

Controlling Bodies: Mothers, Adolescents and Bad Advice

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Abstract

Since the 1990s, medical and media articles containing the word “obesity” inevitably included the word “epidemic” as well. These articles usually pointed to the exponential growth in overweight and obese persons in high-income and low-income countries alike. A recent field of literature called “fat studies” has sought to question this so-called epidemic, bringing to light inconsistencies or down-right falsehoods present in obesity research. While researchers in this field have importantly uncovered many myths surrounding obesity and overweight, examinations of the rhetorical strategies used to approve potentially dangerous weight loss or weight maintenance procedures remain few.

This thesis project hopes to cover just a portion of that gap by examining two groups targeted most directly by obesity researchers: women and children. Particularly, this research examines potentially dangerous recommendations made by doctors and the media to pregnant obese women and obese adolescents. Ultimately, this project uncovers dualisms of wrong versus right bodies and fat stigmatization in the “objective” language of health about obesity. This polemic leaves pregnant women and adolescents little choice except either to conform or to face a world of media and medicine that blames these two groups for the “choice” to remain fat.

Table of Contents

1.0 Obesity and its Discontents.....	1
1.1 Introduction	1
1.2 Methodology.....	8
2.0 Pregnant and Fat	13
2.1 Introduction	13
2.2 The Present State of Weight Gain	15
2.3 Reading the Wrong Body	19
2.4 Fat and Thin Mothers	25
2.5 Erasing Fat Mothers.....	27
3.0 Growing Up Fat	31
3.1 Introduction	31
3.2 A History of Bariatric Intervention	34
3.3 Cutting Out the Young Obese	37
3.4 Wrong Body as Failed Body	42
3.5 Social Judgment.....	47
4.0 Fat, Control, and Choice	51
4.1 The Obesity “Epic-demic?”	51
4.2 Narratives of Fat Contagion	55
4.3 Control of Body, Not Disease.....	58
4.4 Can We Make a Choice?	62
Works Cited	68

1.0 Obesity and its Discontents

1.1 Introduction

*We live in a culture that tells the average American woman, dozens of times per day, that the shape of her body is the most important thing about her, and that she should be disgusted by it. (Paul Campos, *The Obesity Myth*, xviii).*

Weight obsession in the United States and in the Western world is no new phenomenon. Yet during the 1990's, weight, particularly overweight and obesity, took a turn in terminology. During and after the late 1990s, almost every article, book, news brief, publication, or presentation containing the word "obesity" inevitably included the word "epidemic." The combination caught on, effectively serving to pathologize a significant portion of the global community, particularly the American community, based solely on the criteria of body weight.¹ Medicine and media usually ignored people's personal history, dietary choices, and exercise habits if they were overweight and certainly if they were obese. Fat made a person a social and medical anathema. This "obesity epidemic" became a metaphor for a number of modern culture's perceived social ills: poor nutrition, poor exercise, and sheer laziness. Public initiatives to improve these ills abounded, with suggestions of fad diets, exercise regimes, and invasive surgeries invading at every moment to cure the "illness" of obesity and overweight.

Scholars examining the rhetoric of weight or questioning the legitimacy of fat focus health initiatives deal primarily with the scientific evidence supporting morbidity and the mortality rates concerning obesity, situating that evidence as cultural rather than scientifically or medically objective. For instance, in "The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic?" law professor Paul Campos and his co-authors suggest that four primary scientific claims of obesity are based on shaky data.

Campos et al. state that these claims, culled largely from the World Health Organization's report from 2003, include: 1) “[a]lmost all countries (high-income and low-income alike) are experiencing an obesity epidemic” (55), 2) “[m]ortality rates increase with increasing degrees of overweight, as measured by BMI” (55), 3) “[t]he data linking overweight and obesity to adverse health outcomes are well established and incontrovertible” (57), and finally 4) “[s]ignificant long-term weight loss is a practical goal, and will improve health” (57). The authors propose, “Given the limited scientific evidence for any of these [four] claims, we suggest that the current rhetoric about an obesity-driven health crisis is being driven more by cultural and political factors than by any threat increasing body weight may pose to public health” (Campos, “Epidemiology” 55). The article goes on to uncover inconsistencies in statistics about the “rise” of obesity, noting that the actual weight of most Americans has only increased by a few pounds rather than drastically, as anti-fat rhetoric would have us believe.

The most significant feature of Campos et al.'s article and others like it points out that health risks associated with obesity and overweight may be ameliorated through exercise, even *without* weight loss (Campos, “Epidemiology” 57). Numerous other researchers have arrived at this same conclusion. Kraus et al., examining lipoproteins that affect cardiovascular health, found that increased weekly exercise “with minimal weight change” demonstrated the greatest benefit to overweight patients in the study (Kraus et al.). Another study by Lee et al. in the *Journal of Applied Physiology* found decreased total body fat without decreased body weight when obese patients increased their amount of exercise.ⁱⁱ These authors, among others, are working to uncover whether fat itself is the issue in health and whether or not recommending weight loss strategies, like surgery or

unrealistic dietary changes that do not include exercise changes, are even effective. The implications for “weight-loss” programs, pills, and gimmicks, were these articles to gain more mainstream acceptance, would be dire, since an obese or overweight person could improve his or her health without losing a single pound. Weight Watchers, a group that literally watches the pounds shed with men and (mostly) women as an indicator of increasing health, would be instantly unnecessary and out of business.

Though this illness reportedly strikes men, women, and, most disturbingly, children alike, the “war on fat” as it is now known fires most often and most heavily at women and children. Advertisements on television most often show women, not men, in weight-loss commercials, and unless advertisements deal with body and muscle building, they are more likely to have a woman as the focus on the commercial. Everyday weight loss is a woman’s arena. Programs like Nutri-System always show a once fat, now slender woman who has convenient meals delivered to her door to help with weight loss. Consider also advertisements for Ree-Tones or Sketchers Shape-Ups, both shoes designed to help the wearer lose weight as she walks. The commercials show fit women walking around town in the shoes, focusing on their thighs, butts, and abdomen areas almost exclusively. In contrast, a Shape-Ups commercial for men quickly pans only once over two male actors’ bodies and spends the rest of the thirty second advertisement following various men’s feet (Shape-Ups for Men). In the case of children and adolescents, Michelle Obama’s now famous campaign Let’s Move! was directed solely at the obese and overweight youth of America, predominantly through commercials on the popular *Disney Channel*. Various children’s books, like *Maggie Goes on a Diet* and *Eddie Shapes Up* directly target youth for weight loss purposes.

This project will trace just a few of the connections between the positioning of obesity in adult pregnant obese women and in obese adolescents, both boys and girls. While it will be fruitful for future research to examine the connections more explicitly between obese women and obese adolescents girls, this project, because of its focus on adolescent bariatric surgery in section three, cannot expand on that link sufficiently. The focus will rather be on the rhetoric of obesity as it concerns pregnancy and adolescence. Because the stigma of obesity impacts women and children more heavily than men, these two groups for different reasons garner some of the most explicit rhetoric of control.

Pregnant bodies are already managed by medical discourse; some of the very rhetoric I will discuss in this project appears throughout *any* literature discussing a woman's pregnancy. Prenatal care is arguably the area of medicine with the greatest medical intervention into private lives. Rosalind Pollack Petchesky in "Fetal Images: The Power of Visual Culture in the Politics of Reproduction" covers just one area of culture's, not just medicine's, presumed access to the pregnant woman, her body, and her fetus. Susan Erickson examines in "Fetal Views: Histories and Habits of Looking at the Fetus in Germany" the now "natural" practice of receiving ultra-sounds prior to giving birth. Obesity, in many ways, is yet another avenue for medicine to blame the pregnant body for children's health problems. Yet obese pregnancy seems different because authors imply that if women could just lose the weight they could have a "normal" pregnancy, a normal baby, and a normal post-pregnancy body. Articles from the *International Journal of Obstetrics and Gynecology* and the *International Journal of Obesity*, for instance, compare "normal" BMIs to obese BMIs throughout the text (Davies et al.; Melzer & Shutz). Obesity rhetoric in pregnancy promises a normality that will never come; as other

scholars have noted, there is no pregnancy that does not need medical intervention, and there is therefore no such thing as a “normal” pregnancy. Feminist scholar Candace Johnson in “The Political ‘Nature’ of Pregnancy and Childbirth” notes the use of the term “abnormal” and “normal” in arguments for and against increased medical intervention in pregnancy.

Adolescent obese bodies are equally important for study, especially because weight loss recommendations in children come with an ethical element not relevant for adults. Adolescents by law do not have the capacity to choose bariatric surgery for themselves, even though doctors seek adolescents’ consent as well as parents’. Bariatric surgery in children represents a similar promise of “normality”; weight-loss induced by the surgery will correct the wrong bodies of obese adolescents in order to save their future adult selves, creating normal and right bodies. Yet these surgically altered bodies will always need to behave differently than other bodies – eating differently, drinking differently, and consulting doctors differently – marking bariatric bodies as always deviant. Articles I look at in section three of this project examine how the obese adolescent body before and even after surgery is always failed (like the pregnant body).

A primary purpose of this research is to demonstrate how the medical community and the media rhetorically approve methods in obese pregnant women and obese adolescents, methods deemed questionable for others groups. The methods of approval often include a strong moral element to position bodies in these categories as always already failed or “wrong” bodies, allowing for last resort methods to become more acceptable and attractive options. Much research against the rhetoric of obesity focuses on demonstrating that obesity as a medical illness is a myth or at least largely a social

construction. However, ultimately my research will demonstrate why, in the cases of both pregnant women and adolescents, proving the obesity epidemic's reality is unnecessary for the ethical and moral issues raised by this research to be relevant.

In fact, some of the work combating the obesity epidemic inadvertently replicates the dualistic logic the mainstream and media generate. As I will demonstrate in later sections, anti-obesity scholars often situate the body, particularly the female body, between two choices of fat and thin. Counter-attacks on fat hatred can too quickly become a valorization of the fat body, which in turn devalues other forms, sizes, and shapes. Rather than questioning the methods employed to ostracize fatness, scholars sometimes seek to reposition fatness as the epitome of beauty or health, rather than thinness or some other cultural standard. This strategy, of course, does not solve the problem. Replacing a dictator with a queen still leaves little room for choice. Reassessing these attacks in the context of the disturbing rhetoric of bariatric surgery and medical surveillance allows provocative new ways of combating all forms of body control, not just the "tyranny of slenderness," to develop (Chernin).

The discourse of risk is present in both adolescent obesity and pregnant obesity. Doctors and researchers in many of the articles included articulate that obese bodies are at higher risk for particular diseases and conditions than "normal" or even underweight bodies. The medical risk, or lack thereof, associated with increasing overweight is a subject of other research, including some cited later in this project. Text's such as Paul Campos's *The Obesity Myth*, Eric Oliver's *Fat Politics*, or Glenn Gaesser's *Big Fat Lies* all clearly uncover inconsistencies in the discourse of risk about obese and overweight bodies. Sociologist Elizabeth Wheatley writes, "Risk discourse transforms the body into

an object of practices for screening, predicting, and reducing risk and anticipating its future illness potential...People are discursively constituted as bodies at risk, subjected to medical scrutiny, and objects of medical discipline, surveillance, and control” (202). Campos, Oliver, and Gaesser all uncover reasons why increased “medical discipline, surveillance, and control” over obese bodies may be just about that – control. My research here assumes instead that although the discourse of risk about obesity found in the articles examined here *may* be correct in their assumptions that increasing weight comes with increasing health problems, the true goal of most of the articles is *not* to inform of risk but instead to rhetorically approve medical procedures in two groups of already highly regulated bodies: pregnant women and children.

This project will contain four major sections, with subsections within each to divide for clarity. In the second section “Pregnant and Fat,” I examine methods of weight loss or weight stabilization in pregnant mothers and potentially pregnant mothers through articles that predominantly refer to behavioral modification techniques. These articles also contrast obese pregnant bodies with “normal” pregnant bodies, which usually refer to bodies within the BMI range of 18.5 to 25. The third section of this project entitled “Cutting Out the Young Obese” focuses solely on the marketing of bariatric surgery to adolescents. I lay out arguments for bariatric surgery in obese adolescents following the analysis of obese pregnant bodies in order to expose continuing rhetoric of wrong versus right bodies, often couched in terms of health yet with clear moral undertones. The fourth and final section brings together the two strands of research, and I will argue that the increased media attention on pregnant women’s weight gain or loss techniques and on adolescent obesity are too often constructed within objective, scientific health rhetoric,

i.e. solely in terms of risk, largely ignoring that the decisions these two groups must make about their weight and thus their bodies are heavily influenced by sociocultural factors. The decisions are linked directly instead to issues of wrong body rhetoric and a dualism of normal versus abnormal bodies. Thus, many of these articles, both academic and popular, reduce the decisions facing these two groups as a simple one between health and illness, effacing the fact that the obese body is also socially stigmatized, a fact which may influence women and adolescents to make decisions that drop their weight but actually do nothing to improve their health. Finally, this project will conclude by making some tentative claims and projections for future research that will be supported through the course of the rest of the paper.

1.2 Methodology

There are many scholars already tackling the reality of the obesity epidemic itself, questioning whether the increasing number of overweight and obese persons in the last few decades is really increasing, pointing out inconsistencies or complete falsehoods in health recommendations for the overweight and obese, and underscoring the highly cultural, not medical, features of this “illness” (O’Connor). While I will discuss the available research that already examines the medical reality of the obesity epidemic, I will not focus on that research as a method of inquiry about obesity rhetoric. Because this research intends to focus on the rhetorical rationale for cures and the moral undertones in articles concerning obese pregnant women and obese adolescents, anti-obesity articles cannot serve as a main source of information.

Rather, this project will cover a gap in the literature of fat studies, examining rhetorical devices used by the medical community and the media that pathologize these two groups. In the case of the pregnant obese body, while a few texts in the fat studies community have already sought to expose how medicine blames the woman's body even in the womb for the current "obesity epidemic,"ⁱⁱⁱ important research remains to be done concerning how that blame is constructed and why medical intervention, whether through behavioral modifications or surgery, is necessitated by the very appearance of even a mildly overweight pregnant (or potentially pregnant) female body.

Examining the rhetorical devices used to approve bariatric surgery in adolescents is also necessary. While some articles, both for and against bariatric procedures, discuss the social stigmatization that may lead adolescents into doctors' offices, articles identifying how bariatric surgery is then approved for children both medically and culturally remain few. Identifying the rhetoric surrounding both pregnant women's and children's bodies will allow me to identify larger themes within the rhetoric of "curing obesity." This analysis will thus be both rhetorical and hermeneutical, examining lines of argument for and against these groups of obese bodies in the sociocultural context of Western medicine and media, almost exclusively that of the United States.

My primary rhetorical lens comes from the work of rhetorician John Jordan and his notions of wrong bodies. In one of his texts, John Jordan "The Rhetorical Limits of the Plastic Body" argues, "Wrong body rhetoric follows the Cartesian juxtaposition of an outer body against an inner self, as well as the hierarchy that the body should follow the mind's will" (Jordan, "Rhetorical" 339). The right body may be one based on skin color, sexuality, economics, or in this case, size and weight. The obese body represents an inner

self that fails to follow prescriptions of normativity in health. The standards of health and idealization are, of course, set by dominant discourse embedded in explicit and implicit messages from medicine, media, and peers. As other scholars have pointed out and I will cover later here, standards of overweight and obesity have fluctuated over the decades. Both scientific and medical studies as well as social stigma and cultural preferences help to determine “right body” sizes.^{iv} While the latter is recognized as constructed, readers often consider the form as an objective tool to determining right body size, rather than a rhetorically constructed position of the obese body.

In his article “The Rhetorical Limits of the Plastic Body,” John Jordan considers the role of plastic surgery in achieving a body imagined as ideal by patients seeking body modification. He writes, “The body in question is an amalgam of the pre-surgical body of the patient, the body desired, the body the surgeon sees through the disciplinary gaze of medicine, and the body produced by surgery or its refusal” (Jordan, “Rhetorical” 334). He names “the body desired” as the body requested or imagined by the patient, but in the case of bariatric surgery, the issue of idealization is doubly complicated by notions of health as well as by ideas of “right” body size. The ideal body is one that conforms to medicalized prescriptions of health, which then influences how the individual might idealize his or her own body. This notion of right versus wrong bodies as a rhetorical construction is important in understanding how medicine authorizes the procedures and recommendations I will cover later in this thesis.

John Jordan also covers a very important case, that of Ashley X, in his development of wrong/right body dualisms, particularly as they pertain to notions of health. In “Reshaping the Pillow Angel,” Jordan argues that in the case of patient Ashley

X, a young girl with severe cognitive disabilities, her parents rhetorically situated her body as wrong in order to go through with a procedure that would alter her otherwise healthy body. This case will be particularly important to my section on bariatric surgery in adolescents, so it is worth a moment to describe here. Ashley X, according to Jordan, was a severely mentally and physically disabled little girl who, at the age of ten and at the discretion of her parents and doctors, had surgery to prevent the growth of her breasts, the onset of her menstruation, and the onset of normal adult weight gain and development. Her parents and doctors argued that since Ashley's mental development would never pass that of a three month old, it was appropriate to surgically alter her body so that her caretakers (i.e. parents, nurses, and doctors) could properly handle her and her care.

What Jordan notes of this case, and what is particularly important for my analysis, is that Ashley's case resituated the meaning of "health." He writes, "The rhetoric of the Ashley X case indicates that while "health" is still a necessary element in any case for or against medical intervention, the specific meaning of health is fluid, even to the point where long- held presumptions about a patient's body can be overturned" (Jordan 21). Rhetorically, Ashley's doctors and parents were able to situate "health" not as bodily wellness but as one of "well-being," in which "a physically healthy body actually impedes someone's overall well-being" (Jordan 25). In this case, doctors and parents "reworked rhetorics of normality to define her healthy body as "wrong" and to justify her surgical reshaping" (Jordan 25). This understanding of rhetorically reworking normality into wrongness is key for understanding bariatric surgery in adolescents – a procedure which alters an otherwise healthily functioning stomach.

In choosing material for research, I developed an approach that would be

representative, though not totalizing, of both mainstream medical as well as popular media views on both obese pregnancy and bariatric surgery in adolescents. A number of articles examined here come from medical journals, government reports, or academic presses. Within these articles, I focus on the obese pregnant or obese adolescent body as one that seemed to be constructed objectively. I look within these sources for emerging stigma in both medical and media accounts, noting places where the two share or diverge in opinion. In selecting sources, I choose not to restrict my research to one publication, such as the *Journal of the American Medical Association*, so as to garner a broader range of opinions and research.

Throughout this thesis, I do not take the path of many fat studies scholars and valorize fatness. To valorize a particular form seems to lead to the kinds of dualisms I seek to subvert. However, I do avoid denigrating fatness as unhealthy by removing my argument from considerations of medical risk and instead situating the thesis in issues of body normality. By choosing articles from medicine and media, my approach is to show critical ethical issues in mainstream thinking about obesity and fat, rather than critiquing the so-called epidemic of obesity itself.

2.0 Pregnant and Fat

2.1 Introduction

Most overweight - and even obese (defined as someone whose weight is 20 percent or more over her ideal weight) - mothers have completely safe pregnancies and completely healthy babies. Still, obesity always poses extra health risks, and that's the case during pregnancy, too. (Murkoff et. al., What to Expect When Your Expecting 50)

There is picture of a presumably healthy, widely smiling woman holding up a home pregnancy test over the cover of the November 1, 2010 edition of *American Fitness Magazine*. Imposed over the image are large printed words “Obesity and Pregnancy: What are the effects of obesity and fertility on pregnancy?” Other articles from academic and media sources eschew the image but keep the message, with titles as simple as “Obesity and Pregnancy” or “Obesity and Reproduction: An Educational Bulletin,” to ones designed to induce fear, “Asthma More Likely Among Children of Overweight Mothers” and “High Rate for Deaths of Pregnant Women in New York State.” If the headlines and the fear-mongering are true, mothers may have every reason to be frightened. Obesity, according to mainstream thought, is on the rise and is “a major cause of preventable morbidity and mortality affecting approximately 25% of U.S. women and over one third of reproductive age women” (Hall & Heubert 253). Potentially, statistics tell us, these women are already themselves in danger and may be currently producing or in the future produce unhealthy children.

Yet a recent growing body of fat studies literature points to problems or oversights in the cultural and medical targeting of overweight mothers (and inevitably their children). In her article “Fat Kids, Working Moms, and the “Epidemic of Obesity,” Natalie Boero situates blaming of obese and overweight mothers in a social, racial, and

economic context. Her article focuses specifically on mothering techniques under fire from the media. Numerous articles, she contends, blame fat children on mothers who are not home, with one study claiming “to have found that working mothers are more likely to have “overweight” children” (Boero 115). Authors from the Boston University School of Medicine simultaneously blame overweight mothers for both under- and over-emphasizing exercise, creating either apathy or aversion and thus “causing” overweight (Boero 117).

However, Boero’s article contains just one brief paragraph about the pressure placed on obese or overweight pregnant mothers, mentioning that doctors suggest losing weight before trying to become pregnant by suggesting all of the potential side-effects of an obese pregnancy on the mothers themselves and their children (117). Academic responses to the barrage against overweight mothers are few and fail to cover a number of important issues raised in both medical and media articles, including examining how some doctors are now suggesting that obese expectant mothers gain *no* weight at all during pregnancy, a suggestion that goes against traditional wisdom and previous practice.

In 1990, the Institute of Medicine (IOM) of the National Academy of Sciences did not suggest that obese women gain *no* weight during pregnancy, but rather restricted its guidelines for these women to less than six kilograms (slightly over thirteen pounds) of weight gain during the course of the pregnancy (Abrams, Altman & Pickett 1235S). While the 2009 publication of *Weight Gain During Pregnancy: Reexamining the Guidelines* from the IOM remains close to these guidelines at a weight gain of 5-9 kg for obese women (4), more recent publications indicate that zero weight gain is favorable to

pregnancy (Kiel et al.).

This section analyzes a number of rhetorical strategies employed to successfully pathologize obese pregnancy. This rhetoric is first and foremost predicated on a wrong versus right body dualism, where the obese body perpetually stands as an imperfect or even a defective form of the healthy body. The abnormal obese body gives doctors a reason to intervene in pregnancy, whereas normal bodies, at least in these articles, are held as a standard that *may* not require intervention. As I have mentioned, pregnancy is already highly regulated by medicine. Yet the use of (ab)normal dualisms allows medicine an entry point for even greater control over a large percentage of women. Normal weight suggestions within journal articles and media publications about obese pregnancy support a myth that medicine can give a woman normalcy, that there is a potential to achieve a normal pregnancy. In reality, pregnancy will never be “normal” according to medicine and will always require intervention. As Candace Johnson astutely points out, “[P]regnancy and childbirth have been inappropriately declared ‘abnormal,’ ‘diseased’” (895).

2.2 The Present State of Weight Gain

In a presentation titled “Weight Gain in Pregnancy: Past, Present, and Future,” Dr. Naomi Stotland of the Department of Obstetrics, Gynecology, and Reproductive Sciences from the University of California at San Francisco tracks the fluctuations of weight gain recommendations to pregnant women in the United States from the turn of the nineteenth century through the twenty-first century. She notes that the recommendations for gain

have almost doubled since the 1930s, and she also points out that higher percentages of women are gaining over the recommended amounts (even with the changes in criteria). The number of women who are obese or overweight at the time of pregnancy has also increased. As other articles note, these weight gain recommendations were sometimes for the benefit of the health of the unborn child but could also be thought to ease the pain of pregnancy, prevent preeclampsia, and, disturbingly but not surprisingly, preserve the future figure of the mother (Stotland).

The verdict remains out on exactly how much weight to gain during a pregnancy. While Siega-Riz et al.'s article in the *Journal of Midwifery & Women's Health* and Hall & Heubert's article in *Gynecologic and Obstetric Investigation* fail to agree on a minimum weight gain during pregnancy (the prior puts it at eleven pounds and the latter at twenty-six, depending on pre-pregnancy weight), both journals agree on a cap weight gain at forty pounds. The Institute of Medicine's text *Weight Gain During Pregnancy: Reexamining the Guidelines* from 2009 officially declares the minimum resides at eleven and a half pounds and the upper limit is forty pounds. All texts warn of the dire consequences of gaining anywhere above or outside of this narrow range of weight. Yet in the same breath, many articles that warn about the dangers of gaining weight during obese pregnancy admit that weight gain below twenty-five pounds contributes to low birth weights (called SGA, or small for gestational age), a condition that comes with its own risks (DeVader et al. 167).

In "Weight Gain During Pregnancy" from the *Journal of Midwifery & Women's Health*, the authors warn women not to gain too much weight because it means more weight to lose after birth. They then warn that it may also cause gestational diabetes and

increase the need for a cesarean birth. While it may be true that increased pregnancy weight means more weight to lose afterwards, if the focus of doctors and physicians is to protect the health of the child and mother, adverse outcomes of excessive weight gain should come first articles. Instead, article after article takes this approach, situating the post-partum obese body as the first issue in pregnancy weight gain. In fact, in “Pre-pregnancy and Pregnancy Predictors of Obesity,” authors Melzer and Schutz call pregnancy a “risk factor” for obesity. Their first concern is that “[g]estation is one of the natural and biological causes of weight cycling and may constitute a major risk for excessive weight gain and weight retention after delivery” (544). Another article from Kiel et al. indicates at first that IOM guidelines are to “limit adverse pregnancy outcomes,” but the authors then order their own priorities clearly, writing:

Given the increasing prevalence of obesity among childbearing women, *the tendency for post-partum weight retention*, the high prevalence of perinatal complications in obese women, and *the influence of pregnancy in the development of obesity later in life*, reevaluation of the IOM gestational weight gain guidelines for obese women has important clinical and public health implications. [italics my emphasis] (752)

These articles linguistically seem to be more concerned about the post-partum body rather than the pregnancy itself or the baby. Treating pregnancy as a “risk” factor for a disease reinforces “[a] model that perceives women as essentially abnormal, as victims of their own reproductive systems and hormones” (Cahill 334). Obesity, also constructed as abnormal embodiment, gives doctors yet another outlet to seize control over a pregnant woman’s body in order to save her from her own body and child.

Most articles note, either overtly or implicitly, that overweight and obese women are the most likely to gain over the recommended amount, while women who are normal or even underweight tend to gain within recommended limits. Even though this is true,

the focus on weight gain rather than on pregnancy risks again points to doctor's interest in controlling the pre-pregnancy and post-partum body. In *Women's Health Issues*, Weisman et al. note, "Preconception overweight (BMI = 25-29.9) increased the odds of excessive pregnancy weight gain nearly threefold, whereas preconception physical activity levels meeting activity guidelines reduced the odds of excessive weight gain but was marginally statistically significant" (Weisman et al.126).^v Another article from the *International Journal of Gynecology & Obstetrics* arrived at a similar conclusion (Brawarsky et al.).

As I have noted, excessive pregnancy weight gain may be associated with increased risks, but gaining too little weight also comes with its own risks. One article included too few underweight women in its study, so "underweight and normal categories were combined for analysis" (Weisman et al. 128). Lumping these groups together ignores that underweight prior to pregnancy increases chances for miscarriage (Helgstrand & Andersen; Rodrigues et al.) and fetal growth restriction (Dohetry et al). However, underweight prior to pregnancy does leave less weight for women to lose post-partum, which is apparently the real goal of most doctors.

Most articles tend to share another conclusion in common: women should gain *at least some* weight during pregnancy. In the *American Family Physician*, the authors of "New Insights on Optimal Weight Gain During Pregnancy" note that both low and high weight gain increase the potential for problems giving birth or with a baby's development or neonatal health. The authors write, "[T]hose who gained less than 15 lb had increased rates of small-for-gestational-age infants, seizure, meconium aspiration syndrome, and prolonged hospital stay" (Walling). *Weight Gain During Pregnancy: Reexamining the*

Guidelines reads similarly, stating:

[W]eight loss or failure to gain during pregnancy due to dietary caloric insufficiency may possibly induce maternal hormonal and metabolic responses, which may, in turn, have subsequent consequences for the intellectual development of the child... a weight gain less than ~7.5-8.5 kg would likely result in mobilization of maternal adipose tissue and possibly lean body mass. (Rasmussen & Yaktine 99)

Merely maintaining body weight during pregnancy, these authors seem to argue, causes a pregnant woman's body to quite literally eat itself.

Yet some new research cited in both medicine and media argues that women who are obese and pregnant should gain little to no weight at all (fifteen pounds or preferably much less) (Walling; Alvarez). Anne Walling, in "Obese Mothers Should Gain Little or No Weight During Pregnancy," concludes her article recommending "that obese women have more favorable outcomes with limited (up to 15 lb) or no weight gain during pregnancy," even though her study supports increased benefits for obese women only for gaining fifteen pounds or less (Walling). That research is predicated on the notion that these pregnant bodies already failed themselves in the pre-pregnancy state through their overweight. Understanding how these bodies are constructed as "wrong" prior to and during pregnancy will help us understand how doctors are advising women to take a potentially dangerous route during their pregnancy.

2.3 Reading the Wrong Body

Weight gain in pregnancy remains one of the central issues by which to divide the normal, right bodies from the obese, wrong bodies. Though women of normal weight face the same complications as obese and overweight women, if the former gain too much during pregnancy the focus on gain exceeding recommendations remains on obese

women only. Articles from *The American Journal of Maternal/Child Nursing*, *American Family Physician*, *Women's Health*, and others all mention the obesity epidemic or concerns about obesity alongside the research of excessive weight gain in pregnancy. However, statistics from the work of Brawarsky et al. demonstrate that women of normal pre-pregnancy BMIs are almost equally as likely as women of pre-pregnancy obese BMIs to gain excessive amounts of weight (52.3% versus 53.5% of women in each category, respectively). Overweight women – not obese women – were the most likely to gain a lot, with 73.2% of women with BMIs ranging from 26.1-29.0 gaining far over the recommended amount of weight during pregnancy. Why, then, does the focus of excessive weight gain remain on obese women?

Medicine and media mark pregnant obese bodies as wrong prior to these bodies first entrance into the doctor's office. Articles note that preventative measures against overweight gain in pregnancy should be directed at overweight and obese women prior to conception. Weisman et. al in *Women's Health Issues* write, "[P]reconception overweight and physical activity are prime targets for interventions to avoid excessive pregnancy weight gain" (Weisman et al. 131). According to this sentence, thin inactive women should be equally "targeted" as potential excessive weight gain suspects, yet it seems unlikely that doctors will approach normal weight or slightly underweight thin women with the admonition to avoid excess weight gain. As I've mentioned before, Weisman et al. lump underweight and normal weight women into the same category, despite underweight pregnancy coming with many of the same complications as overweight pregnancy. Other authors recognize underweight pre-pregnancy and pregnancy should not be considered similar in any sense to "normal" weight (Rasmussen & Yaktine;

Abrams, Altman & Pickett).

Weisman et al. continue on to cite another report from the *British Medical Journal*, in which Dr. Adam Balen notes of obese women, “Such [obese] women should be encourage to lose weight before having treatments to induce ovulation...both to improve the likelihood of ovulation and to enhance ovarian response. Monitoring treatment is also harder in obese women because their ovaries are more difficult to see on ultrasound scans, thus raising the risk of missing multiple ovulation and multiple pregnancy” (Balen). Being overweight or obese quite literally makes these women medically unmanageable, unable to be regulated, and doctors may deny the option to get pregnant through methods like in vitro fertilization to obese women. In fact, one article from *Human Reproduction* suggests that obese women should go through two levels of medical monitoring for fertility help. The authors Rittenberg et al. write, “[A]ppropriate measures should be taken to develop an effective weight management service for overweight and obese women intending to embark on IVF procedures” (2647). Overweight women are included in the category even though this group does not face the problems identified by Balen with medical equipment and monitoring. Potential problems with medically managing weight gives medicine and doctors an excuse to intrude on the lives of women.

The rights of the wrong body to control its own pregnancy seem to be in question in many of these articles. These mothers potentially pose a threat to their unborn or even unconceived children, and medical interventions seem necessitated in order to prevent mothers from failing their children as they have failed their own bodies. Verbs like monitor, intervene, and manage appear prominently in articles discussing obese

pregnancy. Obese pregnant bodies are linguistically set up to fail, to remain wrong; the prospect of pre-pregnancy weight loss remains grim without the monitoring, intervention, or management of doctors, and post-pregnancy weight loss seems even less likely.

In her study of transsexual bodies, Judith Halberstam discusses notions of “wrong body” rhetoric in terms of gender identification. While she focuses mainly on how wrong/right body rhetoric erases the transitional transsexual body, her commentary on the movement of these bodies is particularly relevant to overweight and obese motherhood. She writes in *Female Masculinity*, “Obviously, the metaphor of crossing over and indeed migrating to the right body from the wrong body merely leaves the politics of stable gender identities, and therefore stable gender hierarchies completely intact” (Halberstam 171). She continues later, “Such rhetoric also assumes that the proper solution to “painful wrong embodiment” (Prosser) is moving to the right body, where “rightness” may as easily depend on whiteness or class privilege as it does on being regendered” (Halberstam 171). Similarly, the rhetoric of moving the obese, wrong pregnant body to a healthy one (i.e. one that conforms to prescribed limits of weight according to the commonly used Body Mass Index scale) erases women’s bodies that resides in the no-man’s land between, the category defined as overweight. The dualism of abnormal, obese bodies and normal, healthy bodies remains intact, and bodies that are underweight are allowed to shift into the stable, healthy category of “normal” while overweight bodies must shift in the category of “abnormal” in order to conform.

Obesity rhetoric of wrong body is thus able in a single move to pathologize not just obese pregnant women but overweight pregnant women as well. Wrong body versus right body dualisms leave only one medically approved option: get weight to a normal

level or put the supposed health of pregnant women and their babies in peril. In “Obesity and Reproduction: An Educational Bulletin,” the authors summarize that obesity “is associated with menstrual dysfunction, decreased fertility, and increased risk of miscarriages...increases the risk of obstetric and neonatal complications” and recommends that “preconceptual counseling for obese women should address the medical, obstetric, and neonatal consequences of obesity and its longer-term implications for offspring” (“Obesity and Reproduction”). Yet the recommendations and figures refer only to the obese body; the overweight body remains in a potential wrong space. Though the authors write that a 5-10% weight loss decreases the instances of co-morbidities in obese women, this amount of weight loss would not put these women in the category of normal weight. Once moving out of the danger zone of the wrong obese body, potentially pregnant mothers must then be concerned about the in-between space of overweight, which is not as good as the right, healthy body, but certainly not as bad as the wrong, obese body.

This dualism of wrong and right appears equally in medicine and in media. *The New York Times* is one outlet particularly keen to keep up on potential weight complications in pregnant women. In an article titled “Growing Obesity Increases Perils of Childbearing,” Anemona Hartocollis writes, “Studies have shown that babies born to obese women are nearly three times as likely to die within the first month of birth than women of normal weight, and that obese women are almost twice as likely to have a stillbirth.” Another article, also from *The New York Times*, warns, “Women who are overweight or obese when they become pregnant may be more likely to have children who develop asthma as teenagers” (O’Connor). In this case, *both* overweight *and* obese

women are embodied incorrectly and achieving normal weight seems to be the only way to protect their children from problems in the future. The article does not distinguish how much overweight causes asthma in future children, so readers are left to wonder whether five pounds or ten will push them over the limit to into unacceptable weights for pregnancy.

Obese women become simultaneously immoral inhabitants of their own bodies as well as always-already bad mothers simply through their choice to get pregnant in those failed bodies. Approving dietary recommendations for such bodies becomes an easy step for the medical community and the media; because a woman has already made a bad choice by becoming pregnant in an obese body, the options left to her can be equally bad. The wrong body of an obese woman should not be pregnant according to mainstream opinion, and if it is, it cannot be treated like a “normal” mother’s body.

Obese and overweight women face the pressure to prevent themselves from becoming mothers at all until they can become “normal.” This includes recommendations to undergo surgery prior to becoming pregnant at all. One author in an article from the *Journal of the American Dietetic Association* writes:

The researchers found that obese women who undergo weight-loss surgery before becoming pregnant are less likely to have obesity-related maternal and fetal complications. The researchers also reviewed the literature for evidence of reduced nutrient absorption, which could result in poor pregnancy outcomes. Based on the limited observational evidence, the gastric bypass and laparoscopic adjustable band procedures seem to present minimal if any risk for nutrient problems, as long as nutrition is maintained and adherence assessed.
(Cunningham 772)

This recommendation, of course, allows minimally a three-fold medical intrusion on the pregnant obese body: first in surgery, second in pregnancy in general, and third in eating habits during pregnancy to prevent “reduced nutrient absorption.” Society often

constructs obese women as ones incapable of changing the habits that allow for continual weight gain, thus suggesting that medicine intervene and “fix” their bodies for them. Prescriptions to maintain weight during pregnancy or to lose it prior to pregnancy rhetorically set up the obese pregnant body to preemptively fail, both as a person and as a future mother.

2.4 Fat and Thin Mothers

Medical publications certainly position obese and overweight mothers as dangerous and wrong. In wrong body dualisms, the fat mother becomes one who can't be a good mother or who shouldn't be a mother at all. Though doctors and researchers cursorily admit that mothers who are too thin can also endanger their children in pregnancy, the focus remains on the overweight and the obese. One stark example from the Institute of Medicine and National Research Council demonstrates how little attention is paid to the dangers of underweight when contrasted with overweight. The authors write, “[R]esearch on GWG has demonstrated that weight patterns (underweight and overweight) and total weight gain have short- and long-term consequences for the health of the mother” (Rasmussen & Yaktine 15). This seems unbiased enough, giving equal nods to the potential problems associated with both categories. Yet, when the authors continue on to examples of complications, it is *only* overweight that appears in the text:

For example, prepregnancy BMI above normal values (19.8-26 kg/m²) is associated with preeclampsia, gestational diabetes mellitus (GDM), cesarean delivery (Doherty et al., 2006; Abenhaim et al., 2007), and failure to initiate and sustain breastfeeding (Hilson et al., 1997; Li et al., 2003; Kugyelka et al., 2004). Increased maternal BMI and GWG have also been associated with higher fat mass in infants and subsequent overweight in children (Hillier et al., 2007; Oken et al.,

2007). (Rasmussen & Yaktine 15)

Reading this might convince any mother with a BMI over 26, considered overweight and *not* obese, that she too is doomed to have both a complicated and harsh pregnancy as well problems after her delivery, according to the comments on breast feeding and weight of the children in the future.

Yet pathologizing the incorrect size of motherhood is a rhetoric that appears in both obesity campaigns as well as fat positive analyses. Consider the following comparisons of “different” views on correct maternal embodiment.

To be sure, there is some direct proportion between the amount of fat a woman bears and her capacity to bear children. Fat is fertile; we have already pointed that out. Certainly, we know that the obverse is even more likely to be the case: thin women are less fertile, less successful at bearing children. After a certain point of emaciation, menstruation stops altogether, and fertility vanishes. (Klein 22)

Note the careful omission of delineations of “fat” and “thin” here; opposition without clarification or definition is key to understanding repeating rhetorical patterns. This quote comes from an anthology *Bodies Out of Bounds*, a text whose goal is “unmasking the fat body, rendering it visible and present,” not questioning a thinner women’s ability to have children (1). One group of women, demarcated by “thin,” become those who cannot contribute their quite literal, physical maternal productions to culture. A comparative article from the *New York Times* reads:

About one in five women are obese when they become pregnant, meaning they have a body mass index of at least 30, as would a 5-foot-5 woman weighing 180 pounds...Studies have shown that babies born to obese women are nearly three times as likely to die within the first month of birth than women of normal weight, and that obese women are almost twice as likely to have a still birth. (Hartocollis, “Obese Mothers”)

While providing slightly more information (a specific height and weight), this example never lets on what a “woman of normal weight” would look like but rather keeps its

verbal focus on the productive methods supposedly destroyed by excessive weight. The point here is that each article and writer attempts to normalize the body based on his or her standards of weight, and each values a woman based on her success of production *only*. The polemicization of weight, fat or thin, erases the lived experience of the single woman and converts her to a walking womb, useful only to society if her body weight makes her an acceptable carrier of a baby.

In these representative examples the coding of the body does not change; the articles are not geared towards individuals with varying needs based on personal history, eating habits, preferences, and a host of other items unrelated to sheer body size. Rather, articles like these seek to control the most effective placement of the body – what body is best in order to create yet more bodies for society? Michel Foucault argues that this is the course of history for power relations; “they manifest in a massive and universalizing form, at the level of the whole social body” (“Subject” 15). These are successful “stories” of the body because these articles obscure the extent to which our bodies are dominated; dominated by a system of stories, a system of power locked on to living through the human experience.

2.5 Erasing Fat Mothers

Though I have focused on both medical and media representations of obese pregnancy thus far, it will be important for a moment now to examine the rhetorical strategy of removing obese and overweight mothers from media articles, in order to make a clear connection between adolescents and obese mothers. For now, it is important to examine how anecdotes from obese pregnant women come only from those losing weight or agreeing to lose weight, and to theorize why this strategy is so consistently employed.

It is typical in the case of epidemics for illness narratives to appear depicting the sufferings, triumphs, or losses of those afflicted. In some ways, medicine would not exist without the narrative. Narratives may tell a doctor how a patient got sick but may also generate experience. As Arthur Kleinman argues in *The Illness Narrative*, “The personal narrative does not merely reflect illness experience, but rather it contributes to the experience of symptoms and suffering” (49). Seemingly, a person designated as ill does not only receive a cure by being able to tell his or her story, but he or she also is shaped by the very act of telling, of having others listen to that story.

Yet in the case of obese pregnant women, particular narratives of obesity are consistently selected. In a culture obsessed with televised stories of pregnancy (*I Didn't Know I Was Pregnant*, *Sixteen and Pregnant*, *Runway Moms* and *Bringing Home Baby*, among others), the printed media seems to keep the obese pregnant body in a perpetual state of weight-loss. In “Growing Obesity Increases Perils of Childbearing” from *The New York Times*, new mother Patricia Garcia’s story is told largely in third person, with author Anemona Hartocollis dictating her story as told by medical charts and doctor’s input. At the very end of the article, Garcia is quoted, lamenting that she would lose weight before another pregnancy: “I’m going on a strict, strict, strict diet,” she said. “I’m not going through this again.” Her promise to her doctor to lose weight authorizes Garcia as a reformed obese body, one that will not imperil a future child with the threat of obese pregnancy. Only with this conformity to weight loss standards is Garcia’s voice allowed a space.

However, many articles do not include a narrative from an obese mother at all, effectively impressing the audience that all obese pregnancies are the same and are as

doctors say those pregnancies to be. By silencing the lived experiences of mothers, doctors are able to have the final say over what is and is not obese pregnancy. In a longer article from *ABC News*' website, a number of doctors outline the dangers of going through pregnancy in an obese body. The health of the baby and the mother are both put in question, yet neither the article nor the included video provide any specific examples or quotes from affected mothers facing these illnesses (James). A shorter piece from *The New York Times* examines a correlational link between asthma and obesity, but the author only mentions obese mothers and interviews none (O'Connor). This article in particular looks at asthma in the teenage children of women who were obese at the time of pregnancy. It is possible to speculate that no narratives are necessary because *no change is possible*; that is, these mothers have already had their children and cannot lose weight to prevent another obese pregnancy from happening. The story, without narrative, serves to warn present obese women to lose the weight before pregnancy or simply become another line in a news article warning about bad parenting.

Another article from *USA Today* entitled "Autism May Be Linked to Obesity During Pregnancy" clearly blames the weight of a pregnant mother on the later disabilities of her child. While author Lindsay Tanner writes, "Mothers were asked about their health," she includes no actual mother's voice, instead choosing to rely on the voices of Paula Krakowiak, researcher at University of California-Davis, and Daniel Coury, doctor of Nationwide Children's Hospital in Ohio. Mother's voices and opinions on their health during pregnancy and the impact their weight may have had on their children remain completely absent.

Expectant obese mothers face two options in the story of their pregnancy:

transform or disappear. As unacceptable bodies in health and in popular culture, pregnant obese women are confronted with a two-fold battle to regain their bodies' right to exist. The narrative of pregnant obese bodies in combination with the wrong body rhetoric of fat leaves pregnant women feeling as if they have little choice over their own bodies, at a time when they should be feeling closer to their bodies than ever. As we will see, this process of alienation is quite similar in the "war" against adolescent obesity, in which yet another vulnerable group is preyed upon by medicine and media alike.

3.0 Growing Up Fat

“The goal for those seeking surgery is not to find a way to accept their bodies, but to make their bodies more acceptable.” (John Jordan, “Rhetorical Limits of the Plastic Body” 339)

3.1 Introduction

As adult Americans got fatter, public and medical concern rose, worrying that adolescents were also “afflicted with the disease of morbid obesity” (Wittgrove 253). The adolescent obese body is somewhat unique in the rhetoric of the “war on fat.” While medical practitioners and the media ask overweight and obese adults to take responsibility for their bodies, blaming them for being fat from all sides, the accusations leveled at adolescents and children become a little more complicated. No one, of course, wants to be accused of injuring an adolescent’s already delicate self-esteem. More to the point, obesity researchers tend to realize that adolescent bodies are still growing. Thus, much of the rhetoric around adolescent obesity places blame outside of adolescents themselves, instead blaming poor school cafeteria food, poor mother techniques (see above), or lack of available exercise options for obesity. The growing obese adolescent body, researchers often posit, must be educated to realize these are bad decisions so that, in the future as adults, they won’t be blamed for making poor choices that they learned through habit.

In this section, I analyze three particular rhetorical features that appear in arguments for and against bariatric surgery in obese adolescents. In each article reviewed, a primary significant feature consistently appears in the construction of obese adolescents, ranging from age thirteen to eighteen, as potential adults. This lessens the shock of approving a possibly dangerous surgical procedure for children by linguistically

situating the patients as almost-already adults. I will briefly review contemporary conversations around adult surgical intervention for obesity and then hypothesize the related connections to adolescent intervention.

Secondly, in many of the articles, the authors situate patients as those “who failed medically [at] supervised attempts at weight loss” (Horgan et al. 87). The surgery is thus positioned as a last resort method to individuals resistant to more acceptable forms of treatment. However, at the beginning and end of a number of articles, the authors urge doctors and the public to consider incorporating surgical options more widely into the potential cures for obesity in adolescents. Surgery offers the potential for patients to have a better, healthier body in the long term despite recognized unknown complications. Surgery is also constructed as an option that forces patients to change eating and exercise habits, while blaming any surgical failures on the failure to conform to these standards. Yet the studies already suggested patients are incapable of doing changing habits; thus, patients are locked in a multiple bind that identifies them as failures on all sides, with surgery the only remedy that offers any hope of redemption. Surgery, then, is posited at the way out of a body marked by the cultural sins of unsuccessful diets, ineffective exercise regimes, and ultimately, failed self-control.

Finally, the authors of these articles tend to predicate ideas of healthy bodies outside of social issues of body image. Particularly in the articles from medical journals, the text effaces influences of cultural pressures to normalize body weight. The authors situate the decision for surgery as one based solely on medical exigencies, citing lowered body mass index (BMI) percentages and decreased co-morbidity factors. I focus on how this gap in the articles reinforces the idea that medical solutions solve only medical

problems, while in actuality patients might seek treatment for reasons beyond health.

The obese adolescent body exists in a contested space of flux, where arguments configure not-quite-adults as needing or requiring surgical alteration in order to gain the potential to be “a normal-weight older adult” (Lawson et al. 138). Compared with more extreme examples of surgical intervention in children that remain questioned and resisted, obesity surgery in both adults and adolescents is increasingly on the rise.^{vi} Public acceptance of the need to treat obesity at an early age is becoming commonplace, and justifications based on healthy body weight are beginning to outweigh reservations over the ethical implications of surgically altering the bodies of adolescents. This rhetorical analysis offers an essential new examination of “the ways that the borders between technology, medicine, authority, and body image are managed” in the case of the widely recognized problem of obesity (Jordan, “Rhetorical” 329). By regarding the unhealthy, obese body as an exceptional case that necessitates an otherwise rejected surgical intervention in adolescents, doctors and authors redefine the limits of medicine and surgery in children. This analysis of how and why the public and the medical community authorizes surgical operations for non-adults may lead us to the conclusion that the body may be increasingly defined as medically malleable at all ages.

Despite the fact that a number of other remedies for adolescent obesity are sought prior to considering surgery, proponents of surgical intervention are now seeking greater acceptance for this treatment in the medical community as well as in popular opinion. One article from a pediatric journal confidently writes, “Many severely obese adolescents ultimately will benefit from bariatric surgery...the crisis of childhood obesity means that life-altering surgery is an appropriate intervention” (Wittgrove 253). In order to

understand how a “life-altering surgery” is being not only considered but approved in adolescents who are still developing both in their bodies and in their minds, it is necessary to uncover the rhetorical strategies the medical community and the media are using in bariatric surgery’s defense.

3.2 A History of Bariatric Intervention

Attempts at body modification based on weight and appearance go back centuries. Common attempts at weight loss and muscle augmentation generally include either changes in eating habits or changes in exercise routines. In ancient Greece, the idealized body, immortalized in countless statues, required discipline, training, and a specialized diet (Goldhill). In the eighteenth century, George Cheyne, a predecessor to the modern Dr. Atkins, offered specialized eating plans for his predominantly wealthy clients (Mullan). However, in the 1950s, an important change developed for persons seeking to revise their body weight. The first surgical procedures to induce weight-loss were now added to the list of ways to limit body size (Dermody & Illing). These first attempts were effective but often deadly, with incredibly high risks of complications including death. Despite these complications, the 1950s and 1960s saw the medical community performing gastric partitioning for the treatment of overweight and obese patients. Originally performed as the jejunoileal bypass procedure, the surgery essentially created a small pouch in the stomach that bypassed the small intestine. However, complications occurred at all stages and included, “life-threatening hepatic failure and cirrhosis, renal failure, oxalate nephropathy, immune complex disease, and multiple nutritional

deficiencies” (Mechanick et al. 4). In the following decades, doctors continued to develop safer, but still risky, forms of bariatric procedures.

As bariatric surgery developed safer methods of constricting food intake through gastric banding, doctors slowly began to increase the range of patients eligible for the procedures. In 1991, the NIH Consensus Development Conference Panel identified patients eligible for bariatric surgery as those persons having a BMI greater than 40 kg/m², but patients with BMIs lower than that number could also be approved if they exhibited “high-risk comorbid conditions,” including uncontrolled heart problems and diabetes (Mechanick et al. 4). Patients with a BMI between 35 and 40 could also claim decreased quality of life as a reason for electing bariatric surgery, including problems with employment, social or familial interaction, or leisure activities. Though once considered a procedure for adults of a specific age range only (<18 and >60), doctors now seek to effectively market surgery as safe and desirable for obese patients of all ages. An article in the *Journal of Gastrointestinal Surgery* suggests that the benefits of decreased comorbidity in older and younger bariatric patients outweighs any “serious” complications resulting from surgery. The authors confidently state, “Bariatric surgery is safe and effective at high volume centers for patients with morbid obesity at both extremes of age,” defining the extremes as patients above the age of 60 or below the age of 18 (Fatima et al.). Though the majority of surgery *candidates*, i.e., those with risk factors needing bariatric surgery for treatment, are at the lowest income brackets and educational levels, the majority of patients receiving the surgery are women from upper income, highly educated levels of society. There are not equal numbers of men electing bariatric surgery at the same income and educational levels (Santry et al.).

However, across all socioeconomic groups, incidence of bariatric surgery has increased exponentially in the United States. However, the rise in patients electing bariatric surgery does not match the argued rise in overweight and obese persons: “Estimates suggest that the number of bariatric procedures performed in the United States increased from 13,365 in 1998 to nearly 150,000 in 2005, and to approximately 200,000 procedures in 2007, according to the ASMBS” (Mechanick et al. 3). With over an 1000% percent increase in seven years and another 33.3% increase in the next two, the numbers would hopefully show at least *some* substantial, correlative increase in numbers of obese persons. Comparatively, from 1999-2000 to 2001-2002, obesity rates moved a marginal 64.5% to 65.7% among adults classified as either overweight or obese, and the margin of increase for children was only slightly bigger, from 29.9% to 31.5% (Hedley). The group most important to bariatric surgeons, the obese or extremely obese, accounts for around 34% of the population in the United States in 2006 (Ogden et al.). For children in 2004, overweight female and male adolescents accounted for 16.0% and 18.2% of the population, respectively (Ogden). The numbers simply do not match, increasing suspicions that bariatric surgery may not only be performed for health reasons. With the rise in bariatric procedures not matching the rise in obesity among adults, the question of how doctors are marketing surgery to patients must be raised in order to understand how adolescents have become a target group for weight loss procedures.

Bariatric surgery largely remains at the clinical trial stage for adolescents, and the procedure does not yet garner full cultural support, as parents often first seek behavioral (eating and exercise) modification or even hormonal treatment (Berkowitz et al.). The number of obese adolescents having gastric bypass surgery was a mere 2,700 between

1996 and 2003 (“Bariatric Surgery for Severe Obesity”). Many articles continue to suggest other treatments for extremely obese adolescents (Kiess et al.). In some cases, opponents contest the long-term effectiveness of surgery, noting that pouch expansion (in the lap-band procedure), abscesses (in gastric banding), or malabsorption of nutrients (in all bariatric procedures) are just some of the complications that teenagers face. Yet despite these dangers, researchers and doctors are still searching for (and finding) ways to portray bariatric surgery in adolescents as safe, desirable, and necessary.

3.3 Cutting Out the Young Obese

A disconnect exists between marketing techniques to adults eligible for bariatric procedures and adolescents, but both techniques share some common ground. Any bariatric intervention, for adults and adolescents, is first and foremost positioned as a health intervention even though the procedure ostensibly alters a healthy organ (placing a band around a stomach that otherwise performs normally). For adolescents, doctors and authors favorable to surgery portray the procedure as even more beneficial to lowering problems associated with obesity and extreme obesity. Later in this section, I will provide some research that disputes whether weight loss in adolescents actually leads to decreased comorbidities related to obesity. First, however, it is necessary to understand how doctors situate adolescent obese bodies in need of medical intervention.

Almost every article reviewed for this essay that discussed the benefits of bariatric surgery, including ones from *JAMA*, the *Journal of Pediatric Surgery*, data reports from the National Institute of Health (NIH), and others, mentioned the potential benefits

adolescents would reap from their new bodies (through weight loss) not just at that moment but also into adulthood. This move rhetorically places patients under 18 as ones who pose the threat of abnormality into adulthood. By fixing these wrong bodies now, they will not have to suffer the consequences as adults. The case I described in section one of patient Ashley X is salient here. The important connection between that case and bariatric surgery in adolescents is how rhetors (either Ashley's parents or doctors advocating surgery) construct the body as right or wrong. In Ashley's case, her parents aimed to "project an image of the body Ashley would have when she grew into adulthood without the Treatment, and to portray that body as wrong for and even harmful to her well-being" (Jordan, "Reshaping" 25). Jordan goes on to point out that those protesting the surgery focused on the wrongness of society's attitudes that would necessitate an intervention as drastic as Ashley's in the name of her comfort and health. Similarly, doctors positing the benefits of surgical alteration of the stomach in an adolescent posit the obese body as one that will be wrong in the future. As potential adults, adolescents are portrayed as responsible for becoming right adults, even if it requires life-altering surgery at a young age.

When the cases are less clear cut among adolescents with no cognitive disability, the problems arising for surgical intervention become murkier around wrong bodies. In some ways, though not as drastic, adolescent obese bodies are positioned in much the same way as Ashley X's body. Doctors, employers, and individuals often construct the obese body as disabled, a body that conveys "the societal presumption that disabled bodies are always already disorderly and therefore in need of medical correction" (Jordan, "Reshaping" 30-31).^{vii} Bariatric intervention situates disabled obese adolescent

bodies as ones with the potential to become “orderly” through “medical correction.” That is, if adolescents with the “illness” of obesity are corrected early enough, they can still grow into correctly embodied adults.

Situating the adolescent body in this way is crucial for medical practitioners seeking to garner support for bariatric surgery in adolescents. In the discussions of candidacy for bariatric surgery and the potential benefits of the operation, authors identify patients under the age of 18 like adults, using criteria comparable to adult candidacy and situating the benefits for adolescents as ones that will affect their adulthood. Academic authors and medical researchers often begin by constructing adolescent weight as one that will continue into adulthood. In one article, the authors write, “Studies show that 50% to 77% of children and adolescents who are obese carry their obesity into adulthood, thus increasing their risk of developing serious and often life-threatening conditions,” though the article goes on to note that “a proportion (20-30%) of obese adolescents may not be destined to become obese adults” (Inge 217). The article is unclear about the discrepancy between the two percentages, since the totals do not account for all obese adolescents. Central concern remains on constructing adolescents as adults, obese or otherwise.

One article from *The Journal of Pediatric Surgery* situated adolescents bodies as almost adults or like adults in three different instances. In his article “Laparoscopic adjustable gastric banding in adolescent: safety and efficacy,” Aayed Al-Qahtani first associates related increased morbidities in obese adults and obese adolescents, including insulin resistance and hypertension among others, morbidities, he writes, once thought to be less severe in children. He goes on, as Thomas Inge does in his article, to mention the

statistic of 50% to 77% of young persons carrying obesity into adulthood. Most importantly, however, this article notes, “The adult experience has demonstrated that surgery is the only effective means of achieving persistent weight loss in obese patients” (Al-Qahtani). The assumption of the article ~~of course~~ is that if a method, no matter how invasive or life-changing, is effective for adults, then its efficacy may also be approvable for adolescents. The criteria of the study conducted for this research considered “patients for surgery [that] met adult criteria set by the National Institutes of Health for surgical correction of morbid obesity” (Horgan et al.). Another article writes, “Based on the efficacy and the safety data reported in large international adult series as well as our own experience with currently more than 300 adult patients, we offered LAGB [laparoscopic adjustable gastric banding] as an alternative to GB [gastric banding] to eligible adolescents” (Horgan et al.). This is standard procedure for consideration of pediatric patients or adolescents in bariatric surgery, whether for gastric bypass or laparoscopic adjustable banding procedures. Though medicine standardly considers adult criteria for children in any new procedure, it is this type of rhetorical positioning of adolescents that creates a linguistic warrant for medical procedures.

The media similarly presents the issue of bariatric surgery for adolescents as one that will aid them as potential adults. In one article from *ABC News Online*, teenagers from ages 14 to 17 received lap band surgery, a procedure the article points out will leave them with a band on their stomachs into adulthood and potentially for the rest of their lives (Hutchinson). The criteria of candidacy for bariatric surgery in adolescents, as it was in medical research, posits these patients as physically similar to adults: “Adolescent candidates for bariatric surgery should be very severely obese (defined by the World

Health Organization as a body mass index of ≥ 40), have attained a majority of skeletal maturity (generally ≥ 13 years of age for girls and ≥ 15 years of age for boys), and have comorbidities related to obesity that might be remedied with durable weight loss” (Inge 217). The adolescent body is one that is almost an adult or that is already adult-like.

However, one of the most significant features of creating adult bodies out of adolescents comes through the media’s use of anecdotes. Though many media articles recognize the disturbing fact that children as young as twelve are receiving a form of bariatric surgery, every article focuses on the stories of the older patients, those at age seventeen or older, when discussing the potential benefits of the surgery. Using the “success story” of an older teen as a metonymical representation of all bariatric surgery adolescent patients allows the media to situate more solidly the entire group as almost-adults who are qualified both physically and mentally to undergo surgery.

In a short article from *MSNBC*, the author writes, “The youngest patients were age 12, but most were older teens. Eric Decker was one of them. In 2003, at age 17, he had gastric bypass surgery, the most common obesity operation in teens and adults” (“Obesity Surgery Triples”). The article goes on to focus on Decker’s story almost exclusively, returning to the larger issue of surgery only in the last paragraph. The photos included with the story show an overweight, uncomfortable Decker next to an after shot of a thinner, smiling almost man. Another article from *MSNBC* entitled “Should Teens Risk Bariatric Surgery?” is the same, focusing on the story of seventeen year old Jonathan Lebron (Roker). Articles from *The New York Times*, *The Washington Post*, and the *LA Times* are all similar (Hartocollis; Andrews; Maugh). While these articles pay lip-service to potential dangers of surgery, ostensibly covering both sides of benefits and

complications, the stories chosen for adolescent bodies position *all* adolescent bodies undergoing bariatric surgery as like adults, whether they are seventeen or twelve.

Both the medical community and the media posture obese adolescents as almost-adults, focusing on the similarities in benefits between the two groups and largely telling the stories of older adolescents coming out of surgery (those who are, in fact, almost legally adults). This rhetorical move lessens the shock for most readers of young people receiving such invasive surgery. Even in one editorial comment against a media article on adolescent bariatric surgery, the focus against young people having the procedure remains on the younger group of children. In a letter to the editor, one responder writes, “Twelve-year-old children cannot be responsible for providing their own caloric intake, so their obesity must result from their parents’ overfeeding them or allowing them to overeat...and to develop their food addiction” (Taverner). The comment does not address older adolescents receiving surgery, and refers to pediatric patients throughout the response as “children.” Effectively posing older adolescents as almost adults through focusing on similar benefits from surgery and telling their stories allows the medical community and the media to lump a somewhat vague group of older adolescents in with adults, where adolescent bodies become adult-like bodies and doctors can approve those bodies for invasive surgery.

3.4 Wrong Body as Failed Body

Quite similarly to the way the rhetoric of the medical community and the media constructs pregnant obese bodies, the rhetoric of adolescent bariatric surgery necessitates

notions of wrong bodies and right bodies. In the particular articles in this section, wrong body rhetoric is constructed around the idea that the wrong body (the obese body) can and should be fixed by surgical intervention because, due to its wrongness, it is incapable of fixing itself. Thus, adolescent bariatric surgery suggestions are always already imbued with moral implications.

In John Jordan's formulation of the wrong body, the obese body is read as "wrong" by physicians and surgeons because a patient's weight does not follow the medical requirements of health. For patients, weight may seem wrong since it may not represent patients' idealized versions of selves, or at least idealized versions inculcated by incessant media and cultural suggestions. Bariatric surgery offers a way to adjust the wrong body into a healthy or an ideal one, into a more acceptable body. These standards of health and idealization are, of course, set by dominant discourse embedded in explicit and implicit messages from medicine, media, and peers.

An important component in authorizing bariatric surgery for adolescents lies in the situation of obese bodies not only as wrong but also as incapable of inducing change in their own bodies without the aid of medical intervention. As noted previously, obese bodies have already been legally designated as disabled and are also often situated as morally culpable for obesity. Eric Oliver in his text *Fat Politics* notes, "[M]ost Americans...believe that fat people are morally deviant, self-indulgent, and unwilling to correct their own behavior" (74). However, considering "most Americans" are now according to medical definition overweight or obese, two explanations seem sufficient to clarify this paradox. Firstly, the diet and medical industries have successfully inculcated a certain measure of self-loathing in a significant percentage of the population. Secondly,

overweight Americans, the larger population targeted by weight stigma, may further stigmatizes the obese as deviants. This belief becomes a semantic battle of “I’m not as fat as that.” Since obese persons are unable to fix their bodies, surgical intervention becomes necessary as a way not only of inducing weight loss but also as a way to forcefully change eating habits. This is due to the necessity of a post-surgery diet, in some cases that is restricted to liquid calories only for weeks after the surgery (Dermody & Illing).

Adolescents are in a unique position within this rhetoric of incapability. Not only is eligibility for surgery is predicated on the notion of failure, but obese adolescents are also sometimes situated -as out of control of their own eating habits (parents control food in the household, so adolescents aren’t to blame). For eligibility in surgery, unlike obese adults, obese adolescents must first attempt six months of medical intervention at the behavioral level prior to being considered for surgery (“Bariatric Surgery for Severe Obesity”). What is entailed in that six months of treatment is left to the discretion of doctors, and it is unclear whether or not any weight loss at all or weight loss removing the patient’s classification as extremely obese counts as success. In most articles, either about adult or adolescent obesity, the general consensus remains pessimistic about *any* long-term weight loss in extremely obese patients, predicting their failure before they even begin efforts at lifestyle changes for weight loss. A flyer promoting bariatric surgery boasts, “Mean weight loss is between 40 percent and 70 percent of excess weight after one to four years” (“Weight Loss Surgery for Severely Obese Patients”). Meanwhile, Weight Watchers, the most successful popular dietary plan, has only shown around a 5% decrease in body weight over the first year, which decreased to 2.5% weight loss within two years (“Diet Plan Success Tough to Weigh”). Other diets show little long-term

weight loss and in some cases may even lead to weight gain. Surgery seems almost like a miracle option that might help adults and adolescents avoid the shame of yet another diet fad failure.

Articles directly target teens as less morally culpable for their obesity than obese adults, likely because childhood and adolescent obesity is often blamed on the lifestyle habits of families or cultural forces. Surgery stands as an option that can move obese adolescents beyond their families' "bad" habits and into a normal body, but only if the teens agree to drop the eating customs they learned and adapt new, post-surgery customs that continue to mark their bodies as deviant: "Dr. Roberta Maller Hartman, a psychologist and Lap-Band patient herself, counsels teens and adults after receiving the gastric band. 'I've worked with a lot of high school students and they just want to be like everyone else and go out and eat pizza with their friends,' she said, 'They can, but they have to take little bites and chew a lot'" (Sherman). Pre-surgery, the body was visually marked as deviant by its weight; post-surgery, the body becomes deviant through habits necessary to avoid complications. Another article from *The New York Times* writes, "It's not just you can't eat Thanksgiving dinner," Dr. Zuckerman said. "You're going to have to have this tiny little meal for the rest of your life" (Hartocollis). Surgery forces the failed body to change, yet it also marks the behaviors and customs learned from family, culture, and friends as wrong. Adolescents in this position are then faced with constant failure, either through their wrong bodies or for the rest of their lives with learned eating customs. To be eligible for surgery, patients first fail at six months of "behavioral modification"; patients then have their wrong bodies fixed in order to prevent future health and social failure; and finally, if post-procedure complications ensue, it is likely

the failure of the adolescents to follow prescriptions of eating and exercise necessitated by surgery.

In one article discussing the successes and failures of lap-band surgery, the authors point to poor eating habits as the reason for complications in surgery. One psychologist recommended, “Success depends most on a patient's ability to modify their behavior. ‘The band doesn't reduce the desire to eat emotionally. That has to be addressed,’ said Dr. Maller” (Sherman). Another article blames “revisions,” those adolescents needed a second bariatric procedure following initial surgery, directly on poor eating habits: “[Dr.] O'Brien added that he was disappointed with the number of revisions in the surgical group, but said that it pointed to the need to educate patients about how to eat properly with the band” (Stein). Even though patients have the chance to normalize their body weight through surgery, the moral component of control over their bodies is still included in the rhetoric of the surgery. The use of “educate” and “address” rhetorically sets up the notion of failure for the adolescents, in that it is doctors who will educate and address the wrong eating habits that may cause complications in surgery, *not* the patients.-

The wrong body of obesity becomes situated as the failed body, one that lacks the moral fortitude to comply with medical and societal parameters of body weight and size. In order to authorize bariatric surgery, doctors need to situate the patient as abnormal both in terms of wrong-ness, in reference to physical size, and in terms of immorality, in reference to the patient's inability to eat right or exercise right or, at best, to have bad genes or to have learned bad habits from adults. The obese body is doubly marked as wrong and immoral. As dietary or exercise changes become more solidly constructed as

an inefficient way of reshaping the obese body, more patients will likely turn to surgery in order to achieve medical and societal acceptance. Adolescents, in this doubly marked body, face the societal pressure to prevent themselves from becoming obese adults, and if bariatric surgery is approved for treatment of adolescent obesity, it may become the go-to option, rather than facing the back and forth effects of dieting weight loss and gain.

3.5 Social Judgment

Unfortunately, many of the medical articles promoting bariatric surgery or suggesting its increased use in obese adolescents fail to mention motivating factors for patients outside of comorbidities. Though the obese adolescent body is situated, at least partially, as a morally failed one, the decision for bariatric surgery is presented as a choice based on issues of health alone. Most of these articles do not cover the impact of social stigma on obese individuals. Articles that focus on social stigmatization of obesity in adults and in adolescents do not cover bariatric surgery, and the opposite stands true as well. In *Pediatrics*, one article on bariatric surgery in adolescents states, “The adolescent candidate for surgery must possess decisional capacity and participate in the decision process as well as have parental support. In other words, the adolescent must want the intervention and understand what is involved” (Wittgrove et al. 254). The authors go on to write that understanding involves awareness of potential complications of the surgery and the need for life-long dietary maintenance post-surgery. There is no mention of social stigmatization which might impact “decisional capacity.” Another article from the *Archives of Pediatrics and Adolescent Medicine* focuses solely on social relationships

without an interest in decision-making processes in surgery, stating, “Overweight adolescents were more likely to be socially isolated and to be peripheral to social networks than were normal-weight adolescents” (Strauss). The integration of surgery decisions and social stigma is not made in academic articles; instead, authors work to focus on the so-called objective benefits of health rather than take into account any social benefits that may come from surgery and thus impact the decision to opt for the operation in the first place.

The social benefits of weight loss induced by bariatric surgery appear most prominently within popular news outlets such as the *LA Times*, ABC News, and BBC News. While medical journals and articles seek to keep science and public opinion wholly separate, media outlets blend popularized medical knowledge with public opinion on obesity. When the media inappropriately portrays the benefits or dangers of recent medical knowledge, misrepresentations of surgery’s benefits are rampant, especially in relation to benefits for the obese. On the ABC News website, a teen who underwent gastric bypass surgery is included as a testimonial to the potential for bariatric intervention to improve self-esteem as well as health. The teen is quoted, stating, “I feel I’ve gained this confidence, people who have known me for years say I have a different presence now” (Hutchinson 1). However, the article only briefly mentions complications with lap-band surgery, citing one in three patients as needing follow-up procedures but failing to mention whether these follow-ups were serious or minor. Rather, the article retains its focus on the potential for surgery to change the social lives of obese adolescents.

A report from *MSNBC*’s website notes the disparity between girls and boys and

amongst races in the number of adolescents receiving bariatric surgery. The article underscores the very social reasons behind the decisions made for a life-altering surgery, yet the article is among the few. In a study of Californian obese teens, the article notes, “[T]hough girls made up 43 percent of the overweight kids in the study, they accounted for 78 percent of those who got operations” (Aleccia). Health writer JoNel Aleccia of MSNBC goes on to acknowledge that girls generally face greater social pressure to be thin, particularly white females, commenting on cultural differences that may perceive higher weights among African Americans and Latinos as more acceptable.

The problem with popularizing medical knowledge in the media is that the public is often misled about the potentials of medical intervention and in the worst cases is completely misinformed. Editor Richard Smith writes in the *Journal of the Royal Society of Medicine* that while a publication in medical journals is usually accompanied by press releases, this information is often not accurately conveyed in the media. He writes, “The mass media do a mostly competent job of reporting on new studies, although the complexities, the “ifs and buts”, are inevitably left out” (Smith 351). In the case of bariatric surgery, the “ifs and buts” tend to be important complications from surgery, and both the media articles as well as the medical journals tend to efface the socially-situated position of obesity *and* surgical complications.

Medicine and media often end up reporting on two sides of the same issue. While medicine focuses principally on the “objective” gains of bariatric surgery in adolescence, the media concerns itself with the more subjective area of the potential social benefits the procedure offers. Recognizing a blend between the two issues would greatly strengthen the research and information in both fields, and give pediatric patients and parents a

better idea of all of the pressures that may influence the choice for surgery or not. Noting the disparity of adolescents opting for the surgery might also attune doctors to the reasons behind a patient's decision.

4.0 Fat, Control, and Choice

Since meaning is negotiated primarily through means of communication and signification, it is possible to suggest that cultural production provides an important site for the construction of ideological processes. (Michelle Barret, “Women’s Oppression Today: Problems in Marxist Feminist Analysis” 134)

4.1 The Obesity “Epic-demic?”^{viii}

Almost every document quoted throughout this analysis assumes the reality of the “obesity epidemic,” and further, each document assumes that epidemic is of national or even global interest. The need for bariatric surgery or for prenatal intervention in obese individuals is predicated on the notion that the obese body is wrong, medically and socially. If the need for surgery or specified prenatal patterns is based entirely around the question of obesity threatening not only the lives of individuals but the general health of the public, the legitimacy of the epidemic must be questioned prior to offering such a surgery to either adolescents or adults.

Responses to suggestions for bariatric surgery and prenatal intervention in all cases oscillate between support and fury. Popular media articles from *ABC*, *BBC*, and *Reuters* express support for adult bariatric intervention but may at least express some reservation about its efficacy in adolescents. In medical articles advocating obesity, we have seen that adolescents are embodied as or like adults in order to rhetorically approve such a procedure to a group who are in legal statute and in body still children, still growing. Similar responses arise to suggestions for obese pregnancy. While the verdict remains out as to what exactly must be done about pregnant obese bodies, all articles, both media and medicine, agree that something must be done to curb the rise of obese and overweight motherhood and adolescence. In fact, the only thing all of these articles

agree on is that *something* must be done about obese bodies, adolescent and adult alike.

Detractors from obesity epidemic rhetoric seek to situate the phenomenon as one largely of social construction in which wrong bodies are targeted for control by the medical community and by the media. Of course, while serious health concerns raised by doctors should not simply be disregarded, potential bariatric patients, involved parents, future mothers and fathers, and concerned researchers should heed the numerous counterpoints raised by activists and researchers involved in questioning obesity epidemic realities.

Most articles and subsequently readers assume that the designation of obesity 1) is static and 2) correlates to significant health problems *solely* on the basis of weight. In the case of the first assumption, articles and readers overlook the fact that definitions of overweight and obesity have changed numerous times in the last century. Most significantly, the World Health Organization adjusted the numbers in 1997, around the time bariatric surgeries began to spike (mentioned earlier in this ~~article~~thesis). Doctors once classified male and female patients as overweight at a BMI of 27; now, those are numbers place overweight at a BMI of 25 and obesity at a BMI of 30 (“Obesity: Preventing and Managing the Global Epidemic”). The numbers were changed *without* clear scientific evidence that overweight or lower levels of obesity constituted a significant risk in health for individuals. Eric Oliver points out that two different studies “calculated that obesity (defined as a BMI of 30 or above) was causing several hundred thousand deaths a year. Yet in neither of these studies did the researchers actually measure the linkage between obesity and death,” leaving it up to the audience to decide whether or not death was linked to body fat or to other factors, such as exercise,

insurance problems (as obese individuals often receive poorer or no health coverage based only on BMI), or genes (24).

There are a number of other questionable aspects about the obesity epidemic, which Oliver clearly covers in his text *Fat Politics*, and the relevance here is that bariatric surgery is recommended to individuals based solely on co-morbidities caused by body weight alone. Particularly, doctors recommend that an adolescent needs to be at an increased risk of a number of conditions, including hypertension, diabetes, cancer, before being approved for surgery. Among pregnant women, recommendations of weight gain are based solely on prescriptions of body weight, not on existing conditions related to obesity (i.e. even if a woman does not present symptoms of diabetes, preeclampsia, etc., she is still told to lose weight). It is assumed, rather, that individuals have these conditions or will have these conditions if they are obese.

Yet, *without weight loss*, these conditions can be alleviated or reconciled. Glenn Gaesser, author of *Big Fat Lies* and professor of exercise physiology, writes, “If weight loss were such a crucial aspect in solving these problems [of health], however, one would expect to see a good correlative relationship between the amount of weight lost and the improvements it is generally thought to be responsible for. Many programs have found that such improvements come about *when little or even no weight is lost*, as long as certain key changes in activity and diet *are made*”(71). The notion that either bariatric surgery or maintenance of overweight or obesity during pregnancy will solve health problems of patients by inducing weight loss remains largely a myth. If individuals fail to sufficiently switch to a healthier diet and begin an exercise regime, they potentially remain at the same risk level they were at when they were obese.

Adolescents already facing the pressures of societal judgment on their wrong bodies then subsequently face the judgments of the medical community. The wrong body may have similar problems to other right bodies, but the problems are because of the body fat and not other underlying issues that afflict right bodies. However, as numerous authors have recently uncovered, the comorbidities facing obese individuals are often little different from “healthy” bodies; yet because these obese bodies are not ideal to doctors, those bodies become perfect candidates for bariatric surgeries. These adolescents and doctors thus rhetorically resituate an otherwise “healthy” body, one in which there is nothing wrong with the stomach, as one that affects an adolescent’s overall well-being. “The body desired,” in John Jordan’s terms, becomes that body which can meet a “right” body size, even if this requires surgical alteration.

Some of the health effects that impact obese bodies and so-called normal bodies are surprising, and the problem, of course, is that the data available is contradictory. For instance, according to one article, “[T]he vast majority of studies show . . . an association between body mass index and morality” (Stevens & Popkin 713). However, Paul Campos, a well-known detractor of obesity epidemic notes, “[T]he health risks associated with greater-than-average weight decline with age, so that by the time people reach their mid-60s, people categorized as obese generally have no increased mortality risk when compared to so-called “ideal weight” individuals” (“Panic” A05). Other studies question the health effects of weight about hypertension and diabetes, two of the well-established comorbidities of overweight and obesity, as contradictory. For instance, hypertension, as Linda Bacon and Lucy Aphramor point out, may be accounted for in obese person by weight-cycling (losing weight and subsequently gaining it back) rather than weight itself.

In effect, the pressures to be thinner may be the cause of negative health effects. Similarly, Bacon and Aphramor point out that diabetes is more clearly associated with low income than with obesity, suggesting “that insulin resistance is a product of an underlying metabolic disturbance that predisposes the individual to increased fat storage due to compensatory insulin secretion. In other words, obesity may be an early symptom of diabetes as opposed to its primary underlying cause” (Bacon & Aphramor). The problem, detractors clearly note, is that correlation between weight and health does not sufficiently recognize other factors that skew results. In this context, the obesity epidemic for adults and for adolescents becomes a sketchy problem of faith in facts: doctors or critics?

4.2 Narratives of Fat Contagion

The experience of the human condition is riddled by death and disease. In contemporary medicine, we as a species have developed quite specific ways of responding to disease or disease potentials. In the introduction to her text *Contagious: Cultures, Carriers, and the Outbreak Narrative*, Priscilla Wald considers how medicine and culture deals with outbreaks of disease: “[T]he scenario of disease emergence was entirely familiar, and it facilitated the worldwide response to SARS. Accounts of prior disease outbreaks helped epidemiologists identify and respond to the problem” (Wald 1). The identification and handling of the epidemic of SARS, asserts Wald, fell into a quite distinguishable narrative pattern, one which identified a protagonist, an antagonist, and a hero. Wald’s analysis of patterns, players, and responsibility is a particularly useful

framework for comprehending how smaller narratives of obesity amalgamate to create meta-narratives for pregnant obesity and adolescent obesity.

One of the most important terms Wald works with in her introduction is “carrier” and the phenomena that arise out of the narratives of a carrier. Carriers may be either unhealthy and marked or healthy and unmarked, and the carrier’s status affects the overarching narrative of the epidemic. Wald writes, “The carrier is the archetypal stranger... This figure embodies not only the forbidden intrusions, the deep connections, and the most essential bonds of human communion but also the transformative power of communicable diseases” (10). A carrier can become both a stranger and a member of a culture, marking the boundaries between members that do not exist in geography but within the body itself. Once carriers are identified, they are made visible in order to situate carriers and non-carriers into a social schema.

Medical researchers have searched for a number of causes of the “obesity epidemic,” including a virus (Carter, Ow & Smith), a genetic deficiency^{ix}, or as many researchers have concluded, a combination of inherited traits and learned behavior from family and culture (Marti & Moreno-Aliaga). Yet popular accounts and media presentations present obesity as a disease, one that is “spreading” throughout the globe, reinforcing the carrier-like qualities of obese persons even though it is a state of being that is not communicable. Eric Oliver uncovers the analogous relationship of obesity and diseases, noting that the spike in news articles in 2000 was caused, not by new research, but by a set of carefully designed PowerPoint slides that mimicked a presentation about the spread of the AIDS virus (39). Pediatrician William Dietz created the slides based on examples of other disease infection demonstrations, including HIV, successfully

transforming what had been an incomprehensible table of numbers into a series of maps that showed states in the US growing darker and darker as the “epidemic” of obesity spread (Oliver 39).

The carrier is, in part, delineated by his or her capability to infect others. Since the general public and the medical community seems, at least partially, to construct the obesity epidemic as a disease, the bodies marked by obesity become similar to carriers. Marking adolescent obese bodies as well as pregnant obese bodies seems for clear epidemiological reasons; these two collective bodies share some of the greatest cultural potential to generate more fatness in the next generation. Whether or not the obesity epidemic is a media generated phenomenon, a public health crisis, or some strange blend between the two, marking adolescents and pregnant women is a clear rhetorical move to exercise the greatest control over the bodies that impact the future of a culture or generation or the human race. And unlike Wald’s healthy human carrier, the historical typhoid Mary, obese bodies do not have the potential to hide their carrier status, even if they are not even “infected” with the comorbidities or health issues of “typical” obese bodies.

In fact, the very notion of obesity as disease-, as epidemic, necessitates some action on the part of the medical and social community to control these bodies. As Wald points out, “Communicable disease illustrates the logic of social responsibility: the mandate to live with a consciousness of the effects of one’s actions on others. The idea of a healthy human carrier means that it is possible to constitute a threat without knowing it, making the mandate especially urgent” (22). An obese mother, even a healthy one, could potentially “infect” her children with obesity, either through lifestyle or genes, if she does

not first make the switch to a more healthy body. Similarly, adolescents have a social responsibility to become productive adults, and carrying obesity into adulthood represents an effect on adolescent's future adult selves.

Popular culture, the media, and medicine necessarily construct or allow narratives around these two bodies that have the greatest potential for control and change, in order to affect the status of obesity most powerfully. The obesity narratives included here almost exclusively include interviews of seventeen year olds (almost adults) to authorize bariatric surgery for a wider range of adolescents, or feature only mothers willing to change their habits to be in the right body for their babies. These narratives serve to simultaneously stigmatize and pathologize these individuals, affecting both the behavior of these obese individuals as well as the behavior of others in the larger community. This consequence, Wald notes, is typical of an outbreak narrative: "They promote or mitigate the stigmatizing of individuals, groups, populations, locales (regional and global), behaviors, and lifestyles, and they change economies" (Wald 3). Unfortunately, demanding change in adolescent or pregnant obese bodies serves to further ostracize bodies already cast as outsiders in most modern cultures.

4.3 Control of Body, Not Disease

Ultimately, the reality of the obesity epidemic becomes irrelevant when the patterns of narrative about adolescents and pregnant women become clearer. The goals of these narratives are not necessarily about the management of risk but about the control of a sinned or wrong body, a body that is outside of culture norms and marked by the

modern failure of excess. Power struggles over delineations of body size becomes a site to appropriate control. Michel Foucault considers the utilization of power as one that is not body to body, or in this case doctor to patient, or of one solely between the group and another, in this case the unhealthy obese and the healthy slender. Power is rather about “a way in which certain actions modify others. Which is to say, of course, that something called Power, with or without a capital letter, which is assumed to exist universally in a concentrated or diffused form, does not exist” (Foucault, “Subject and Power” 10). Power is a set of machinations that influence behavior, not the power of the media or of medicine itself. It is the diffused and ingrained belief itself that obese bodies are wrong bodies that allows medical justifications for intervention in adolescence and pregnancy to continue.

Obese bodies marked in opposition to the healthy bodies generate polemical choices that force pregnant women and adolescents into polemical choices: be healthy and stand on the side of the good body, or be unhealthy and choose to potentially “infect” the community with the disease of obesity. This polemicization gives a single type of body, the obese body, as one to focus energies on, to single out as the enemy. By constructing a certain type of “right” body, a myopic view of what human existence is arises.

In this logic, obese bodies and healthy bodies no longer contain individuals. Medicine and media are able to metaphorically quarantine individuals away from their own bodies. Foucault asserts, “The aim of these struggles is the power effects as such...the medical profession is not criticized primarily because it is a profit-making concern, but because it exercises an uncontrolled power over people’s bodies, their health

and their life and their death” (“Subject and Power” 14). Medicine and media exercise control over obesity and health, which allows for the diffuse power surveillance of culture to then control individuals who fall under the umbrella of obesity and health (which, of course, is potentially every individual). Mock-placement of power is given to individuals, through the choice of bariatric surgery or of maintaining weight in pregnancy, but accountability is not to individuals themselves but to the cult identity of health or obesity.

Bodies become named or coded as parts of a group, not as individuals, or in Louis Althusser’s term, bodies are interpellated into systems of control. Whether one is obese or healthy, overweight or underweight, a body is always named within a system by the very act of existing. Through this interpellation, Althusser argues, “individuals are turned into subjects (which are always ideological)” (Felluga). Allowing the body to be either obese or healthy, symptomatic or asymptomatic names us as subjects and *not* as individuals with agency. This naming allows the individual to be “interpellated as a (free) subject in order that he shall submit freely to the commandments of the Subject, i.e. in order that he shall (freely) accept his subjection, i.e. in order that he shall make the gestures and actions of his subjection by himself” (Althusser). The polemic of healthy and obese insidiously suggests that individuals in either category perform the requisite actions of that category, i.e. receiving bariatric surgery, i.e. keeping the weight off during pregnancy.

The narrative of the epidemic of obesity becomes one of potential, of “infection” by other obese individuals, of mothers passing it on to children, of adolescents growing into obese adults. Health becomes a norm waiting patiently to fall into obesity, and all

face the potential of abnormality. These narratives generate bodies as containers for normal fulfillment, empty spaces without individuals but with subjects. Foucault argued, “The code discourses come to define is not that of law but that of normalisation” (“Two Lectures” 107). Each discourse employs an objectification of the body: the body is an object that can *become* normal, *be* normalized. The body is assimilated to a form, a thing, an entity with a certain definition inside that one can create according to always already designated categories.

Power, in all forms but particularly over the body, functions through action rather than inaction to allow an outlet, a way for bodies to ostensibly participate in their own transformation. Foucault argues, “What makes power hold, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse” (“Truth and Power” 119). The obese body is imbued with a power to change, either through surgery or through weight maintenance; it is a body in constant state of potential to do something, to become something better. The obese body is never halted in its tracks but asked to be constantly in action.

Thus, the pregnant or adolescent body becomes complicit through its very being, whether seeking through action to belong to the eponym of healthy body or being narratized by others as needing to become a healthy body. The stories of “cures” through surgery or through weight-loss or maintenance create the story of the obese body without its consent. Stories like these have staying power because of their power to make people (want to) live within the story, to be a body that turned itself around, or to make people believe others live those stories. A successful story of the body obscures the extent to

which bodies are dominated by that story; the story operates at what Foucault states is “the level of the whole social body” (“Subject and Power” 15). Outlets for energies merely serve as a mask for the domination of bodies, driving away energy for self-liberating acts by constantly keeping the body in need of maintenance and perfection, constantly in need of the medical community’s advice and the media’s cultural approval.

4.4 Can We Make a Choice?

Many of the discussions on power are predicated on notions of ideology; bodies work within and among power because of the structures of ideology. The Western cultural productions of options like bariatric surgery for adolescents or pre-natal monitoring for mothers depend largely reflect the beliefs and values of the culture. These mechanisms reflect the construction that there *is* an ideal healthy body one can achieve.

Ideology is not a centralized idea or concept; it is, rather, a discursive set of actions that act both through the dominant power structures (medicine and media, in this case) and through the behaviors of each individual. When the behaviors of the individuals reflect the demands of the structures, demands on behavior become more strongly compelled, demands to conform as “healthy” subjects. Judith Newton and Deborah Rosenfelt reflect:

Ideology...is not a set of deliberate distortions imposed on us from above, but a complex and contradictory system of representations (discourse, images, myths) through which we experience ourselves in relation to each other and to the social structures in which we live. Ideology is a system of representations through which we experience *ourselves* as well, for the work of ideology is to construct coherent subjects. (xix)

In essence, it is not just the images and myths but the experience and actions of the

bodies subsumed under those images and myths that create ideologies.

Thus, once the *option* for bariatric surgery or for prenatal weight maintenance enters discourse, adolescent or female bodies are expected to take some course of action, an action that is, in many ways, already decided for these bodies. Since the healthy body was already constructed as the right body before these options entered the ideological field, the “choice” for operation or for prenatal maintenance is not a choice at all for obese persons. There is, for medicine, for media, and for ideology’s sake, *only one right choice*. All other choices are always already wrong. To either remain obese or to seek “health” through another avenue^x is to flout the authority of the system and to displace the body’s subjectivity within it.

A body choosing something other than the healthy body or even the typical notion of the healthy body is one that is out of control. Lynda Birke, in her text *Feminism and the Biological Body*, considers how choices about the body in Western ideology are centered with the subject. The subject, the body itself, has the control to make itself healthy, thinner, better. Yet, she points out, there may exist “the sick body,” one in which self-control fails and the body loses subjectivity. She notes, “[A] fat body is a body symbolising the failure of control both bodily and socially” (87). The social body (headed in the figure of a doctor) can make decisions for the individual that is unable to maintain control over fat and over the subjectified self. Adolescent and pregnant bodies are thus situated as being incapable of choice on this front.

Because of these bodies’ further positions as either child or female, there is a third barrier blocking any action beyond those prescribed by the media and medicine, and the first two, ideology and control, work in collusion with this final method. Children’s

bodies are legally under the control of their parents. Though the above articles mention that a child's consent is sought prior to continuing with bariatric surgery, ultimately no child would be allowed to go through the procedure with the knowledge and participation of parents.^{xi} While the choice for surgery remains one that must be jointly reached between parents and children, extreme cases of surgical intervention on the body of the child with *only* the parent's consent do exist.

Patient Ashley X, as noted in section two, is a severely disabled young girl. John Jordan argues in "Reshaping the Pillow Angel" that Ashley's parents and her doctors were able to approve an invasive surgery, one that marked her irreversibly for the rest of her life, not for her own health but for the convenience of her parents and for the need to conform to prescribed notions of body normalcy. Her body was modified because of a "medical...model of disability care," one which "work[s] to 'normalize' disabled persons" (23). Her parents used their rights as caregivers to make the decision she was unqualified or unable to make about the development of her body. At what point, either overtly or covertly, will parents be able to intervene on their obese child's behalf and elect for bariatric surgery as they would elect to have a tonsil removed?

In the case of pregnant women, lack of control over the body has a long and tedious history. Though dated, Susan Bordo's critique of gender ideologies that efface the pregnant woman's body remain highly relevant to an analysis such as this. She cites a number of court cases, largely from the 1980's, in the United States that upheld choices by doctors to force procedures on pregnant women, such as forced cesareans (79-80). This, she contends, is "the ideology of women-as-fetal-incubator," in which doctors and many women treat the pregnant female body not as the woman's but as a vessel, an

object for carrying a baby.

Yet the methods of control over the pregnant body have become more effectively institutionalized and need less coercive state control; Louis Althusser's concept of the state apparatus (police forces, laws, etc.) no longer need to function because control over the pregnant body is now firmly entrenched in the ideological state apparatuses, in schools, in pamphlets, in the news, and on and on. The very way medical birth is designed is one out of the pregnant woman's control. With such invasive policies, an action as simple as keeping off the weight doesn't seem like too much to ask of pregnant obese women, does it?

Yet these choices medicine and media ask women and children alike to make should be carefully scrutinized to avoid prejudice. Whether or not the obesity epidemic is based in medical fact, in sociocultural making, or in a no-woman's land between, the fact remains that these policies impact significant portions of the population in the United States alone, and even more world-wide. John Jordan warns, "When requests are made for surgical alterations that are medically feasible, but ethically questionable and socially undesirable, attention should be paid to the rhetorical forces informing the decision making" ("Reshaping" 24). Ethically questionable and socially undesirable, but for whom? We must put to the table that if *any* medical decision seems questionable or undesirable for *any* group of people, based on weight, height, race, gender, or another category, that decision should be analyzed and perhaps laid aside as one that may be just as social as it is medical.

It is an awareness of how medicine, media, and doctors rhetorically situate obese pregnant mothers and obese adolescents that will help to understand how the decisions

these two groups have to make may be influenced by more than just health or wellness. A rhetorical examination of features that are social or moral inside of language that positions itself as scientifically object exposes some of the problems with assuming that these procedures and suggestions are good options or the only options. It is the way that the rhetoric of obesity is couched in a power struggle of ideology that is the most important feature of this thesis project. Knowing that bodies of all sizes are sites of contested power and control changes the way we may view the medical decisions aimed at bodies, particularly bodies that are identified as problematic, uncontrollable, or wrong.

Future research needs to trace the link between bariatric surgery in adolescents and bariatric surgery in women. One article noted in the section on adolescents commented that young white girls were more likely to opt to have bariatric surgery, and another piece on pregnant women commented that white women faced the greatest social repercussions against fatness. Yet there is a disconnect; while research concludes white women and girls are most affected, racial prejudices and differences need to be more carefully researched in the field of fat studies, especially in differences of insurance policies, doctors' prejudices, and other forms of stigma obese ~~these~~ women and obese children may face. The choice for bariatric surgery in young girls also needs to be carefully researched for an underlying reproductive element; are young girls more likely to seek surgery for reproductive purposes?

In the face of such ideological pressures, we wonder if we can make informed decisions about our bodies at all. Yet it seems that a clear understanding of the mechanisms, in this case particularly wrong body rhetoric and fat stigma, at play within ideology at the very least grants bodies the tools to fight back against oppression and control. If

individuals within targeted groups, including obese adolescents and obese pregnant mothers, can fight back using similar rhetorical tools as the medicine and media, there may be a way to show the acute ethical and social issues with medical recommendations to these groups without attacking the obesity epidemic itself. As the epidemic is so entrenched in American culture and somewhat in the global mind, chipping away at the logic of treatment may bring about a more efficient shift in the stigmatization of fat bodies. At the same time, this rhetorical focus may also avoid replicating dualistic logic that might simply replace “normal” with “abnormal,” thus stigmatizing simply a different set of bodies.

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ⁱ The World Health Organization's website estimates that 1.5 billion adults are overweight, and of those, 500 million adults are obese.

ⁱⁱ Lee, S. "Exercise Without Weight Loss is an Effective Strategy for Obesity Reduction in Obese Individuals With or Without Type 2 Diabetes." *Journal of Applied Physiology* 99.3 (2005): 1220-225.

iii See Boero “Fat Kids,” mentioned in this article, and Marilyn Wann’s *Fat?So!*, which includes a case of a pregnant mother placed on a diet because the child *in utero* was considered overweight.

iv Louis Dublin, as Eric Oliver notes in *Fat Politics*, adapted the BMI index for insurance purposes, purposes that had no biological basis and did not account for any other factors influencing mortality.

v Weisman, Carol S., Marianne Hillemeier, Danielle Symons, Cynthia Chuang, and Anne-Marie Dyer. “Preconception Predictors of Weight Gain During Pregnancy: Prospective Findings from the Central Pennsylvania Women’s Health Study.” *Women’s Health Issues*. 20.2 (2010): 126-132.

vi See, for example, John Jordan’s examination of patient Ashely X in his article “Reshaping the Pillow Angel: Plastic Bodies and the Rhetoric of Normal Surgical Solutions.”

vii In 2008, the Equal Employment Opportunity Commission defined morbid obesity (now termed extreme obesity) as a legal disability. Persons categorized as overweight did not qualify for disability rights.

viii Marilyn Wann devised this term at a keynote lecture at Sarah Lawrence College’s *Breaking Boundaries* annual Women’s History Month Conference in 2011.

ix See Gina Kolata’s *Rethinking Thin* in her chapter titled “The Girl Who Had No Leptin” for an examination of blaming obesity on a genetic inability to produce leptin, a physiological mechanism that controls appetite and satiety. Kolata, Gina. *Rethinking Thin: The New Science of Weight-Loss - and the Myths and Realities of Dieting*. New York: Farrar, Straus, and Giroux, 2007.

x See the Health at Every Size model, created by Linda Bacon, for a lifestyle change that allows for health at all body sizes, without a focus on weight loss or gain.

xi As in other articles cited here, Abu-Abeid et al.’s 2003 article “Bariatric Surgery in Adolescence” in the *Journal for Pediatric Surgery* states, “Patients together with their families were counseled about the lifestyle change that would be necessary as a result of surgery.” Abu-Abeid, S. “Bariatric Surgery in Adolescence.” *Journal of Pediatric Surgery* 38.9 (2003): 1379-382.