research studies, the long-term (5 years or more) failure rate of diets is 90 to 95 percent (Gaesser, 2009). In the early 1990s, my graduate student Jeanine Cogan examined the results of 50 published weight loss programs (Cogan & Rothblum, 1993). The typical participant across all of these studies was a White, middle-class woman who was 48 percent over "average" weight before treatment, who lost 12.8 pounds during a 13-week treatment program, and then regained 4.3 pounds over the next 6.5 months. To put this into context, I tell students that if the participant's "ideal" weight should be 120 pounds according to BMI charts, then at nearly 50 percent over that average she would weigh about 180 pounds. That meant

that her weight would decrease to about 167 pounds after treatment, and then rise back to 171 pounds 6 months later. I ask students whether a change from 180 to 171 pounds would make a difference in this woman's health or even affect her clothing size. Certainly she would be nowhere near the "normal weight" category according to the BMI. There has been little research about how people feel about their repeated failures in losing weight. As early as 1958, Albert Stunkard stated, "Most obese persons will not stay in treatment of obesity. Of those who stay in treatment most will not lose weight and of those who do lose weight, most will regain it" (p. 79). More than 60 years later this statement is still true.

The Health at Every Size Movement and Strategies for Overcoming Student Resistance

A logical ending to the discussion of the myths about health and dieting is introducing students to the Health At Every Size (HAES) movement, a public health initiative that focuses on health for all people, regardless of body weight (see Bacon, 2008; Burgard, 2009). HAES emphasizes improving nutrition and enjoying food, and also the joy of movement instead of adherence to a structured exercise program. HAES clinicians strive to end bias against fat people, and underscore the fact that we cannot tell people's health or fitness level just by looking at them. Health is defined as physical, emotional, and spiritual well-being, and HAES clinicians focus on everyone appreciating their body and its appearance.

Deb Burgard (2009) describes how regimens that are prescribed for fat people would be defined as eating disorders if thin people engaged in them. She also states:

> If people have to do things in their day-to-day life in order to achieve a particular weight that a study says would be healthier, and the things they have to do (like stomach surgery, starving, or exercising 4 hours a day) are not compatible with loving self-care, then by definition, that is not a "healthy" weight for that individual. It would be like starving a St. Bernard because a study of dogs shows that greyhounds live longer. We are genetically like different breeds of dogs, but we can't tell what breed we are by looking. (p. 44)

HAES practitioners de-emphasize weight and dieting, and argue that if diets don't work in the long run, we are doing people a disservice by promoting such failure experiences. It is not easy to take on the multibillion-dollar weight loss industry in one lecture, or even one semester. Over the years I have used a few strategies for overcoming student resistance. First, I begin by stating that I have two areas of research, one mainstream and the other radical. I tell students that my "mainstream" research is on lesbian studies! I was hired by my current university for a position in lesbian studies; not that long ago professors would have been fired for coming out as sexual minorities. I explain that my "radical" research area is fat studies. This statement not only implies that what is considered radical today may become mainstream in the future, but also introduces the term "fat" early on.

Conclusion

As a fat woman myself, I realize that students would be more convinced by a thin professor. So I explain that in any area of oppression, the earliest scholars were usually white, middle- or

upper-middle-class men, simply because members of oppressed groups (women, people of color, working-class people) experienced barriers to entering the academy. Thus, there are some prominent thin scholars who have conducted research in fat studies, yet it is a mark of success when members of an oppressed group begin to write and teach about themselves. I also remind students that there is great room for fat allies to do good work to help address fat oppression. For example, thin people are sometimes more likely to hear fat-oppressive comments directed at fat people behind their backs and can, and need to, become fat-affirmative activists.

In sum, discussions of weight, health, and dieting cannot be ignored in fat pedagogy as long as our society is obsessed with these factors. As a social scientist and researcher on weight stigma, I have had to become well-versed in medical studies on the association among weight, health, and dieting. I thus encourage all educators interested in pursuing fat pedagogy to check out the Yahoo! Groups site ShowMeTheData.com wherein researchers analyze the results and potential confounds of current health and medical studies. With such information at hand, educators engaged in fat pedagogy can feel more confident in addressing typical forms of resistance and provide an environment that can foster a paradigm shift in attitudes about weight and stigma.

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