Fat America: A Historical Consideration of Diet and Weight Loss in the U.S.

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The United States is a nation obsessed with fat and, according to Fraser (1997), Americans are so wary of it that "two out of ten Americans now believe that all fat should be eliminated from the diet entirely" (p. 122). The popularity of this anti-fat movement becomes increasingly evident in the types of products available in U.S. supermarkets: almost every product has a no-fat, low-fat or reduced fat counterpart. Additionally, shoppers are constantly reminded of these options as they pass glossy magazines touting the latest diet foods and store displays promoting "healthy" (also known as low-calorie/low-fat) lifestyles. However, this obsession with "health" food is nothing new. Even though, as Kolata (2007) notes, "there is no real starting point for dieting, no date when it became clear that men and women were depriving themselves of food they craved because they wanted to look better or regain their health" (p. 34); it is clear that the United States government has long been invested in obesity, weight loss and the diet industry in general. In this chapter, first I map out some key historical threads that are especially linked to the phenomenon of reality TV weight loss programs and, then, I explicate obesity's reconceptualization as a medical disorder and interrogate the social implications as they pertain to the war on obesity.

U.S Weight Loss Policy in the 20th and 21st Century

For the purposes of this project I have identified the policies created in the 20th and 21st centuries as essential to the discussion of weight loss and RTV because this period brought about, "the formulation of the new bodily ideal" (Featherstone, 2001, p. 180). During this time U.S. beauty ideals became less obsessed with the molded/corseted body and began to favor a more slender aesthetic. Featherstone explains, "one of the most noticeable features of the twentieth century […] has been the triumph of the thin woman over the fat woman. It can be added that in the second half of the twentieth century this ideal is becoming firmly established for men too" (p. 184).

It is during this time period that the obsession with weight loss and thinness emerges as a dominant cultural ideal. Equally as important, new broadcast innovations made it easier to advertise and promote these new bodily ideals and, as Featherstone notes, "the Hollywood cinema helped to create new standards of appearance and bodily presentation, bringing home to a mass audience the importance of 'looking good'" (p. 179). Since then, "within consumer culture slimness has become associated with health and the health education message that being overweight is a health risk has become absorbed into the conventional wisdom" (Featherstone, 2001, p. 185).

In the last century the U.S. government has become increasingly involved in fitness promotion and has worked to develop a series of programs/institutions designed to reduce obesity rates across the nation. Around the time of World War II government interest in weight loss intensified while the need for fit/healthy soldiers was seen as essential to national security/defense. As a result, "in 1940, the U.S. National Academy of Sciences established a committee to advise the government about nutrition problems that might affect national defense; this committee became the Food and Nutrition Board in 1941" (Nestle, 2007, p. 35). As one of the first government committees specifically charged with examining fitness/nutrition the Food and Nutrition Board worked to raise public concern about rising obesity rates by linking these rates to a decline in national security. Following World War II this fear only intensified, and as early as the mid-1950s the issue was deemed a national obsession (Berrett, 1997). During this post-war period,

the discourse of diet evoked a society in which the problem was always too much rather than too little, a choice of focus that allowed dieters (an millions of their fellow Americans) to ignore the hunger afflicting what Michael Harrington would describe as 'the other America.' Governmental attempts to instill a

national spirit of fitness sharpened that vision (or blindness) by simultaneously describing such luxury as a source of weakness and calling on the public to defend it. (Berrett, 1997, p. 806)

Even President John F. Kennedy made his feelings about the importance of fitness public in saying "there are an increasingly large number of young Americans who are neglecting their bodies, whose physical fitness is not what is should be, who are getting soft […] Such softness […] can help to strip and destroy the vitality of a nation. This is a national problem" (Berrett, 1997, p. 806). As the government continued to increase its involvement in the nation's "health" problems, arguments promoting fitness as a "means by which individuals could improve America" (as quoted in Glassner, 1989, p. 182) increased in popularity. Furthermore:

> [t]hose advocating exercise and healthful diets spoke of 'regeneration' and preparing Americans for a bright new day. They also evoked notions – which had been deployed in health movements earlier in the 1800s – of citizenry that had recently been strong and virtuous but was going flabby as the result of too much affluence. (Glassner, 1989, p. 182)

Despite efforts to curb previous trends the rates of obesity only continued to climb and by the 1980s there was a documented "widespread and growing interest among middle and upper class Americans in the pursuit of fitness" (Glassner, 1989, p. 180). Capitalizing on this interest in fitness, in 1994 Surgeon General C. Everett Koop helped to create and promote "Shape Up America!" (hereafter SUA) (Herndon, 2005), which is still an active program today. According to SUA's website, its purpose is to "educate the public on the importance of the achievement and maintenance of a healthy body weight through the adoption of increased physical activity and healthy eating." The concept is simple: if the government can educate its citizens, than they will utilize that knowledge and lose weight. Unfortunately, despite governmental efforts, these educational programs have not been successful and by the year 2000 obesity rates reached their highest level yet, with "the number of overweight people in the world for the first time match[ing] the number of undernourished people – 1.1 billion each" (Nestle, 2007, p. 16). Although the premise of SUA is promising, its reliance on dieting is inevitably its downfall and, as I will explain later in this chapter, it signifies a trend that continually repeats itself.

Still determined to "solve" the problem of obesity, federal and state governments have created a range of programs aimed at promoting weight loss. The most notable of these arose in 2001. Surgeon general David Satcher "fired the first shot in the federal government's current war on obesity when he released the *Call to Action to Prevent and Decrease Overweight and Obesity*" (Oliver, 2006, p. 177). While previous programs focused more heavily on the promotion of education about healthy living practices, the "war on obesity" relies on a more simplistic approach: eat less and exercise more. For example, people are directed to eat foods with reduced fat and calorie content, focus on portion control and spend more time being active. As Oliver (2006) puts it, "the country needs to go on a diet" (p. 177). In order to help promote the eat less, exercise more approach Mark B. McClellan, M.D., Ph.D. and Commissioner of Food and Drugs created the FDA's Obesity Working Group, designed to research the obesity epidemic and determine the best course of action (FDA, 2008). According to the FDA website,

> the agency released, on March 12, 2004, the final report of its Obesity Working Group. The group's long- and short-term proposals are based on the scientific fact that weight control is mainly a function of caloric balance. That is, calories in must equal calories out. So FDA is focusing on "calories count" as the basis of its actions and the message of its obesity campaign. (Report of the Working Group on Obesity, 2008)

Following suit, the United States Department of Health and Human Services launched the African American Anti-Obesity Initiative in 2005 and the Childhood Overweight and Obesity Prevention Initiative in 2007, which both rely on the "eat less, exercise more" model.

So how is it that with all the scientific evidence suggesting these programs should work, that obesity rates are continuing to increase? This, in part, can be attested to the fact that the definition of healthy foods changes on a regular basis and the foods people are made to believe are healthy one day are deemed unhealthy the next or vice versa (e.g. eggs, chocolate). Adding to the downfall of dietary success is the fact that serving sizes are also in a constant state of flux. According to Nestle (2007) the distinct variations in dietary advice lead individuals to "suffer from 'nutritional schizophrenia,' and [they] cannot figure out how to achieve 'nutritional utopia'" (Nestle, 2007, p. 91). The most notable culprit leading to this "nutritional schizophrenia" is the food pyramid.

In the 80s and 90s the food pyramid, with its flashy pictures, colors and numbers hung proudly on the majority of public school cafeteria walls acting as a stern reminder of the importance of a "well-balanced" meal. While the pyramid was presented to the masses as *the* key to healthy living, it was troubling to some food producers while it "appeared to favor vegetarian diets, to reinforce 'the myth that meat is not good for you' and to give the impression that meat, dairy and eggs are bad food" (Nestle, 2007, p. 70). While meat and dairy farmers (iconic figures of the American heartland) stood to lose money if people chose to closely follow the pyramid, "officials increased the number of servings in the guide and made other conciliatory changes. Industry-friendly food guides avoid controversy by omitting 'eat less' recommendations" (Nestle, 2007, p. 70). And so, despite the fact that the beloved food pyramid "does not adequately assign foods to groups, define serving sizes, or distinguish 'good' from 'bad' kinds of fat" (Nestle, 2007, p. 68) and even though it does not clarify "that some serving numbers are meant to be the upper limits (meat, dairy, and the fat/sweets groups), whereas others are meant to be lower limits (grains, fruits, and vegetables)" (p. 68) it is used to "educate" and promote fitness among the masses. This is highly problematic when considering that the vast majority of weight-loss programs rely on the pyramid as a foundational element. While the government is working to promote the eat less, exercise more method it is undermining people's success by being unclear as to what people should eat less/more of.

Although it may seem illogical for the government to undermine its citizens' ability to lose weight, upon further examination it is evident that this is a kind of strategic plan and a prime example of Bordo's discussion of the bulimic nature of U.S. consumer culture. In creating programs like SUA, the "war on obesity" and other such programs government organizations are working, under the guise of health promotion, to simultaneously reestablish the importance of consumption (in terms of food/binging) while avoiding the *appearance* of overconsumption (through diet/purging). Maintaining this balance is of particular importance to hegemonic U.S. society on a fundamental level while "the body becomes a useful force only if it is both a productive body and a subjective body" (Foucault, 1984, p. 173). In this way people are not seen as just citizens, but as "biological citizens". As Rose (2007) explains, the term "biological citizenship describes "all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings" (p. 132).

The formation of good biological citizens through the forces of biopower, according to Foucault (Foucault, Rabinow & Hurley, 2004), is accomplished through a consideration of the *disciplines* and the *regulatory controls* of the body. *Regulatory controls,* for Foucault, are "conceived of as the exercise of sovereign rights, of feudal rights, as the maintenance of customs, as effective procedures for enrichment [. . .] or for preventing urban revolt" (p. 18). As Hewitt (2001) notes, these regulatory controls are "a biopolitics of the population" (p. 233) and are in integral part of establishing "good" citizenship. Additionally, modern conceptualizations of an ideal citizen, according to Foucault, require "that we cease to imagine 'power' as the possession of individuals or groups – as something people 'have' – and instead as a dynamic or network of non-centralized forces" (Bordo, 1993, p. 191). In this way, the focus on fat and diet "may function as one of the most powerful normalizing mechanisms of our century, insuring the production of self-monitoring and self-disciplining 'docile bodies' sensitive to any departure from social norms and habituated to self-improvement and self-transformation in the service of those norms" (Bordo, 2003, p. 186). Moreover, "[fatness marks the individual as a failed citizen in a number of ways: as not of the dominant social class, as an inadequate worker and consumer" (LeBesco, 2004, p. 59), and those who actively/productively participate in this process are able to become successful/valuable cultural citizens.

The idea that a "good" cultural citizen is one that pursues weight loss is increasingly problematic when considering the disparities between whites and non-whites in the United States and the social institutions that encourage these differences. Of course all individuals are encouraged to participate in cyclical dieting, but ethnic minority groups and poor people face different challenges than better earning white U.S. citizens. Moreover, as Nestle (2007) explains, "In the United States, low-income groups seem to have about the same nutrient intake as people who are better off, but they choose diets higher in calories, fat, meat, and sugar, and they display higher rates of obesity and chronic diseases" (p. 27). While this one of the dominant ideologies circulating about food and nutrition today, it is important to recognize that this "choice" to eat higher calorie foods is more often based on economic status than on personal choice. Nestle (2007) explains: "the gaps in diet and health are economically based, but they also derive in part from the social status attached to certain kinds of food – meat for the poor and health foods for the rich, for example" (p. 27). Because hegemonic U.S. society works to promote the idea that minority

groups have all the same weight loss opportunities as dominant groups, they are posited as victims of self-induced circumstance rather than as victims of a society that hinders their ability to succeed.

No matter what social group a person belongs to the expectation is that everyone will participate in this cyclical process. Thus, "diet has become a four-letter word in the commercial weight-loss business" (Fraser, 1997, p. 140). While people are growing more averse to participation in diet programs, the food/nutrition industries have had to reinvent the way people talk about weight loss and fitness. Instead of diets there are "food plans" and "lifestyle programs" (Fraser, 1997, p. 140). Instead of being overweight/obese/different, people are ill and in need of treatment. This move, from biological variance to disease, is part of medicalization, "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad, 1992, p. 209). In the following section I will describe the medicalization process and clarify its importance within the context of the war on obesity.

The Medicalization of Obesity

Obesity, "a condition caused by an excessive amount of adipose tissue" (Gard & Wright, 2005, p. 19) has a complex history in the United States. According to the World Health Organization, "overweight" is when a person has a "BMI [body mass index] equal to or more than 25, and 'obesity' as a BMI equal to or more than 30." Unfortunately, BMI, an accepted method of measuring overweight/obesity for decades, does not account for muscle density, bone structure or other factors that affect a person's physical weight. What seems to be a clear-cut and well-tested method of identifying obesity (and therefore health risks) is actually just another ambiguous variable in the discussion of obesity with ranges that have fluctuated significantly over the years (Cutler, et al, 2003, p. 96). Furthermore, although body weights are an inherent variable for all persons, it is only in recent years that society has moved create labels and standardized measurements for these variations. As Fraser (1997) explains, "as we have seen, a hundred years ago, except in extreme cases, fatness was considered a simple physical trait, a natural variation in human size" (p. 171) and not a medical condition. Positioning fat as abnormal/unnatural grounds the discourse that fat bodies are medically deficient and thus in need of medical attention.

As previously noted, obesity does have an understood and agreed upon definition with regard to who qualifies as obese. However, although excessive weight gain is commonly accepted as a detriment to one's health, "the disease status of this 'undesirable weight gain' seems to depend on its association with various illnesses not because fatness or weight gain itself is a disease" (Gard & Wright, 2005, p. 94). Furthermore, Levitsky reports "nobody ever dies of obesity […] it is often a marker for other health problems caused by a sedentary lifestyle, but is itself not necessarily dangerous" (as cited in Fraser, 1997, p. 176). Despite these discrepancies obesity is currently conceptualized as a medical issue while, as Conrad (1992) explains, the medicalization process does not lie solely in the hands of the medical community but rather is a "sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession" (p. 210). In adopting a medicalized notion of obesity hegemonic U.S. society can further encourage citizens to participate the cyclical process of weight-gain and diet in two ways. First, when people are labeled "sick" they are more likely to participate in regiments to improve their health. Second, framing obesity as a disease insinuates that there *is* a "cure" and therefore a permanent and obtainable weight-loss solution.

Additionally, medicalization serves a more general purpose in this society. As Fraser (1997) explains, during times of mass immigration, those of European descent "wanted to be able to distinguish themselves, physically and racially, from stockier immigrants" (p. 18) and "most efforts at measurement [of obesity] were meant to identify miscreants and justify racial and economic prerogatives among a white, aristocratic elite" (Oliver, 2006, p. 18). Generally speaking, medicalization helps dominant social groups to further distinguish obesity as a disease of the "other" and increases U.S. citizens' fear of fat. As Kelly Brownell suggests, obesity is "a condition that is unacceptable in our society" (as cited in Kolata, 2007, p. 70). This is because obesity is most often attributed to a person's lifestyle (whether that lifestyle is self-selected or not) and "unlike people who are blind or deaf, fat people are told that they could be thin if they really wanted to" (Kolata, 2007, p. 70). Therefore, those who remain obese are so because they choose to be. This line of thinking is problematic while "the constant blame-the-victim message … [is] not only demoralizing fat people but leading to a society in which prejudice against the overweight and obese has become the last remaining

socially acceptable one" (Kolata, 2007, p. 18). This is particularly interesting when considering that the number of obese people in the United States is increasing and, if current trends continue, the vast majority of U.S. citizens will become obese in the coming years.

While it is somewhat simple to identify what social groups benefit from medicalization, an examination of whom this hurts is more complex. Some obvious problems worth identifying are the misconception that the cause of obesity is an unexplainable bodily condition and the delusion that heart/respiratory/etc. ailments inevitably result from obesity. Although, these issues are certainly causes for concern and investigation, there are more dire consequences of the medicalization process that I investigate.

As LeBesco (2001) notes, "inarguably, current discourse surrounding body size and shape has worked to incorporate the protests of fat people against their own bodies; when civil rights are being demanded on the basis of genetic subjection of fat people, the fat body is effectively rendered uninhabitable" (p. 76). Therefore, medicalized obesity is highly problematic for fat advocacy groups like the National Association to Advance Fat Acceptance (NAAFA), a group that aims to de-normalize thin as the socially acceptable standard. Elaborating on this issue Kirkland (2003) explains, "establishing obesity as a disability [or disease] would contradict NAAFA's identity concept by setting fatness apart from thinness or normalcy and acknowledging that it is an affliction rather than simply par to the variation of healthy bodies" (p. 27). In this way, rather than working to de-stigmatize obesity, medicalization merely bolsters negative feelings towards overweight and obesity.

The goal of debunking the convolution of health and thinness has been the focus of many feminist scholars (e.g., Bordo, Spitzack, LeBesco) who have also critiqued medicalization. As Carole Spitzack (1990) argues, "a primary component in female socialization, then, requires teaching women to make 'objects' or spectacles of themselves. In learning to prepare herself for the active gazes of others, a woman becomes adept at seeing herself as others see her; she sees herself as an other" (p. 34). Throughout her discussion of the female body Spitzack explains that women are socialized to practice self-surveillance and that, in a Foucaultian sense, "a woman must identify herself as the principle of her own subjection, playing the roles of tower guard and prisoner simultaneously" (p. 45). Similarly, Bordo (2003) argues:

> culture not only has taught women to be insecure bodies, constantly monitoring themselves for signs of imperfection, constantly engaged in physical 'improvement'; it also is constantly teaching women (and, let us not forget, men as well) how to *see* bodies." (p. 57)

This idea of creating the ideal body image is, as Grosz (1994) discusses, an integral part of history for both men and women. She writes, "Freud had predicted that all 'man' would become a 'prosthetic god' through the supplementary use of tools and the instruments of civilization to compensate for 'his' biological defects and limits of 'his' facticity" (p. 79). When considering gender and the body it becomes clear that bodily maintenance is not only an aesthetic issue, but an issue of dominance and control as well because, while women are supposed to remain slender/small/submissive, men are to be hard/muscular/dominant. In her discussion of gender, the body, and medicalization Bordo (2003) notes, "what is obscured by the medicalization … is an adequate understanding of the ubiquitous and thoroughly routine grip that culture has had and continues to have on the female body" (p. 66). She suggests that "biology may protect men from eating disorders is not to be open to possibilities; it is to close one's eyes to the obvious" (p. 53). Through this medicalization process "medical labels have come into common parlance to give credibility to the aesthetic and moral evaluations" (Gard & Wright, 2005, p. 181) and today, "moral judgments are now bolstered by assumptions about the kinds of health practices that individuals engage in, that they have put themselves at risk and, furthermore, they are a cost to the nation that could be prevented" (p. 181). Furthermore, "these associations are possible only in a culture of overabundance – that is, in a society in which those who control the production of 'culture' have more than enough to eat" (Bordo, 2003, p. 192). While the U.S. is a prime example of a "culture of overabundance" it is important to consider the implications of this, as they relate to current ideologies regarding bodies and health.

There is no question that the U.S. population holds a prejudice against obese people because of this idea. Kolata (2007) acknowledges that there are distinct disparities between how obese and non-obese people are treated by the general public and reports that obese and overweight individuals "are less likely to be admitted to elite colleges, are less likely to be hired for a job, make less money when they are hired,

and are less likely to be promoted. One study found that businessmen sacrifice $1,000 in salary for every pound they are overweight" (p. 67). Taking this a step further, the war on obesity links to a "war on minorities" because there is a direct correlation between obese populations and minority populations. Nestle (2007) explains that rates of obesity among African-America and Hispanic children are increasing faster than those of white children and reports, "by the early 1990s, for example, 23% of white girls aged 6-11 were overweight, compared to 29% of Mexican-American girls and 31% of black girls" (p. 175). The disparities in body shape and size between whites and non-whites has been a long been an issue in the United States in particular. Even today minority groups unwilling to change their habits (refuse to participate in the diet industry game) are not merely shunned for having "wrong" bodies, but face an even more intense punishment in that they are permitted from being upwardly mobile. Take for example black and Latina women in the U.S. According to Fraser (1997) they "tend to be much less obsessed about their weight than white women" (p. 142). Instead of commending them for having an apparently heightened level of self-confidence "diet company advertisers are especially targeting upwardly aspiring minority women with the message that they're not going to make it in the professional world unless they lose weight" (Fraser, 1997, p. 143).

Conclusion

Turning again to the link between cultural citizenship and thinness I argue that the labeling of obesity as "disease" functions as a rhetorical device that works to reaffirm the binary oppositions between "thin"/healthy/productive and the "obese"/unhealthy/idle. The reinforcement of these binary oppositions works to ensure individuals remain aware of their status and remain focused on the end goal: thinness. The overarching theory behind this is that the adoption of a medicalized notion of obesity will generate a heightened sense of urgency, and as individuals become aware of their "illness" they will work harder and be able to achieve a state of healthiness/thinness. They can then be welcome as "normal" members of society. Unfortunately, even if this theory sounds promising, it is entirely implausible, because no matter how strong a desire some people have to achieve a state of thinness/health (think Hollywood movie-star thin) it is simply not an option for the majority. The only aspect of the theory that holds true is that the medicalized notion of obesity does generate more intense feelings of anxiety/fear of becoming obese.

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