FORMING FAT IDENTITIES

by

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ABSTRACT OF THE DISSERTATION

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Using data from a large national sample and 40 in-depth qualitative interviews, I explore how fat identities are formed. To understand this process, I argue one must deconstruct it into both the tangible trait around which the identity is formed (overweight) and the social meaning this trait symbolizes (fat). I conceptualize a fat identity as learned, trying, and all encompassing. It is learned via exposure to messages about weight, trying because of the physical and social challenges being overweight poses, and all encompassing because it permeates all experiences. Based upon these three criteria, I argue that fat identities exist on a sliding continuum.

I found many factors to define the length of one's climb to the fat threshold. This threshold designates the point at which fatness becomes an integral part of one's self concept. Present and past physical weight helps determine one's initial placement on the continuum. However, race and gender help to determine where on the continuum the threshold is placed.

Moreover, I found the physical and social changes that come with aging play an important role in one's slide up and down the fat continuum. Older people are more likely to be concerned about health conditions; younger people are more concerned about

the visible and social aspects of being fat. Finally, although I did not find evidence to support my hypothesis that discrimination forms fat identities, I did find that experiencing discrimination strengthens fat identities.

I conclude by calling for future research that follows the model put forth here. By looking at identities as an interaction between a physical trait and a social identity, researchers will be better equipped to understand identity formation, and how to alleviate the hardships involved with possessing a stigmatized identity. I conclude with suggestions for educating the public about the health implications of obesity while decreasing the stigma surrounding fat. I suggest using culturally sensitive plans designed around the specific needs of the diverse demographic of which the United States is comprised.

Dedication

This dissertation is dedicated to Mommy, Debbie, Linda, and Anne; four fat ladies who've made me wise.

Acknowledgments

Where do I begin? At seven years old my sister's friend, Dana, whispered into her ear, "Your mother's fat." My sister, who turned out to be fat herself, didn't know what to say, so she just said, "I know." So, I guess I have Dana to thank for teaching me my first lesson about what it means to be fat. Then, when I was eight, a child in my Hebrew school carpool, Jason, told me that all Jewish girls are ugly. I went into the elementary school bathroom, looked in the mirror, and for the first time wondered if I was fat. My mother thought I was crazy.

These are my earliest memories of when my fat identity formed. I wrote in my diary about them and spent years wondering who's fat? Am I fat? What's the cutoff? My early graduate school studies allowed me to frame these questions in a more intellectual manner and to put me on a journey that has not given me the peace with my weight that I sought, but has helped me to understand why I, the only non-overweight woman in my family, feel so fat.

Eviatar Zerubavel and Allan Horwitz who both graciously agreed to be on my dissertation committee framed my early thinking about how the most taken for granted aspects of society are subject to social definition. Their lessons repeat in my mind daily as I navigate my social world with a more acute eye.

John Worobey is simply the kindest man I have met. He is open, intelligent, and thoughtful and was the first professor to point me in the direction that would ultimately become this dissertation. I have valued our long discussions, and am grateful for the support, guidance, and friendship he's provided me over the years.

Words cannot express how fortunate I am that Tom Rudel suggested that Deborah Carr be my new adviser in my third year at Rutgers. The day I met her I had no idea how she would become my guide throughout the rest of my career at Rutgers, and potentially my intellectual career as a whole. Debby is brilliant, giving, and she makes everyone she comes in contact with strive to be just a little better than they thought they could be. Most of all, Debby took a beaten up student who was considering leaving the graduate program, and enabled me to write this work that has been in my heart since childhood, and needed the intellectual know-how to end up on paper.

My husband Seth would be a much richer man had I left school years ago. However, he has encouraged me and sacrificed for me for eight years, and it is because of him that I was able to find the stamina to finish.

My father said to me nine years ago, "Karen, I think you need to get a graduate degree. I don't care in what, but I think you need one." Thank you for sending me on this path Daddy!

And then my mother and sisters. These are three fat women who cannot be any more different from each other, yet they have all taught me what it means to be fat. Debbie is so dissatisfied; Linda sees a thin future self; my mother has figured out how to make peace. This dissertation is for them and about them. I have watched them struggle, and I've seen them misunderstood. These have been the single most formative experiences of my life.

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CHAPTER 1
The Major Themes
Theoretical Frame and Literature

A recent Gallup Poll shows that although over 60 percent of Americans are overweight or obese, only 40 percent see themselves as such. Furthermore, if everyone polled achieved their "ideal" weight, 36 percent would still be what the medical community considers overweight and 2 percent would be obese (Moore 2004). Despite research indicating there is high cross-cultural consistency concerning attractive facial features and, to an extent, body shape, there is far less consistency with regards to body size (Furnham, Dias, and McClelland 1998; Cunningham et al 1995). In this work, I explore how one assesses his or her weight—an important lens into how and why weight matters. Using statistical analyses and analysis of in-depth interviews, I have set out to gain a better understanding of who assesses themselves as overweight and why some people's medically defined weight does not determine how they assess their weight categorization. I do this by looking at the broader aspects of what it means to lie on the fat/thin continuum in U.S. society, and what parts of a person's social and psychological composition make him more or less likely to identify as fat.

This dissertation achieves this goal via three analytical chapters that are followed by an in-depth discussion of this work's findings in Chapter 6. All three analytical chapters ask the same question: What factors strengthen and foster a fat identify? In the first analytical chapter, Chapter 3, I begin to answer this question by assessing the effects of present weight, past weight, socio-demographic variables, and cognitive or psychological factors, such as self satisfaction and outlook on life, on bodyweight identification. The chapter that follows complements the third chapter by looking at the

effects of various indicators of physical health, or one's vulnerability to messages about health, on fat identities. In Chapter 4, as a prelude to the next chapter, I also explore fat's visibility and the tension between health and beauty ideals that often dictate how one rates his or her weight. Carrying the visibility theme to the fifth chapter, I explore how being discriminated against affects one's weight assessment. Finally, I conclude with the sixth chapter that ties together the findings from Chapters 3 through 5, reframing what has been learned from this work and how it might be built upon in future works.

This study adds to the rapidly growing body of literature about overweight and obesity, but adds a component which is often dismissed—fatness as a dual construct. Although there are many qualitative pieces on the fat experience, and numerous quantitative pieces on the growing health crisis that obesity presents, to my knowledge no work has wedded these two concepts together to show that there is more to overweight than merely a biological truth or a personal and social experience. In this work I demonstrate that, while a biological fact that many people experience, fat identities are social constructs defined and labeled through social processes. To emphasize this point, this chapter is dedicated to placing fatness—as many have done in the past with blackness, gender, homosexuality, and mental illness—within the theoretical confines of identity formation, boundaries, and social constructionism.

Obese versus Fat: the Medical versus the Social

Who is Fat?

Throughout this work the reader will see the use of the terms *overweight*, *obesity*, *corpulence*, and *fat*. In the quantitative sections of each chapter, I use the bodyweight cutoffs defined by the National Institutes of Health (see below) to discuss levels of

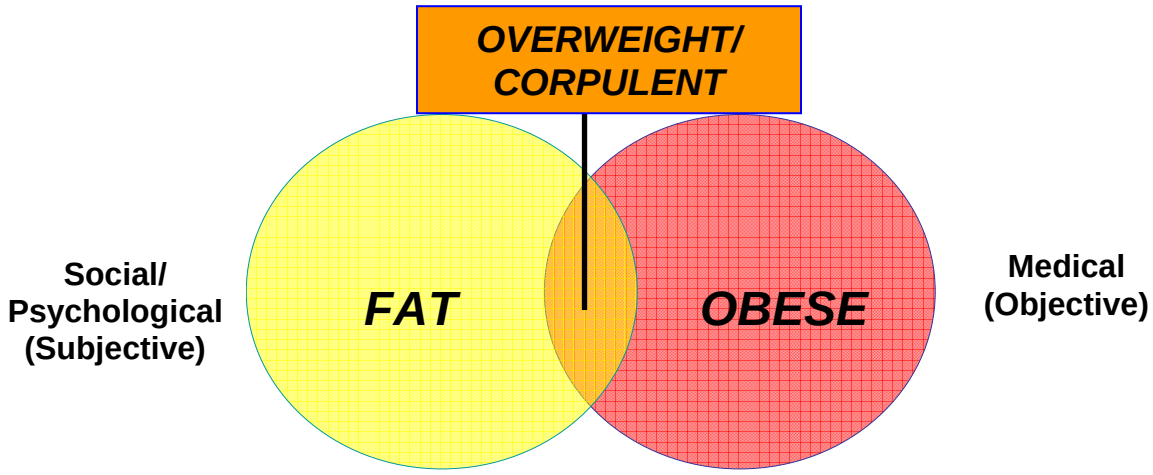
overweight. As such, *overweight* and *obesity* solely denote levels of weight in these sections. However, throughout the rest of this dissertation I take the widely used words *fat* and *obesity* and place them within a specific defining schema. Put most simply, *obesity* is strictly a medical term; *fat* is strictly a social term. *Overweight* and *corpulent* are used in both ways depending upon the context of the passage (Figure 1.1). It might be easier to conceptualize these terms as objective versus subjective weight evaluations. However, this must be done with caution. Although, as I will discuss shortly, there is growing scientific evidence that obesity is a risk factor for numerous chronic medical conditions, there is bias in how findings are reported, what findings are reported, and why certain findings are given attention while others are not (Campos 2004; Cogan 1999; Rothberg 1999). Alternately, social definitions are not entirely subjective. The social consequences of being corpulent are frequently quite real, as when someone is denied a job because of his or her weight (Solvay 2000). Furthermore, both the medical consequences of overweight and the social implications of it are going to be felt differently based upon a person's specific sociodemographic characteristics and past and present weight. As such, throughout this work, I will use the terms objective weight and subjective weight to refer to obesity versus fat, but I do this understanding that, on a level deeper than this dissertation may delve, this is not entirely accurate.

In addition, there is a distinction between being fat and having a fat identity. If one has a fat identity, he or she is fat. Any time I mention the words *fat* or *fatness* they refer to the negative social connotation associated with corpulence. However, to have a fat identity, one has to have, to some extent and in some context, learned he or she is fat, must suffer consequences for being fat, and it must, at some point, impact situations not

directly related to weight. Cooley's (1956) "looking-glass self" helps to explain the relationship between being fat and having a fat identity—although it is not an all-inclusive explanation. Cooley theorized that self-judgments are a reflection of how we perceive we are judged by others. Hence, if overweight people are treated like they are fat, they will begin to see themselves as such, and begin to identify as a fat person. However, there are instances of one having a fat identity that is strictly a function of a psychological disturbance, as opposed to one's body. For instance, an anorexic who is dangerously thin, will view him or herself as fat, and may even see an overweight body in the mirror. Hence, a fat identity is not always a social reflection on an overweight body. It is a perception based upon how an individual's set of beliefs, background, and psychological disposition controls how he or she processes information about ideal and non-ideal bodies.

Also, there are instances when one can be socially defined as fat but not possess a fat identity. Take for instance a Sumo wrestler who comes to the United States after retirement. For his entire life he was praised for his excessive weight, and reaped benefits from it. As such, he may identify as a celebrity, or a wrestler, but not a fat man. However, once he comes to the United States, he may lose his celebrity status and be viewed by others as simply fat, immoral, unhealthy, and ugly. Thus, others may view him as fat, but unless he sees himself as such, he does not possess a fat identity.

Figure 1.1. Terminology



Fat from Past to Present: Medicalization and Standardization of Beauty

The History of Body Weight: Its Meaning and Measurement Across Time

To gain a better understanding of the difference between being fat and obese, one has to look at the history of weight classification, and how the medical and the social have met throughout time. The earliest classification system that I am aware of is Wilhelm Ebstein's 1864 classification of obesity into three categories:

> Ebstein…has very appropriately divided the corpulent into three classes: "the enviable, the ridiculous, and the pitiable." The corpulent, of the first stage of obesity, have just enough fat stored under their skin to round the outlines of their body and to make them seem enviable to their skinny and angular fellow mortals. In the second stage, the fat has become so abundant in certain regions, and the body so unwieldy, that the unenviable figure and movements of the victim evoke a smile from others. In the third stage, the obese has become so helpless and is

> the subject of so many bodily afflictions, that he is indeed and object of pity. (Rogers 1918:5)

This piece, published in *The American Journal of Nursing*, illustrates the tension between the medical and the social that accompanies so much of the work about weight. Although authors of scholarly works today are obligated to make a clear statement about what aspect of weight their work is about, I suggest that if such political correctness were stripped from recent scholarly works, language similar to Ebstein's late 19th century words would emerge because overweight is both a social and physical problem. Looking at how body size has been viewed over the past century, and ultimately how it has emerged as the overpowering phenomenon it is today, helps to elucidate how these two very different parts of the corpulent experience are absolutely inextricable. As such, I begin my review in the 1880s when Henry Tanner committed a feat that would have enduring implications for fat people.

Health. By fasting for 42 days, Tanner proved that people could go longer than had previously been thought without food, and turned eating more than necessary to survive and thrive into an unnecessary indulgence (Seid 1989:77);[1] therefore, those who overate were now seen as excessive. As a result, not only were people now encouraged to diet, but the ideology that fat was something that people could control was furthered. Moreover, if people did not control their weight and eating, then the repercussions of being fat, whatever they may be, were deserved. As such, a perceived lack of control became displeasing to both those who lacked the control and others who were dismayed by seeing other people's lack of control. This was compounded with dropping childhood mortality rates, better medical knowledge, and more plentiful food resources—and

[1] Stearns (2002:35) notes a similar line of thinking by Upton Sinclair who around 1910 began writing in popular magazines about the benefits of fasting.

combined these events that all occurred around the turn of the century transformed overweight from a symbol for prosperity and health into a symbol of gluttony and poor health (Stearns 2002).

Around this time, the message that fat is unhealthy began to permeate the lay public through popular magazines and insurance companies began to correlate mortality with fatness, a trend that was beginning to take prominence in the scientific communities around the turn of the century. Insurance companies determined that they could charge higher rates to insure people who were considered overweight or obese. In the process of determining where the cutoff between what was "dangerous" and what was not laid, insurance companies solidified a boundary between fat and thin in American culture. This took great prominence when Louis I. Dublin, working for Metropolitan Life Insurance Company, actively began promoting the idea that people should fear obesity because it kills with his 1951 claim of obesity as "America's No. 1 Health Problem" (Seid 1989:116).

Dublin's work leading up to this claim had multiple implications for the fat boundary in America. First and foremost, corpulence now gained a new stigma: "No more was it merely ugly. It was lethal" (ibid.).[2] In addition, Dublin set out to standardize ideal body weight. In 1942 he produced charts stating ideal weights for men and followed this up a year later with such charts for women. Being the first time that "healthy" weights had been institutionally regulated in the United States, it had great implications for forming a dichotomous boundary between fat and thin:

> *Overweight, obesity, plumpness, chubbiness*, and other terms, which once described very different sizes and had very different connotations, would begin to

[2] See Seid (1989) for an excellent discussion of the sketchy and inconsistent methods use for determining fatness as a factor in premature death.

> be used interchangeably as Dublin's views became more widely adopted. Americans would seem to be divided into only two groups—the fat and the thin. (Seid 1989:117.)

Present day weight categorization gives proof to the longevity of this late 19th century to mid 20th century thinking. One of the most common ways of measuring overweight and obesity is by dividing a person's weight in kilograms by his height in meters squared. This ratio is commonly referred to as Body Mass Index (BMI) and is employed by health professionals to help determine one's risk of developing obesity related disease. The National Institutes for Health are one of the many national and international voices that not only accepts BMI as a valid measure of disease potential, but defines one as being overweight when his or her BMI equals or exceeds 25 (roughly 5'5 and 150 pounds), obese when his or her BMI equals or exceeds 30 (roughly 5'5 and 180 pounds), and defines "extreme obesity" as a BMI greater than or equal to 40 (roughly 5'5 and 240 pounds) (NHLBI 1998). Because this is a widely accepted classification system for health risk assessment in the United States, I use this to guide the analysis and thinking throughout this work. Using these demarcations, as of 2004, 66.3 percent of the US population was overweight or obese, 32.2 percent had a BMI between 30 and 39.9, and 4.8 percent of the population had a BMI greater than 40.

There is a large and persuasive body of epidemiological research that has documented that being overweight or obese is a risk factor for numerous chronic health conditions, including heart disease, diabetes, and some forms of cancer (Calle, Rodriguez, Walker-Thurmond, and Thun 2003; Yan et al. 2006). However, this is not without caveat. In 1998, the National Heart, Lung, and Blood Institute (NHLBI) published a comprehensive list of the risk factors associated with overweight including:

> hypertension, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, some types of cancer,…, complications with pregnancy, menstrual irregularities, hirsutism, stress incontinence, and psychological disorders. (P. 12)

The quote above is quite notable for two reasons. First, although NHLBI later explains that weight does not pose a risk to one's health until the person's BMI exceeds 25, earlier on page 12 it states: "[a]bove a BMI of *20* kg/m^2, morbidity for a number of health conditions increases as BMI increases"(NHLBI 1998:12, italics added by the author). This speaks to the vastly conflicting information about the health consequences related to overweight—even within one document. This becomes even clearer when reviewing other works that claim that a certain amount of overweight may even provide protective benefits from mortality from cancer and heart disease (Flegal, Graubard, Williamson, and Gail 2007, see Campos 2004 for a review of this literature), especially if one is in shape (Ernsberger and Koletsky 1999; Miller 1999). It also neglects the health problems posed by excessive thinness, especially for older adults who suffer from more frequent bone fractures (Langlois, Harris, Looker, Madans 1996).

Second, it is notable how many illnesses to which obese people are vulnerable—from the very serious such as heart disease and cancer to aesthetic concerns such as hair loss. Hence, it is quite possible, if not probable, that all overweight people will be afflicted with one of these illnesses in his or her lifetime—whether or not it is truly related to weight. Because nearly any symptom can be attributed to weight, and the line between overweight and not is dynamic based upon varying scientific studies, the health implications of weight have a potentially tremendous impact on fat identity formation. Furthermore, by connecting the social view of overweight as glutinous, immoral, and

ugly, with the physical fact that obesity increases one's risk of numerous health conditions, fatness has been greatly medicalized.

Put most simply, medicalization is the "process by which nonmedical problems become defined and treated as medical problems" (Conrad 1992:209). What makes a fat identity so vulnerable to medicalization is that obesity *does* cause medical problems and many fat people are overweight enough to be classified as obese. However, one can be fat and not obese and fat people often have trouble distinguishing between health problems that are and are not associated with their weight. It does not help that doctors also do this. By associating a patient's health problems with his or her weight, doctors frequently miss underlying health problems. This leaves overweight people frustrated, discriminated against, and unhealthy (Zengerle 2007). As such, with the declarations throughout history that obesity is a disease (see Kolata 1985; Nestle and Jacobson 2002), simply having extra adipose tissue, whether there is enough to deem one obese or not, causes people to view their fatness not only in terms of social discomfort, but as a medical problem as well.

Fitting In: The Standardization of Fashion. Along with standardized ideal weights came standardized clothing sizes. With changing fashions and modifications in how people buy clothing, the boundary between fat and thin has changed and continues to wax and wane. Prior to the 1920s people bought or made custom-fitted clothing. Yet, with the standardization of dress sizes this practice became nearly non-existent and consequently women were now required to fit into pre-made clothes at pre-determined sizes (Brumberg 1988; Stearns 2002). In addition, in the late 1950s more smaller sizes and fewer larger sizes were beginning to be stocked in clothing stores (Seid 1989), even

though this has changed in recent years as the clothing size indicators become smaller and the clothing becomes larger (for example, a size 6 today was a size 8 in the 1980s) (Brody 2004). As a result, clothing manufacturers and their advertisers act as gatekeepers between fat and thin.

In sum, the medical community, media, and the lay public have actively contributed to the fat boundary, unleashing a phenomenon that would continue to grow in years to come as the boundary between fat and thin—although always lying on a continuum and subject to each person's "unique configurations" and the "cultural environment" in which he or she lives (Bordo 1992:62)—has become an enduring part of life. Having a fat body comes with expectations from self and other that ultimately leads to a fat identity.

What is a Fat Identity?

Background

Identities are the role expectations that come with "…various meanings [that are] attached to oneself by self and by others, and locates one in social space through the relationships implied by the identity" (Hitlin 2003:120; see Stryker and Burke 2000). Identity is both a cognitive and social construct. Our self identity is formed based upon who we are as individuals and how we are different from others. Where and how we differentiate ourselves (or are differentiated by others) is a fluid process; "[w]e experience ourselves not only as 'I' but also collectively as 'we'…" (Zerubavel 1991:14). It is only through comparison with others that "difference" or uniqueness is possible, and it is through this process of social comparison that identities are formed (Hyman 1960; Stryker and Burke 2000; Turner 1975; Zerubavel 1991). Being both social and

psychological in nature, identities are formed by internalizing external expectations and forming internal expectations based upon one's personal values (Brekhus 1996; Hitlin 2003; Stryker and Burke 2000; Turner 1975). Thus, identity formation is a dialectic process between self and society. People draw from their history and psychological make-up when processing external messages (e.g., from peers, family, and media).

All people have both personal and group identities. Group identities are macro-level identifiers, such as being Jewish or female, that shape how one perceives and is perceived by others. Group identities help to shape personal identities. Personal identities are distinctive to each individual based upon his or her unique combination of history, personality, values, and socio-cultural location (Hitlin 2003). Fat is both a group and personal identity. It is experienced uniquely by each individual depending upon one's history of overweight and weight loss. A fat identity is also a salient identity (see Stryker and Burke 2000). It affects all interactions—even those that should be outside of the realm of weight-based judgments (see Kim, Sobal, and Wethington's [2003] study about religion and weight for an example of this).

Ideal-Typical Fat Identity

In *The Protestant Work Ethic and the Spirit of Capitalism* Max Weber used his notion of the ideal type to explain the effect of "dogmas" associated with the varying sects of Protestantism on society because, he argued, "…we can only hope to understand their specific importance from an investigation of them in their most consistent and logical forms" (Weber 1992[1930]:98). Similarly, fatness is made up of a broad range of personal and social experiences. Thus, defining a fat identity in its purest form is a vital part of elucidating the formation (and shedding) of one. This is a difficult task as any

element can be contested. However, from my interviews, review of the current and past literature, data analysis, and as a participant observer in a society that values thinness, I have come to define fat as follows:

1) A learned identity: Fat people have been taught they are fat.

2) A trying identity: Fat people's lives are more difficult because they are fat, physically, psychologically, and socially.

3) An all-encompassing identity: Fat people know they are fat and are always aware of their fatness because it affects all aspects of their lives.

These criteria are not mutually exclusive. By the nature of identity, they often overlap in a fat person's experience. However, for the purpose of simplification, I will explain them as unique entities to the greatest extent possible.

The learned identity. In a sense, the learned identity is the most important criteria for a fat identity. One cannot be fat if he or she is not, at some point in life, directly or indirectly taught the social consequences of being overweight. Thus, although a person can have a BMI that places them objectively as overweight or obese, one must (at least privately) acknowledge his or her fatness and understand its social consequences in order to have a fat identity. Therefore, by being an apt learner of weight-based social expectations, overweight people become fat. In his important work on homosexuality and stigma, Plummer (1975:21) points out self-stigmatization, or "self-reaction," is a result of an "awareness of the societal hostility" towards certain stigmatized behavior. Thus, through the conscious and subconscious process of gaining information and internalizing it, overweight people gain an identity as a member of the fat category. As such, group membership is formed via social and personal processes. Categories are

formed based upon distinct characteristics that group certain people together, and the individuals gain membership in groups via identification with characteristics that categories are formed around.

To identify as a fat person, then, one has to learn that they are fat, learn the consequences of being fat, and then transpose the identity into other environments. We are taught what is fat (i.e. not ideal weight) versus what is not (i.e. ideal weight) via messages conferred through social outlets including media, doctors' offices, friendships, and family relationships. In addition, the greater the opportunity one has to encounter these messages, the easier it will be for him or her to become "fat." For instance, adolescents who not only use their peers as their reference group, but the extremely thin Paris Hilton and Nicole Richie as well, are more likely to identify as fat than an adolescent who hopes to emulate the zaftig rapper and actress Queen Latifah. Once one learns he or she is fat, the salience that this identity will take on depends upon the frequency of the message exposure and the consequences of being fat (Goffman 1963).

A trying identity. Learning that one is fat (as opposed to overweight) is a fundamental part of fat identity formation. However, lessons learned are fleeting if they are not realized in day-to-day life. As such, fatness has to make one's life harder in order to fully internalize externally taught lessons about fatness. A fat identity as I refer to it throughout this work is a negative identity. If one knows his or her weight is greater than ideals, but must look in a mirror to be reminded of this, then he or she is simply overweight—not fat. Fat people know they are fat because it is hard to be fat—socially, psychologically, and physically. Here I will briefly review each of these.

Socially. As Link and Phelan (2001) clarify, the categorization and labeling that overweight people are subject to does not necessarily lead to stigmatization; all people are at one time or another, and in certain social contexts, negatively labeled. It is only when category membership leads to discrimination and a loss of power that one is stigmatized. This loss of power makes it more difficult for stigmatized individuals to attain equal status across the many aspects that make up most people's lives. Sociologists and psychologists have documented stigmatization and discrimination faced by overweight and obese people. Fatness is considered one of the most enduring social stigmas (Cahnman 1968); fat people are subject to both institutional discrimination such as being rejected for a job or turned down for health insurance (Carr and Friedman 2005; Puhl and Brownell 2003) and interpersonal (or overt) discrimination (Schwartz, Chambliss, Brownell, Blair, and Billington 2003) such as teasing (Jackson, Grilo, and Masheb 2000) and problematic relationships with family members (Carr and Friedman 2006; Crandall 1995). Furthermore, fat people are described as physically unattractive and undesirable (Harris, Harris, and Bochner 1982; Puhl and Brownell 2001).

In addition, many view fat people as responsible for their weight because they possess a characterological flaw or "blemish" such as laziness, gluttony, or a lack of self-discipline and self-control (Allon 1982; Crandall and Schiffhauer 1998; DeJong 1980; Harris et al. 1982). Others have illustrated a striking amount of stigmatization that results from blaming fat people for increasing health care costs because of the toll obesity has taken on the health care system of late (Campos 2004). As a result of this blame and stigmatization that corpulent people experience, their overweight turns from a physical trait into an identity.

Psychologically. In part because of the discrimination or health problems overweight people face and in part because of a discrepancy between one valuing thinness, yet being corpulent, fat people frequently suffer from lower psychological well being than their thinner peers (Higgins 1989). As such, research shows that significant weight loss is often responsible for increased self-esteem (van Gemert et al 1998). However, numerous other studies indicate that fatness in itself does not cause lower self-esteem and resulting mental health issues (such as depression); it is the "social meaning" of fatness, and people's perceptions of their fatness, that is important (Carr, Friedman and Jaffe 2007; Carr and Friedman 2005; Pesa, Syre, and Jones 2000; Ross 1994; Sarwer, Wadden, and Foster 1998). Furthermore, researchers who have looked at varying sociodemographic variables when looking at the relationship between self-esteem (and more severe mental health problems such as depression) and obesity found this relationship to generally be dependent upon moderating factors such as race, gender, age, and ethnicity (Heo, Pietrobelli, Fontaine, Sirey, and Faith 2005; Palinkas, Wingard, and Barrett-Connor 1996; Ross 1994; Simon et al 2006). This suggests that being fat is an interaction between physical reality and social norms that together make having a fat identity a trying identity.

Physically. Being overweight increases a person's risk for numerous health conditions. In recent years, the public health community has placed attention on obesity and over-eating as risk factors for major illness, proclaiming obesity will surpass smoking as the number one cause of preventable deaths in the 21st century (Mokdad et al. 2004). As mentioned earlier, epidemiological research has documented a link between obesity and heart disease, diabetes, some forms of cancer, and numerous others (Calle,

Rodriguez, Walker-Thurmond, and Thun 2003; NHLBI 1998; Yan et al. 2006). In addition to diagnosed illnesses, overweight people are often unable to physically keep up with thinner peers when conducting basic daily activities such as walking in a mall, grocery shopping, or doing household chores (Houston, Stevens, and Cai 2005). Beyond this, there is rampant medicalization of obesity. Because it is a tangible and politically correct method of social control, overweight is framed as a medical issue, even when empirical evidence is conflicting (Campos 2004; see Flegal, Graubard, Williamson, and Gail 2007 for a recent example of the equivocal health consequences for varying levels of weight). As such, even when people may not have weight related health conditions, research has shown that overweight people are more likely to assess themselves as less healthy than their normal weight peers after adjusting for objective health assessment (Ferraro and Yu 1995). Thus, although people's objective health may or may not suffer because of their weight, the perception that their health is suffering may hold as important a role in fat-identity formation as having a weight-related health condition.

Together, social, psychological, and physical consequences of being overweight turn the objective reality of being overweight into an identity of which fat persons are continually conscious. This is largely because being fat acts as a road block to goal attainment. This aspect of a fat identity is an inherent part of the minority group status that accompanies being fat and possessing an identity that is formed around it. Yet, it is also unique to the fat experience because overweight and, especially, obese people are not only limited socially. They are also limited physically. As such, I hypothesize health and discrimination to be key causes, outside of sociocultural factors, of fat identities.

In addition, generally the more overweight one is, the more limited he or she is in his or her ability to undertake mundane tasks such as mowing the lawn and keeping pace with friends when shopping. Very overweight people are also limited in more serious ways such as being ineligible for the latest knee replacement surgeries and sharing the same chance of longevity as a thinner peer. Thus, the social and physical limitations placed on fat people—and especially obese fat people—makes a fat identity an all-encompassing identity.

An all encompassing identity. For a characteristic to become a part of a person's identity, the categorization to which the person is subject must take salience over his or her numerous other category memberships (Jones et al. 1984:157). This final criterion for a fat identity is the most fluid. It is extraordinary rare for any identity to take over one's entire being. However, how encompassing an identity is determines where in the salience hierarchy a person's identity will lie. At the pinnacle is a perfect role-person merger; when the role of being a fat person pervades all interactions, in all settings (Turner 1978). The corpulent in our society are especially vulnerable to such a merger because of the intensity and frequency of the negative messages about weight and because of the relativity and visibility of overweight. Because definitions of fat vary widely across social groups, what is viewed as thin to some, is fat to others. Therefore, a wide range of body mass indexes is vulnerable to the fat label. In addition, overweight and other visible characteristics are especially subject to social scrutiny. Because of this, they are generally called upon when one is making subconscious decisions about how to act during, and react to, various social situations.[3] Moreover, obesity is not only visible,

[3] It is important to note that not all "social situations" necessarily encompass an interaction with other people. As we learn from Cooley's (1956) "looking glass self," we are social beings even when alone.

but is often associated with physical symptoms as well, especially as one ages. Consequently, a fat identity, in its ideal-typical form, is an all-encompassing identity. It lies on the top of the "identity hierarchy" and affects all aspects of one's life (Stryker and Burke 2000)—from dreams, to eating decisions, dressing decisions, vacation choices, and job offers and choices. However, most people do not have an ideal-typical fat identity; most people can escape from it at times when their other roles, values, and identities take over.

The Fat Continuum

In 1948, Alfred Kinsey made a controversial proclamation: as with everything else, sexual orientation lies on a continuum. He claimed, "The world is not to be divided into sheep and goats. It is a fundamental of taxonomy that nature rarely deals with discrete categories... The living world is a continuum in each and every one of its aspects" (Kinsey 1948:639). According to Kinsey, sexuality is dynamic; it changes with time and place. Although Kinsey's research methods have been challenged,[4] and his proclamation abhorred by many, especially within religious and conservative groups, he was one of the first social researchers to empirically show that the categories that society has set up to help us make sense of our world—homosexual/straight, black/white, fat/thin—are ambiguous, with some people living almost entirely in one category, others living morphed between categories, and others moving between categories over time. From interviews with over 11,000 men and women about their sexuality, he found that he could not label most of his subjects with simple dichotomous categories of homosexual and heterosexual. Instead, he found it more accurate to place their sexuality on a Likert-

[4] Kinsey is accused of inflating his results by using children, pedophiles, and other non-normative subjects. It is beyond the scope of this work to analyze whether his data are valid. Yet, his conceptualization that sexuality lies on a continuum has had an enduring effect on how social categories are seen.

type scale ranging from 0 to 6, with a six indicating only engaging in and desiring homosexual relations and a zero solely engaging in and desiring heterosexual relations. Hence the continuum in social research was born.

This notion of the continuum has also been used in racial and ethnic studies, gender studies, and studies of the mentally ill and is aptly applied to a study about fat (see Williams 1999 and Levit 1998 for examples). An identity's salience is determined both internally and externally based upon where on the continuum we lie. On the north end of the fat-thin continuum lies the ideal-typical fat identity that I explained in the prior section. Because fat is a meaningful category in U.S. society, the more corpulent one is, the more likely he or she is to identify as such, and the more likely it is that one's fatness will permeate through all social interactions and experiences. On the south end lies the ideal-typical thin identity that is meaningful to this work because it is a point that fat people strive to reach. Beyond this, it is not a social entity that I explore, although I recommend that future works do so.

The fat continuum is comprised of the three criteria explained above that all exist on continuums as well. Although a fat identity must encompass all three of these criteria, the effect that they have on identity formation is fluid. The effect that they will have varies through time and context, and the salience that one's fatness has on his or her life changes as well. As such, as the impact of each of these criteria has on a person waxes and wanes, so too will the salience of one's fat identity. In other words, all people have multiple identities, whether they be mother, father, coworker, boss, Irish, son, daughter, grandchild, student, etc. Thus, for many fat people their fatness frequently rises to the top of the identity hierarchy based upon the three criteria above; yet all people live on a

sliding continuum where socio-cultural characteristics and the impact of weight on one's life determines who has the longest climb to the fat threshold (i.e. the line on the fat-thin continuum that once surpassed causes one to identify as fat more often than not).

Fat Identities: How they are Formed and Why they are Maintained

Throughout the remainder of this chapter I explore the connection between fatness and identity formation. Studying the formation and maintenance of fat identities provides an interesting and important view of the vast influence that boundaries have on people and society. This is so for a number of reasons including the following properties that, when taken together, make fat identities a valuable vehicle through which to gain a better understanding of identity formation and maintenance:

1) Fat and the Life Course: When in the life course one gains weight has implications for how and why it will affect a person.

2) Changing Weight, The Ethic of Personal Control and Responsibility (i.e. the Protestant Ethic) and Social Expectations: Not only can one's weight change, but fat people are expected to change their weight through various techniques that are readily and, frequently, freely available (i.e. decrease caloric intake and increase exercise).

3) Fatness is visible.

4) Entering The Fat Category: Both self and other are responsible for placing someone into the fat category.

5) Fat Identities are Dependent Upon Social and Demographic Factors: The attributions stated in the 4th property are contingent upon one's sociodemographic make-up. Here I specifically focus on race and gender.

While other subgroups formed around such identifiers as race, gender, and

sexuality may share some of the above properties, fatness possesses all of them. Throughout this work I show how each one of these properties is an important factor in how people come to identify as fat. Here I discuss each one, giving a short synopsis of why it holds a vital role in illustrating the process of fat identity formation.

Fat and the Life Course

Fat identity formation and aging are uniquely tied because aging is inevitable and weight gain is possible for everyone. Based upon this simple similarity, age and weight are frequently intertwined in a manner that has been largely missed in literature about aging and weight. As I discuss in Chapters 3 and 4, aging is absolutely inevitable, but gaining weight is not; thus weight is used by many to slow the aging process. As such, because both aging and weight gain are in the realm of all people's possible selves, they are both unique identities. This relationship between aging, future selves, and fat is an important theme that runs through this dissertation. It affects how, when, and why fat identities are formed and highlights the nuances involved with studying identities in general and fat identities specifically.

Past research suggests a strong relationship between life course placement and why weight matters to people. Younger people are more likely to worry about the aesthetic consequences of overweight. Older people, who are generally more vulnerable to a wide array of health conditions than younger people, begin to see extra weight as health concern (or both a health and aesthetic concern) (Hankey, Leslie, Lean 2002; Hurd Clarke 2002; Jaffe 2005; Sachs-Ericsson et al. 2007). In addition, research indicates that those who have been obese since childhood are more vulnerable to being obese adults

(Ferraro and Kelley-Moore 2003), and body dissatisfaction stays continuous throughout the life course, although it becomes less important as people age (Tiggemann 2004).

People who have been overweight since childhood have endured the burden of overweight from their youthful formative years, through young adulthood when appearance and weight are strongly emphasized, and through their reproductive years, when being obese can present medical problems from difficulty conceiving a child to gestational diabetes and difficulty maintaining a pregnancy (Baeten, Bukusi, and Lambe 2001). Past one's reproductive years, why weight matters to him or her will vary based upon specific life situations. Perhaps a recent divorcee will place more emphasis on his or her weight for aesthetic reasons as he or she re-embarks on the dating scene (DePaulo 2007). Or a menopausal woman will become more concerned about her weight because post-menopausal weight gain leaves women at greater risk for breast cancer (Eliassen, Colditz, Rosner, Willett, and Hankinson 2006) and heart disease (Wing, Matthews, Kuller, Meilahn and Plantinga 1991).

Beyond the varying reasons why weight matters depending upon one's age and place in the life course and the specific risks associated with middle-age weight gain, how one's weight affects his or her identity is highly dependent upon when he or she gains the weight. This is similar to how the blind and amputees are differently affected by their disability depending upon when in their lives they became blind or lost a limb. For instance, research indicates that being blinded or having severe hearing loss later in life often results in an increase in depression and anxiety, denial, and discrimination and embarrassment (Fitzgerald 1970; Fitzgerald and Parkes 1998). Although both blindness and deafness are hardships whether one is deaf or blind from birth or becomes blind later

in life, those who lose their hearing or sight later in life have to readjust how they identify and navigate their worlds. Similarly, recent amputees have to cope with the emotional toll of accepting a changed self image and challenges to once taken for granted simplicities such as showering and getting dressed in the morning (Wilson and Krebs 1983). Alternately, those who have had a disability such as deafness since birth only know life as a deaf person. They frequently attend special schools and programs with other deaf people where they form their social networks and methods of interacting with the world as a deaf person (Van Cleve and Crouch 1989).

People expect there futures to be informed by their pasts and identity's are largely informed and influenced by these expectations. Markus and Nurius (1983) argue that people's possible selves (their future selves) are a reflection of their past selves and their present selves. As such, based upon this theory I hypothesize that those whose past selves are thin, but present selves are overweight, should have more hope that their possible selves will be thinner. Alternately, for those who lose weight later in life, it may be impossible to fully shed the lessons learned in their youth and to flee from the impact weight has had on their life. Furthermore, multiple discrepancies theory (MDT) suggests that people's happiness and satisfaction are determined by (1) "perceived gaps between what one has and wants," (2) what "relevant others have," (3) "the best one has had in the past, expected to have 3 years ago, and expects to have after 5 years," and (4) what one "deserves and needs" (Michalos 1985:347). Thus, one's satisfaction and happiness are largely determined by how one perceives his or her needs and desires have been met relative to those of significant others and his or her past self. As such, there is an intimate relationship between forming expectations about one's future based upon one's present

and past, and how meeting these expectations or not affects one's sense of self. Thus, studying fat identity formation with a life course approach is a fruitful and important avenue towards understanding how fat identities are formed.

Very few studies have looked at fat identity formation within this framework. Carr and Jaffe (2007) sought to understand whether gaining weight later in life or having been overweight since childhood was more harmful for one's psychological well being. They found those who have been overweight since childhood to be less likely to assess their weight as somewhat or very overweight than people who became overweight later in life. This was in line with temporal comparison theory, which suggests that people evaluate their present selves through comparison with their past selves (Albert 1977). Prior research has demonstrated psychological benefits from evaluating one's present self as better than the past and that most people tend to do this (Taylor and Brown 1988; Wilson and Ross 2001).

This is in contrast with modified labeling theory (MLT) that proposes that those who have internalized cultural beliefs about stigmatized groups are going to suffer more mental health consequences from being labeled (Link, Cullen, Struening, Shrout, and Dohrenwood 1989). Consequently, those who have been coping with a stigma since childhood, MLT might suggest, will have had more exposure to the consequences of possessing a stigmatized identity and will therefore have internalized these beliefs more-so than someone who attains a stigmatized characteristic later in life. As a result, their mental health will suffer more greatly than someone who acquires a stigma later in life. This perspective has seen some support with evidence that adults who were overweight as children possess less self-confidence, poorer body image, and lower sociability than

overweight people who were thin in their teenage years (Mustillo et al. 2003). Furthermore, overweight youths who lose weight in adulthood may not enjoy the same level of psychological well being as those who were never overweight because of the "phantom fat" phenomenon, where the memories of being a fat child linger and continue to affect how one identifies (Cash, Counts, and Huffine 1990).

Using the same data and methods, I replicate Carr and Jaffe's (2007) analysis in this dissertation. Although they found support for temporal comparison theory, in this work I explain the impact of both trajectories on how people come to identify as adults by taking a nuanced look at the findings in conjunction with an analysis of 40 in depth qualitative interviews with people of varying ages and genders. By doing so, I show a complex interplay between life course, social-psychological, and physical variables that help to influence how one forms a fat identity, factoring in the effects of health, medicalization, beauty concerns, and discrimination.

Changing Weight, the Ethic of Personal Control and Responsibility (i.e. the Protestant Ethic), and Social Expectations

Weight's changeability is one of its most salient features, and it is a major theme in all three analytical chapters. The social expectation that people should reduce their weight if they are overweight makes it a unique trait that leaves fat people to be widely considered a failure in U.S. society. As a result, based on the tremendous financial success of the diet and fitness industry [and lately bariatric surgeons (i.e. surgeons who perform stomach stapling and lap band procedures)], it is clear that people do not wish to be fat. There are two motivators that compel people to attempt to lose weight: 1) internal motivators, such as dissatisfaction with one's self and 2) external motivators, such as

being told by others that they should lose weight. Empirical research shows that people who believe that they have control over their behavior and are motivated to lose weight because of their personal desire to do so will have greater success at long-term weight loss than those who lose weight at the prodding of others (Williams, Grow, Freedman, Ryan, and Deci 1996). However, these internal and external motivators are frequently indistinguishable. People do not want to feel unhealthy or to be discriminated against. As such, they are often dissatisfied with their weight for personal and social reasons.

In this work, I suggest that this symbiotic relationship between personal and social pressures with regards to body weight dissatisfaction is largely a result of an ethic of personal control and responsibility frequently referred to as the Protestant work ethic[5]—the ideology that hard work equals success, and failure "is caused by the moral failings of self-indulgence and lack of self-discipline" (Quinn and Crocker 1999:403)—that permeates much of U.S. society. Historically, the self-disciplined or, possibly better put, self-denying, "practices of Protestantism transferred the denials of the monastery into the everyday life of the family, the school and the factory" and placed Protestant values of hard work, rationality, and "the calling" into modern society (Turner 1984:157). Thus, as mentioned earlier, when Henry Tanner fasted for 42 days, appetite was now seen as something that people could control and fatness became gluttony and something that

[5]At a graduate student conference at which I presented, Jack Katz mentioned to me that cultures with extremely high Protestant populations such as Norway do not live by the Protestant work ethic's tenets, thus making the term technically incorrect (personal communication, April 30, 2003). It has also been pointed out to me that certain associations made with the word *Protestant* (such as white, Christian, and often moneyed) may detract from my larger point that regardless of race, ethnicity, religion, or socioeconomic status, this ideology may assist in making fat matter to some people (Deborah Carr, personal communication, January 18, 2005). As such, I will refer to this ideology as an ethic of personal control and responsibility throughout this work.

people were expected to change. As a result, a vast diet and exercise industry has developed to assist people with these desires and needs.

Throughout this dissertation I revisit the link between fatness and ideological beliefs frequently. Past research has demonstrated the importance of this ethic with regards to expectations placed on fat people and the consequences of not living up to these expectations. For instance, numerous studies that have demonstrated a link between the stereotypical view of fat people being lazy and "allowing themselves to go," and not living up to their responsibility to control themselves (Crandall and Biernat, 1990; Allon, 1982; DeJong and Kleck 1981; DeJong, 1980; Maddox, Back, and Liederman, 1968). Maddox et al. (1968) sum up this position:

> In a society which has historically been suffused with a Protestant Ethnic [*sic*], one characteristic of which is a strong emphasis on impulse control, fatness suggests a kind of immorality which invites retribution. Correspondingly, the reduction of overweight, and the avoidance of the contagion of gluttony implies self-denial, which ought to bring appropriate rewards, including good health. (P. 288)

More specifically, DeJong (1980) lent some early empirical support to the impact of the ethic of personal control by conducting a study of 64 high school students who consistently showed less dislike for fat people who could explain their fatness with some sort of medical explanation (such as a thyroid condition), hence displacing the blame from the fat person to the "condition." Furthermore, research has shown that cultures that do not have a strong belief in an ethic of personal responsibility and control tend to be more favorable towards overweight bodies. For instance, in a study of Americans and Mexicans, Crandall and Martinez (1996) found Americans to possess greater anti-fat attitudes than Mexicans. They attributed this finding to the more individualistic nature of Americans, a greater cultural preference for thinness, and a greater belief that one is

personally responsible for his or her weight. In addition, research indicates that people act more favorably towards people for whom they attribute a stigmatizing condition to a circumstance that is out of the person's control (Weiner, Perry, and Magnusson 1988).

Expectations generated by a belief in this ethic are not reserved for thin people (Crandall 1994). Through internalizing social ideologies and messages that we see on television and read about in magazines, newspapers, and "self-help" books, fat people frequently begin to feel like failures if they cannot fulfill society's expectations (Cusumano and Thompson 1997; Thompson and Heinberg 1999). Crocker, Cornwell, and Major (1993) found this to be true in overweight college women who were more likely than normal weight women to blame themselves for the negative feedback they received from a male evaluator (a potential date). Others have found that those who hold anti-fat beliefs rooted in a belief in a belief in an ethic of personal control and responsibility are more likely to suffer from poor mental health as a result of the weight-based stigmatization to which they are subject (Friedman et al. 2005; Quinn and Crocker 1999), but those who blame their stigma on other people's prejudice tend to have higher self-esteem (Crocker and Major 1989). Furthermore, a strong belief that we can and should control ourselves plays a beneficial role in giving social actors an "illusion of control"—the belief that our outcomes are going to be better than an objective judgment might predict (Langer 1975). However, this illusion leaves people with little choice but to believe all people—not just one's self—has this control. If one person can control his or her weight, and another cannot control his or her weight, this jeopardizes all people's belief that we can control our bodies—a belief that many hold as fundamental part of the ideology by which they live. Thus, believing in an ethic of personal control and

responsibility has important implications for how people divide moral from immoral and fat from thin.

Fatness is Visible

This is a dominant theme in all three analytical chapters. The visibility of any trait, especially a stigmatized one, is going to have an enduring effect on one's self concept. Goffman (1963:48) argues that a visible stigma may be the most "fateful," because it can be called upon in any situation. Research indicates that visible stigmas and disabilities not only affect one's present self concept, but their educational and professional outcomes as well (Jones et al. 1984). Hence, a traits' "concealability" is a profound determinant of how salient its impact will be on identity formation (Jones et al. 1984:33). Characteristics that cannot be hidden are more likely candidates to becoming "master statuses"—those statuses posed by Goffman (1963) as the most influential on one's daily interactions and identity. Thus, the difficulties involved with being physically overweight and socially fat are likely more difficult the more overweight one is—something that is suggested by research that looks at differences between subgroups of the overweight population (see Carr and Friedman 2005 for an example).

Moreover, we live in a culture that values beauty; thus, "what is beautiful is good" (Dion, Bersheid, and Walster 1972) and fatness and ugliness, although different characteristics, are frequently viewed as one and the same. Attractiveness is greatly rewarded in the United States with such tangible benefits as increased earnings and greater power to achieve goals (Patzer 2006). Beyond the broader disadvantages of being both fat and ugly, there are personal disadvantages as well. For instance, being fat leaves one vulnerable to the kind hearted-insult "you have such a pretty face" (Millman 1986)

that some of my informants reported being vulnerable to in situations as varied as at home from their grandmother to out on a busy city street. Thus, weight's visibility makes being fat an inescapable identity, as no one knows when her or she will be vulnerable to discrimination or a remark that will remind them that they are defined by what is the most visible.

Entering the Fat Category

Another underlying theme in all three analytical chapters is exploring how one gains (and loses) a fat identity by entering the fat category. To do this, one must understand how categories are formed and maintained. Although there are no tangible and visible boundaries between groups, they are a critical and taken-for-granted part of all social actors' lives. Thus, understanding the boundaries that guide how we view our social worlds is an essential part of investigating how some overweight people become part of a negative social category, while others never cross the boundary, even if their objective weight predicts that they should. Boundary formation, categorization, and stereotyping are generally inextricable and overlapping concepts. Throughout this work I view the difference as it relates to the unit of analysis: *Boundary formation* is an impersonal response to difference. Lines are drawn between characteristics such as overweight and underweight. *Categorization* is personal. In the process of categorization, people are placed within boundaries, based upon their personal traits. At this point they are no longer overweight and underweight. They are now fat and skinny. Finally, the process of *stereotyping* ascribes meaning to the categorized people within the boundary. This ascription leads to labeling, stigmatization, and—frequently false—assumptions about people, such as that fat people are lazy and undisciplined.

Why this process occurs has been a subject of much debate among sociologists and psychologists. However, generally it has been attributed to the human drive to manage the complexity involved with processing ambiguity. We aim to make sharp distinctions that allow us to process our social worlds more efficiently (Douglas 1966; McGarty, Yzerbyt, Spears 2002; Turner 1975; Zerubavel 1991). It is easier and more efficient for people to think in black and white; therefore the shades of gray are often ignored. Consider males and females and black and white people who are often discussed as opposites. This is done despite the fact that gender and race lie on continuums, with varying skin tones, femininity and masculinity, and adherence to social norms governing racial and gender categories. Moreover, social actors often help to construct boundaries and categories, or fail to combat them, because it seems natural or inevitable to categorize. Consequently, boundaries are deeply embedded in society (Douglas 1966), and the lines that help us to "make distinctions in our every day [lives]"—and thus navigate our social worlds—are frequently a taken-for-granted and unnoticed part of society (Zerubavel 1991).

Although a taken-for-granted aspect of our social worlds, boundaries have real and, frequently negative, implications for people. By demarcating in-groups versus out-groups, boundary formation has the ultimate consequence of turning a potentially neutral social category into a cluster of stigmatized, labeled people. Goffman (1963:2-4) conceptualizes stigma as a "spoiled identity" which can be an (1) "abomination of the body" (a "physical deformity"), (2) a "blemish of individual character" (a "characterological flaw" such as "weak will"), or (3) a "tribal stigma" (an ascribed trait such as race and sex). Overweight is a particularly difficult stigma because it

encompasses all three of these traits: It is visible, and hence a physical deformity (see below); it is framed as immoral because fat people are not living up to his or her responsibility to maintain their weight (see discussion of the ethic of personal control and responsibility above); and many argue that it is a tribal stigma because of the attention the "fat gene" has garnered recently (Marx 1994). To compound things further, being fat carries the additional complication of being a possibility for everyone. Thus, weight is a personal issue for many and it is a characteristic that people fear and actively work to avoid. When a situation or a characteristic threatens one's "illusion of control" (Langer 1975), people take active measures to avoid this situation through discrimination and avoidance of the corpulent person. Thus, overweight is a particularly negative characteristic to possess as it invokes many people's personal fears about their own future.

However, who is responsible for placing some people in the fat category, and others not? To return to MLT, the answer is both the social actors and society. Through socialization we learn about social ideals and norms regarding weight. We learn these messages from the media, from interacting with other people in our community, and from our family and friends (Puhl, Moss-Racusin, Schwartz, and Brownell 2007). Furthermore, research has shown that children as young as 4 years old have internalized stereotypes about overweight subjects from parents (Jaffe and Worobey 2006). We learn from others; then we internalize these messages and impose them on ourselves and others. This helps social actors shape their own values and expectations, along with the expectations and values of peers. Using Foucault's concept of the panopticon, Germov

and Williams (1999) explains how this process works and how it promotes culturally defined ideals:

> The "body panopticon" refers to women's[6] constant monitoring of their own bodies and those of other women. Thus, women who themselves seek to conform to the thin ideal actively participate in stigmatizing women who do not exhibit conformity. Therefore pressure to conform not only stems from cultural dictates and material interests, but also from women acting as "body police" for themselves and other women. (P. 126)

Therefore, the consumer culture in which we live—that is constantly shaping our visions of the ideal look and the ideal body (Bordo 1992)—and our own visions of what is attractive and what is not, contributes to turning overweight people into members of a socially constructed out group of fat people.

Fat Identities are Dependent upon Social and Demographic Factors

This final property is most prominently explored in Chapter 3. A person's slide up and down the fat continuum is largely due to the social environment to which they are most frequently exposed. Therefore, fat identities are relative. As I argue in this dissertation, they depend upon how an individual's unique sociodemographic make up intersects with health, aesthetics, and discrimination. Throughout this work, I draw upon Bordo's (1992) position regarding how people internalize messages that become a part of their identity:

> [P]eople's identities are not formed *only* through interaction with such images [media images of the ideal body], powerful as they are. The unique configurations (of ethnicity, social class, sexual orientation, religion, genetics, education, family, age, and so forth) that make up each person's life will determine how each *actual* woman[7] is affected by our culture" (P. 62)

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[6] While Germov and Williams (1999) are specifically speaking of women in this context, I think that this concept of the "body panopticon" can easily be translated to studies of fat in general, as both men and women are constantly watching and judging each others' fatness (although the situation is more prominent for women).

[7] Again, Bordo is specifically speaking about women. However, I believe her argument is easily generalizable to all genders.

Empirical research supports Bordo's assertion. Sociological and psychological research suggests that higher socio-economic groups, whites, and the well-educated are more likely than poorer people, nonwhites, and the poorly educated to value thinness (Averett and Korenman 1999; Friedman et al. 2002; Hayes and Ross 1986; Ross and Mirowski 1983). As a result, poorer, nonwhite, and poorly educated people are less likely to have internalized, or care about, the social dictate to be thin (Kuchler and Variyam 2003; Rand and Kuldau 1990; Ross 1994). They are also less likely to report a diminished quality of life because of their weight (White, O'Neil, Kolotkin, and Byrne 2004). Well-educated whites tend to have greater access to weight-loss resources and knowledge than underprivileged minorities. As a result, they have greater knowledge to base their desires upon and the necessary wherewithal for achieving their goals. Consequently, well-educated whites logically suffer more from the mental health consequences associated with the discrepancy between valuing thinness and being corpulent (Higgins 1989)

The link between overweight and mental health has been explored in depth. While many report that higher body weight results in lower psychological well-being (Dong, Sanchez and Price 2004; Heo et al 2005; Herva et al. 2006; Simon et al. 2006; Wadden et al. 2006), others have found the opposite (Carr, Friedman and Jaffe 2007; Jorm et al. 2003), and others have not found any relationship (Faith, Flint, Fairburn, Goodwin and Allison 2001; Istvan, Zavela and Weidner 1992). Many of these studies find that the relationship between weight and poor mental health depends upon many factors, including one's specific social configuration that includes one's gender, race, ethnicity, and age (see Carr and Friedman 2005; Carr, Friedman and Jaffe 2007; 2004;

Heo et al 2005; Palinkas, Wingard, and Barrett-Connor 1996; Pesa, Syre, and Jones 2000; Ross 1994; Sarwer, Wadden, and Foster 1998; Simon et al 2006).

Socio-demographic features play an important role in how messages regarding weight ideals are internalize and interpreted. For instance, a growing amount of research indicates that although racial and ethnic minorities hold weight ideals, they tend to be significantly higher than ideals held by white people (Averett and Korenman 1999; Crandall and Martinez 1996; Fitzgibbon, Blackman, and Avellone 2000; Paeratakul, White, Williamson, Ryan, Bray 2002). Although this provides racial and ethnic minorities with protection from forming an identity around his or her weight, researchers worry that this is setting them up for greater health consequences (Bennett and Wolin 2006; Kuchler and Variyam 2003; Paeratakul et al 2002). Furthermore, definitions of physical attractiveness are more closely tied to thinness for women than men (Friedman et al. 2002), although a number of studies suggest that black men and women are more accepting of full-figured women (Cunningham, Roberts, Barbee, Druen, and Wu 1995; Hebl and Heatherton 1998). All of these factors show that where the boundary between fat and thin lies is on a continuum, subject to each person's race, gender, and age. However, beyond these group identities, people have their own unique histories, personalities, and psychological dispositions that leave them to identify as fat at a different scale weight than the medical community or their peers dictate.

In sum, in this section I highlighted some of the theoretical and empirical research that has helped to explain why each of these five properties is important for both social and psychological assessments of self and others. However, to my knowledge no research has looked at how these properties work together to make weight meaningful to

people. To understand fat identity formation, one must understand how nuanced and personal weight assessments are. We all live on multiple continuums: sexual, gender, racial, health, etc.; where we lie on these continuums determines what weight means to us. With this understanding I now set forth to illustrate how and why fat identities are formed.

Conclusion

The lay public—those who learn much of what they know from popular media and doctors who may or may not keep abreast of the latest research—are in the unenviable position of having to figure out for themselves where the line between fat and thin lies; because of the mental work that goes into determining the line between fat and thin, we have a stake at maintaining it. Consequently, social actors learn the boundary between fat and thin and maintain it by first internalizing messages from peers, family, doctors, and media; second, interpreting these messages based upon their unique social configuration and values; and third, contributing to the process through their own social regulation. That everyone internalizes social messages a bit differently makes studying fatness a bit nebulous.

This is a study about how people come to self identify as fat. Gaining weight can make someone overweight or obese. But what specifically causes one to identify as fat? In this chapter I reviewed the major themes that I use throughout this dissertation to help explain the social layer that drapes overweight people to turn them fat. Through looking at the history of how the medical and fashion communities standardized weight categories, I gave the reader necessary background for understanding how the boundary between fat and thin was formed. The medical and fashion communities enabled people

to cut through the ambiguity and make a clear determination of what was too overweight. By doing so, they stigmatized fat people and praised thin people for their ability to adhere to social norms.

Although clear standards regarding healthy weight should eliminate the ambiguity between ideal and not ideal weight, weight has unique properties that make this cutoff continually muddy. To fully identify as fat, one's fatness has to fit the three criteria of the fat identity ideal type: It must be learned, trying, and all encompassing. In other words, for weight to completely and totally permeate one's identity, one must internalize external messages regarding the negativity of being overweight, one must feel consequences and limitations from being overweight, and one's weight must become a master status. How one comes to gain a strong enough fat identity to reach the pinnacle, or north end, of the fat continuum depends upon the properties that taken together are unique to a fat identity. Hence, why weight matters depends upon: (1) one's place in the life course; (2) one's belief that weight is controllable; (3) how visible one's overweight is; (4) how vulnerable the person is to the boundaries, categories, and labeling that make fatness a stigmatized category; (5) how one's other identity markers, such as race and gender, interact with beliefs about weight .

Through a discussion of the history of weight categorization and an understanding of the fat-thin continuum and the properties that make a fat identity unique, something becomes clear. Health considerations, aesthetic considerations, and discrimination are essential lenses through which to view fat identities. It was the health community and life insurance companies that first set up the boundary between acceptable and unacceptable weight and the consequences of not fitting in are a wide range of overt and

institutional discriminations. Thus, fat people who are subject to the stereotypes outlined above often have trouble finding acceptable, fulfilling work (Saporta and Halpern, 2002; Solovay, 2000), find themselves being discriminated against at home (Carr and Friedman 2006; Crandall 1995), and are subject to negative comments when they walk down the street, sit in a bathing suit on the beach, or cannot fit into a chair in a restaurant or a seat on an airplane. Also, because obese people are often forced to operate under the "if it covers me up I'll take it" rule (Cooper 1998:20), they are considered unfashionable and unattractive. As such, fat people do not fit within social and physical boundaries. In this dissertation I argue that fat people are taught this from health and beauty messages espoused by the medical community and media; from feeling ill or out of breath in comparison to peers; and by being stigmatized and discriminated against. All of these experiences make life harder, and all leave people's fatness an integral part of whom they are. However, a person must internalize the stigmatization and must make decisions based upon the effect their fatness has on their lives in order to form a fat identity. Self and other assessments are an iterative process; they mutually influence each other and both in turn affect one's identity.

In the following five chapters I reinforce this argument by isolating varying parts of the fat experience to show what factors cause one to identify as fat. The next chapter (*Chapter 2*) looks at the methodology I use in the analysis for Chapters 3 through 5. Together, quantitative analysis of a large survey of Midlife Development in the United States (MIDUS) and analysis of 40 in-depth interviews has lead me to draw the conclusions I present in this work. *Chapter 3* is the most general of the analytic chapters. In this chapter I look at individuals' unique social mappings to help to understand what

factors bring some people closer to an ideal-typical fat identity, and others further from one. In other words, in this chapter, I explore how people learn that they are fat. *Chapter 4* makes the specific argument that health impacts fat identities for two reasons: health symptoms and medicalization. Obesity is linked to numerous health conditions that affect quality of life. Hence, *feeling* fat makes it a trying aspect of one's life. Yet, not all fat people "feel" their fatness because not all overweight people are going to feel health symptoms or fall ill. Despite this, the rampant medicalization of fatness in the United States makes it nearly impossible for an overweight person to escape the message that their physical shape is something to be feared and disliked. In that chapter I also look at the conflicting motivations of health concerns versus aesthetic concerns for losing weight. In *Chapter 5* I look at the discrimination that fat people face, furthering the argument that a fat identity is a trying identity. Throughout Chapters 3, 4, and 5 I intertwine my health and discrimination arguments with a discussion of the ethic of personal control and responsibility, demonstrating how this belief system affects how Americans think and feel about their bodies. Finally, *Chapter 6* brings all of these elements together to discuss how people's socio-demographic experiences, health experiences, aesthetic concerns, and discrimination experiences protect some and make others vulnerable to forming a fat identity.

CHAPTER 2
Data and Methods

There is much debate among social scientists about the best way to get to the heart of social issues; some argue that we need to document the broader trends and patterns that large datasets provide, and others argue that we need to speak to the people that live the experiences we are trying to analyze. In essence, however, there is a symbiotic relationship between the two methods:

> The bottom line here is that quantitative and qualitative data are, at some level, virtually inseparable. Neither exists in a vacuum or can be considered totally devoid of the other. To ask which is "better" or more "valid" or has greater "verisimilitude" or whatever ignores the intimate connection between them. To do good research we need to use both the qualitative and the quantitative. (http://www.socialresearchmethods.net/kb/qualdeb.php)

Quantitative research is a statistical analysis of ideas that are generated from studying people. It seeks to generalize more detailed and nuanced understandings observed in qualitative research. Here I use both methods—analysis of a large dataset and in-depth interviews—to illustrate how fat identities are formed and why. Throughout the three analytic chapters in this dissertation, the quantitative and qualitative results complement each other as opposed to replicate each other. The detail I collected from speaking to fat people illustrates the patterns found in the statistical analysis. This is the merit of having both avenues for investigation into fat identities, which are personal and unique but universal within the United States.

Sample

The National Survey of Midlife Development in the United States (MIDUS) is a national multistage probability sample of noninstitutionalized English-speaking adults ages 25 to 74, selected from working telephone banks in the contiguous United States. In

the first stage, households were selected via random digit dialing. In the second stage, disproportionate stratified sampling was used to select respondents from within households. The sample was stratified by age and gender; men and persons age 65 to 74 were oversampled. A telephone interview and a follow-up mail questionnaire were administered in 1995-1996. More than 4,000 persons participated in the telephone interview (N=4,242 including 2,155 men and 2,087 women), and 87 percent of them also completed the self-administered mail questionnaire (N= 3,690 persons including 1,846 men and 1,844 women).

My analyses are limited to those who completed both the mail and telephone components of the study, those whose Body Mass Index (BMI—explained below) is 18.5 kg/m^2 or greater, and those who responded to both the height and weight inquiries so that a BMI could be calculated for them. People who do not supply height and weight information may be particularly disturbed by their weight, may simply not know their height or weight, or may be reflecting the stigma associated with reporting a high weight in their decision not to do so. This is evidenced by past research that has found people who do not report their height or weight to be between obese I and II plus in terms of psychosocial outcomes and perceived discrimination (Carr, Friedman, and Jaffe 2007; Carr and Friedman 2006). As such, although they may be an interesting category to include in future research, I eliminated these people to provide clarity of results. In this work I am interested in understanding how specific body weights do, and do not, influence identity formation. Therefore, it is outside the scope of this work to attempt to extrapolate how this unique subgroup identifies.

I eliminated anyone with a BMI less than 18.5 for two reasons. First, preliminary analysis indicated that only 2.1 percent of the sample who answered both the telephone and mail questionnaires is underweight and only 4 out of the 76 underweight respondents assessed as somewhat or very overweight. This resulted in unstable coefficients in the logistic regression analysis. Also, because underweight people who assess as overweight are a unique and often psychologically troubled subgroup, it is beyond the scope of this dissertation to analyze underweight subjects' body size assessment practices. In addition, I chose not to combine the underweight and normal weight categories because being normal weight and underweight are inherently different entities. Underweight people tend to be less healthy, older, and potentially psychologically unstable (Flegal, Graubard, Williamson, and Gail 2007; 2005; Jorm, Korten, Christensen, Jacomb, Rodgers, and Parslow 2003). As such, instead of compromising the integrity of the normal weight category, I chose to take them out of the sample altogether. As a result of these eliminations from the data set, the final sample had 3,202 cases. Because of the moderate rate of nonresponse, caution should be taken in extrapolating my results to the total population in the same age range (see Brim, Ryff, and Kessler 2004 for further detail on the MIDUS study).

Measures

Dependent Variable

I use one outcome variable to help understand the link between BMI and perceived weight: *Perceived body size*. The *perceived body size* question asked the respondents: "Which of the following do you consider yourself?" I recoded the five options (very underweight, somewhat overweight, normal weight, somewhat overweight,

very overweight) into two categories: underweight/normal weight and somewhat/very overweight (please see discussion below for further information about recoding decisions). Conceptually, *perceived body size* is a proxy for the weight identities that I discuss throughout this work.

Independent Variables

Body mass index (BMI) is the key independent variable of my analyses in Chapter 3. All MIDUS participants were asked to report their weight and height. Self-reported height and weight measures are inherently subjective. Some studies show that individuals tend to underestimate their weight and overestimate their height (e.g., Bowman and DeLuca 1992). Other researchers counter that self-reported weights are highly correlated with scale weights (Palta et al. 1982; Stunkard and Albaum 1981). Thus, the bias introduced by using self-reported data is generally considered "small and inconsequential" (Palta et al. 1982: 230). As such, it is a widely used source for calculating BMI.

BMI is calculated based on the formula where BMI equals weight in kilograms divided by height in meters, squared. Continuous BMI scores were recoded into six categories based on cut points defined by NHLBI Guidelines (1998). The five categories are: *underweight* (BMI < 18.5), *normal* (BMI between 18.5 and 24.9), *overweight* (BMI between 25 and 29.9), *obese* (BMI between 30 and 34.9), and *extreme obesity* (BMI of 40 and above). The latter two categories are combined in this analysis due to the small number of cases in the extreme obesity category. I then recoded each category into dummy variables, leaving me with three variables: normal weight, overweight, and obese

1+. As mentioned above, I selected out all people whose BMI was below 18.5 and therefore did not have an underweight category.

Past Weight and Weight Loss. A key part of this work is about how past weight and the efforts people put into losing weight is an important part of understanding the intricacies of a fat identity. As such, I test for weight at age 21 and dieting as potential moderating and mediating variables. The *Weight at 21* variable was constructed in the same manner as BMI. Respondents were asked to report their weight at age 21. Because most people are fully grown by time they are 21, I calculated their BMI at 21 using their weight at 21 and current height, using the same formula and categorization technique described for present BMI. The MIDUS asked respondents "During your lifetime, about how many times have you lost 10 pounds or more (excluding women after childbirth)?" I recoded this variable into a dichotomous variable; a 1 indicates having *ever* lost 10 pounds or more and a 0 indicates never having lost 10 pounds or more.

Demographic and socioeconomic status characteristics. All demographic variables are potential moderating or control variables. Gender, race, and age can all function as master statuses; as such these identities may potentially alter the effect of BMI on perceived body size. Therefore all three are included in the analyses. *Sex* is a dichotomous indicator coded as 1 for female and 0 for male), *race* is a categorical variable that indicates black, other race, and white; white is the reference group. *Age* is a categorical variable that indicates those who are ages 25 to 44, 45 to 64, and 65 to 74; 25 to 44 is the reference category.

I additionally control for marital status and socioeconomic status. *Marital status* is a categorical variable that indicates persons who were never married and are not

cohabitating, and formerly married and not cohabitating. Currently married/cohabiting is the reference group. Socioeconomic status indicators are potential pathway variables for the relationship between weight and perceived body size. Education is an important method for learning and internalizing messages about fat and may support or diminish the relationship between body weight and perceived body size. *Educational attainment* is indicated by years of completed education recoded into the following dummy variables: less than 12 years, 12 years (reference category), 13 to 15 years, and 16 or more years of education. I also control for *Employment status*. It is a dichotomous variable indicating that one is currently employed.

Psychological and Cognitive Factors. Finally, I consider neuroticism and self-satisfaction. One's psychological disposition likely affects how one internalizes and processes messages about weight. As such, these indicators are added to the model as potential mediators. *Neuroticism* ($\alpha = .74$) is assessed with a four-item scale asking respondents how well each of the following describes you: (1) moody; (2) worrying; (3) nervous; (4) calm; higher scores reflect higher levels of psychological distress. *Self-satisfaction* is assessed with the single item: "overall, how satisfied are you with yourself? Would you say a lot, somewhat, a little, or not at all." Only 6 percent of respondents reported the latter two responses, so I constructed a dichotomous variable contrasting "a lot" with "somewhat" or less satisfied.

Chapter-specific Independent Variables

Health (Ch. 4). All of the health indicators are tested as key independent variables and as potential mediators of relationship between a BMI and perceived body size. How one rates his or her weight may be affected by current health conditions—

especially those that are directly related to overweight and obesity. As such, I control for these conditions in a variable called *chronic health conditions*. Respondents were asked "In the past 12 months have you experienced or been treated for any of the following?" After which they were given a list of 29 health conditions. In my chronic weight-related health conditions indicator I only include the conditions that research has directly correlated with obesity. As such, I use 19 of the 29 (two additional conditions "*Anxiety, depression, or some other emotional disorder*" and *diabetes* are used as indicators independent of the global health conditions indicator. Each is coded as a 1 for yes and 0 for no): (a) Asthma, bronchitis, or emphysema; (b) lung problems (aside from tuberculosis); (c) arthritis, rheumatism, or other bone or joint diseases; (d) sciatica, lumbago, or recurring backache; (e) persistent skin trouble (e.g., eczema); (f) thyroid disease; (g) recurring stomach trouble, indigestion, or diarrhea; (h) urinary or bladder problems; (i) being constipated all or most of the time; (j) gall bladder trouble; (k) persistent foot trouble (e.g., bunions, ingrown toenails); (l) trouble with varicose veins requiring medical treatment; (m) high blood pressure or hypertension; (n) migraine headaches; (o) chronic sleeping problems;(p) stroke; (q) ulcer; (r) hernia or rupture; (s) piles or hemorrhoids. I then totaled the health conditions and made five dummy variables: a) *no health conditions* (reference category), b) *one health condition*, c) *two health conditions,* d) *three health conditions,* e) *four or more health conditions*.

Self-rated physical health was evaluated with the question: "In general, would you say your physical health is excellent, very good, good, fair, or poor." Responses were recoded into three dummy variables indicating: very good/excellent (reference category), good, and fair/poor.

I also consider measures of *functional limitation*. Not only might diagnosed medical conditions cause people to identify as fat, but the intrusiveness of basic physical limitations may make fatness more difficult and act as a barrier to living life as fully as he or she might hope; this then may make people more likely to identify as fat. *Functional limitations* are measured with the instrumental activities of daily living (IADL) scale (α=.93). The IADL scale assesses the difficulty one has performing selected activities of daily life. Respondents are asked: "How much does your health limit you in doing each of the following? (a) lifting or carrying groceries; (b) climbing several flights of stairs; (c) bending, kneeling, or stooping; (d) walking more than a mile; (e) walking several blocks; (f) vigorous activity (e.g., lifting heavy objects) and (g) moderate activity (e.g., vacuuming). " Response categories range from 1 to 4, and include: not at all, a little, some, and a lot. Scale scores reflect one's average response across the seven items where higher scores reflect greater functional impairment.

Shortness of breath is an additional indicator of the ways that weight may become a trying identity. Participants are asked: "Do you get short of breath in each of the following situations? When hurrying on ground level or walking up a slight hill; when walking with other people your age on level ground; when walking at your own pace on level ground; and when washing or dressing." Responses are recoded into a dichotomous variable where "1" indicates those who answered "yes" to any of the four items; the reference category includes those who indicate no shortness of breath.

Finally, as I discussed in Chapter 1, there is a pervasive belief in an ethic of personal responsibility and control in U.S. society. As such, people feel they have, or at least should have, control over their own health destinies. Therefore, I test how this

perception affects weight perceptions using a measure for *perceived control over health*. It is measured with the single item: "Please indicate how much you agree or disagree with the following statement: Keeping healthy depends on things that I can do." Response categories range from strongly disagree to strongly agree, where higher scores reveal higher levels of perceived control.

Discrimination (Ch. 5). Discrimination is a fundamental way that (1) people learn they are fat; (2) a fat identity becomes more trying; and (3) fatness becomes inescapable. As such, I test whether discrimination indicators act as pathway variables for assessing oneself as somewhat or very overweight. Because of the tremendous impact I hypothesize interpersonal discrimination should have on weight identification, I calculated five different indicators for daily interpersonal discrimination. I first calculated the *daily interpersonal discrimination scale* (α= .93). It describes recent interpersonal experiences that involve character assaults and unkind treatment. Nine questions evaluate the frequency of exposure to daily occurrences. Respondents were asked: "How often on a day-to-day basis do you experience each of the following types of discrimination: (a) you are treated with less courtesy than other people; (b) you are treated with less respect than other people; (c) you receive poorer service than other people at restaurants or stores; (d) people act as if they think you are not smart; (e) people act as if they are afraid of you; (f) people act as if they think you are dishonest; (g) people act as if they think you are not as good as they are; (h) you are called names or insulted; and (i) you are threatened or harassed. The four response categories range from 1 ("never") to 4 ("often").

I next coded a dummy variable indicating *ever experiencing daily interpersonal discrimination.* I coded "Never" responses as a 0, all others as a 1.

Third, I developed a dummy variable indicating anyone who scored in the top 25 percent of the *daily interpersonal discrimination scale*.

Fourth, to gauge what types of interpersonal discrimination have the greatest impact on perceived body size, I incorporated subscales indicating three dimensions of interpersonal mistreatment, developed and tested by Carr, Friedman, and Jaffe (2007); lack of respect, treatment that suggests one is of blemished character, and teasing/harassment. Sample members were asked "How often on a day-to-day basis do you experience each of the following types of discrimination?" Response categories are never, rarely, sometimes, often. Factor analyses yielded three subscales. *Lack of respect (*$\alpha = .93$) indicates the frequency with which one was: treated with less courtesy than other people; treated with less respect than other people; received poorer service than other people at restaurants or stores; treated as if not smart, and treated as if not as good as other people. *Blemish of character* ($\alpha = .81$) refers to the frequency with which: one is treated as if they are dishonest; and treated as if they are frightening to others. *Harassment/teasing* ($\alpha = .86$) refers to the frequency with which one is: called names or insulted; and threatened or harassed. Responses were averaged and scale scores range from 1 to 4, where a 4 reflects more frequent mistreatment.

Fifth, respondents were also asked: "What was the main reason for the discrimination you experienced?" Body shape and appearance are intimately tied. Therefore, I computed a dichotomous *weight/appearance based discrimination* variable;

respondents who answered height or weight or appearance were coded as a 1 and all others a 0.

Missing Data

Because many of the indicators I use are based upon sensitive data such as health conditions and weight, many of the variables had missing data. For continuous variables, I replaced missing values with the sample mean. For categorical variables, I replaced missing values with the modal category. Missing values were replaced in continuous variables that were recoded into categorical variables and then dummy variables, such as weight categories, before the variables were recoded as categorical variables. All analyses with variables that had over 3 percent missing cases were also run with an additional indicator for "system missing." I did this to ensure that the people who did not answer the specific questions being studied did not represent a unique subgroup that may shed further light on weight identity formation. However, these missing data indicators did not yield significant results and were left out of the final analyses.

Analytic Plan for Quantitative Analysis

The analysis has three components. Each step contributes to the larger goal of learning what factors contribute to fat identities. The first step uses bivariate analyses to contrast what factors are most frequently associated with normal weight, overweight, and obese people in my sample. Using factorial ANOVA and Tukey's post-hoc tests, I assess whether respondents across the three weight categories vary significantly from each other.

Second, using binary logistic regression I evaluate the extent to which present BMI affects perceived body size, net of potential confounding, pathway, moderating, and

control variables. Third, in this work I hypothesize that the relationship between one's weight category and perceived body size is based upon factors that interact with one's body size. For instance, age and race are two variables that potentially moderate the effect of weight on perceived body size. Thus, to test more clearly how demographic and past weight variables influence body size perception, I use interaction term analysis. For Chapter 3, I examine the extent to which the associations between BMI and perceived body size vary based upon one's past weight, dieting history, gender, and age using binary logistic regression. In Chapters 4 and 5, health and discrimination variables, respectively, are added to all models. In these chapters I also ran interactions for health and discrimination and all of the above variables. For some of the interaction analyses, the overweight and both obese categories are collapsed into one category because, by the nature of interaction analyses, cell sizes are decreased when interaction terms are calculated. Consequently, this is problematic for logistic regression.

Sample Size Issues

Logistic regression is a useful tool for gaining an understanding of the causal relationships between bivariate dependent variables and categorical or continuous independent variables. However, it is highly dependent upon a large sample size. Consequently, I contended with sample-size problems throughout my analysis because there are many fewer obese respondents than normal weight respondents in my sample. Therefore, I have had to use various techniques to account for this. Although there are conceptual reasons for separating out obese I and obese II+ into separate categories, I could not because only 7.5 percent of the sample is obese II or greater. Consequently, the resulting odds ratios were extremely high (in some cases, obese II respondents were 435

times more likely than normal weight subjects to assess as overweight. Although this is an intuitive result, it is an indication that the analysis is flawed.).

Each chapter begins with a quantitative section that enables me to illustrate broad patterns within weight identity formation. In Chapter 3 I examine how basic sociodemographics and past weight and weight loss affect the relationship between BMI and perceived body size. In Chapter 4 I illustrate how health variables affect the relationship, and in Chapter 5 I look at how perceived discrimination affects the pathway between BMI and perceived body size. Statistical analysis is a powerful tool for understanding complex relationships, but it masks the distinctive characteristics of the people being analyzed. To control for this, in each chapter, I take the foundations set by the statistical analysis and add an additional layer by illustrating how fat people perceive their fatness, and how the relationship between their body weight and body image is affected by the variables tested in the quantitative section. By doing this, I am able to gain a perspective about the fat experience that is not available from quantitative analysis alone.

Qualitative Interviews

I conducted 40 in-depth, face-to-face interviews (see Appendix A for the interview protocol). All interviews were semi-structured; the specific content of the interview varied based on each subject's personal experiences and history. I recruited my sample using two different methods: a web posting on the New York City/New Jersey area craigslist.org that resulted in 15 interviews and word of mouth/snowball sampling which resulted in 25 interviews. The web posting specifically sought to recruit persons for whom being overweight was an important part of their life (see Appendix B). The

query specified that the researcher was interested both in people who were currently overweight as well as those who had been overweight at one time. As such, the sample encompasses a wide range of body shapes and weights; BMI ranges from 19 kg/m^2 to 55 kg/m^2 (Appendix C). The sample is disproportionately Jewish (63 percent) and female (78 percent) and ranges in age from 20 to 64. The sample is disproportionately white (36 out of 40) and it is predominantly a middle- to upper-middle class sample. All participants graduated from high school, and all but two also graduated from college, one of whom was enrolled in college at the time of the interview. Barring these similarities between informants, my subjects all have their own perspective on what it means to be fat. Analyzing the consistent threads that run through interviews, as well as the differences between them, sheds light on how fat identities are formed and what social processes contribute to them.

I analyzed my interviews via grounded theory (Glaser and Strauss 1967). Although I read each interview with the understanding that I wanted to gain a better understanding of why weight matters, I did not have any preset ideas in mind as to why they matter. Through analyzing my interviews I began to see reoccurring patterns and themes, which helped me to formulate my understanding of fat identity formation. I did not use any computer software to analyze my interviews and I transcribed each interview by hand. After transcribing all 40 interviews, I read each interview three times. The first reading helped me to carve out what domains were important for fat identity formation. The other two readings enabled me to place specific quotes into these domains, helping me to formulate a coherent story. Ultimately, I analyzed each interview for the following themes (a) former weight; (b) dieting; (c) moral concerns; (d) health (broken down into

health symptoms and medicalization); (e) psychological well-being; (f) aging; and (g) beauty concerns. Of course, many times quotes fell into more than one category or slightly out of the fixed categories I set. In these cases I placed them in as many categories as seemed appropriate.

Much of what my informants talked about relates to dieting and the hardships associated with being overweight. These discussions about their dissatisfaction with their weight, and the pain associated with gaining and losing weight are extremely informative avenues for understanding how stigma, moral concerns, medical concerns, and discrimination are inextricably intertwined with forming fat identities.

CHAPTER 3
The Learned Identity

Being fat is both a concept and a lived experience. Conceptually, it is a social role based upon constructs that are the product of various social systems working together—i.e. the healthcare industry, media, etc—to produce weight categories that people generally interpret as dyadic: ideal and not-ideal. In comparing oneself to this ideal—and internalizing the consequences of not fitting this ideal—fat becomes a lived reality, and a descriptor becomes an identity. Although a fat identity is a possibility for everyone, what brings people closer to the ideal typical fat identity described above? And what factors act to protect people from forming a fat identity? In this chapter, using my analysis of the MIDUS survey and my 40 in-depth interviews, I begin to answer these questions.

A fat identity is dynamic and depends upon how one's personal traits interact with society's expectations. In this chapter I show how the first of the three criteria for an ideal-typical fat identity—a learned identity—is a fundamentally important criterion for determining where on the fat continuum a person lies. In subsequent chapters I explore two common aspects of the fat experience—health symptoms and discrimination—to help further illustrate the importance of conceptualizing fat as a learned, trying, and all encompassing identity that is influenced by an individual's unique clustering of sociodemographics, history, values, and weight.

To begin my exploration, in this chapter's quantitative section I specifically ask:

1) *How do normal weight, overweight, and obese MIDUS respondents differ?*

2) *What effect does present BMI, past BMI (BMI at 21 years of age), and a history of weight loss have on perceived body size?*

3) *How do age, race, and gender moderate the BMI/perceived body size relationship?*

3b) How does present BMI mediate the effects of gender, race, and age on perceived body size?

4) To what extent do psychological/cognitive factors mediate the present BMI/perceived body size relationship?

5) *Do the effects of past weight, weight loss, and demographic variables on perceived body size vary by weight category?*

The scope of this chapter is the greatest because it lays the background for the analyses in Chapters 4 and 5. The qualitative section draws from these findings to illustrate some of the complexities involved with fat identity formation and shedding.

Descriptive Statistics

How do normal weight, overweight, and obese MIDUS respondents differ?

Table 3.1 displays descriptive statistics by BMI weight category for all variables included in this chapter's analysis. I compared the three BMI categories by conducting factorial ANOVA and Tukey's post-hoc tests. The right hand column denotes significant contrasts between specific pairs of weight categories. Keeping in mind that I excluded all underweight people, and anyone who did not respond to the height or weight question from all analyses, slightly less than 40 percent of the sample is normal weight (BMI of 18.5 to 24.9) and a little under 40 percent of the sample is overweight (BMI of 25 to 25.9); the remaining approximately 20 percent of the sample is obese 1 or greater (i.e.

obese or extremely obese).[8] These proportions are comparable with national estimates showing that 18 to 25 percent of the U.S. population is obese, while 60 percent to 70 percent is overweight or obese (Ogden et al. 2006). The proportion of blacks in each category rises systematically as weight category increases. Four percent of the normal weight sample, 6 percent of the overweight sample, and 10 percent of the obese sample are black ($p < .001$). Gender does not map as systematically; 62 percent of the normal weight sample, 37 percent of the overweight sample, and 36 percent of the obese sample is female. Finally, overweight and obese persons are, on average, three to four years older than normal weight subjects.

The bivariate analyses reveal a first glimpse into the patterns that will be highlighted throughout this chapter. As weight category increases, a higher proportion of respondents assess themselves as somewhat or very overweight; 98 percent of people who are obese, 83 percent of people who are overweight, and 36 percent of normal weight people rate themselves as "somewhat or very overweight." All category means differ significantly at the $p < .001$ level. Similarly, as weight category increases, a smaller proportion of respondents assess themselves as "about normal weight." Sixty four percent of normal weight people, 17 percent of overweight people, and only 2 percent of obese people assess their weight as "about normal weight" ($p < .001$ for all comparisons). As might be expected, as weight category increases, the proportion of subjects reporting that they were normal weight at 21 decreases. The opposite is true for those who report being overweight at 21. Thirty six percent of obese people and 20 percent of overweight people reported being overweight at 21, while only 4 percent of

[8] Significant muscle mass can cause someone to have a BMI that is classified by NHLBI as overweight or obese, when in fact they appear normal weight. This is more frequently the case with men, but I was unfortunately not able to control for this possibility with any accuracy using the MIDUS questions.

normal weight people were. Similarly, although no normal weight subjects were obese at 21, 2 percent of the overweight ones and 14 percent of the obese ones were.[9] Finally, as weight category increases, a higher proportion of respondents reported having ever lost 10 pounds, having only a high school degree, and having low self-satisfaction. Alternately, as weight category increases, a smaller proportion of respondents reported being underweight at 21, having a college degree, and to be very satisfied with themselves.

[9]Preliminary analysis revealed nearly 90percent of the MIDUS sample is heavier or the same weight as they were when they were 21, which ranges from 4 to 54 years earlier. Because these are retrospective measures, this percentage should be taken with caution.

Table 3.1. Means and Proportions for Dependent and Independent Variables by BMI Categories

	Total	Normal Weight[a]	Over-weight[b]	Obese 1+[c]	F-statistic (df=2)	Significant Subgroup Differences
Self-Assessed Present Weight						
Perceived body size: "About Normal"=1	.32	.64	.17	.02	727.72***	F (see note)
Perceived body size: "Somewhat/Very Overweight"=1	.68	.36	.83	.98	727.72***	F
Prior Weight and Dieting						
Ever lost 10 lbs	.73	.62	.76	.87	79.52***	F
Underweight at 21	.06	.11	.04	.02	50.63***	ab,ac
Normal Weight at 21	.72	.84	.74	.48	163.22***	F
Overweight at 21	.17[F]	.04	.20	.36	184.68***	F
Obese 1 + at 21	.04	.00	.02	.14	135.29***	ac,bc
Demographic Variables						
Gender (1=female)	.50	.62	.37	.53	85.14***	F
Race (1=Black)	.06	.04	.06	.10	15.86***	F
Race (1=Other)	.05	.05	.05	.05	.19	
Age	47	45	48	49	17.79***	ab,ac
Married or Cohabitating	.35	.39	.32	.36	7.72***	ab
Never Married and Not Cohabitating	.10	.12	.08	.10	4.88**	ab
Formerly Married and Not Cohabitating	.21	.22	.20	.21	.35	
Presently working	.74	.74	.75	.72	1.12	
GED or less	.10	.09	.10	.13	5.32	
High School Degree	.27	.22	.28	.31	10.02***	ab,ac
Some College	.30	.30	.30	.31	.49	
College Plus	.33	.39	.32	.25	21.91***	F
Psychological/Cognitive Factors						
Not/Somewhat satisfied with self	.41	.39	.40	.47	6.65**	bc,ac
Very satisfied with self	.59	.61	.60	.53	6.65**	ac,bc
Neuroticism	2.23	2.24	2.23	2.22	.35	
N	3202	1223	1264	476		
Percent	100	38.2	39.5	22.3		

[F] The means are significantly different for all weight categories.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Multivariate Analyses

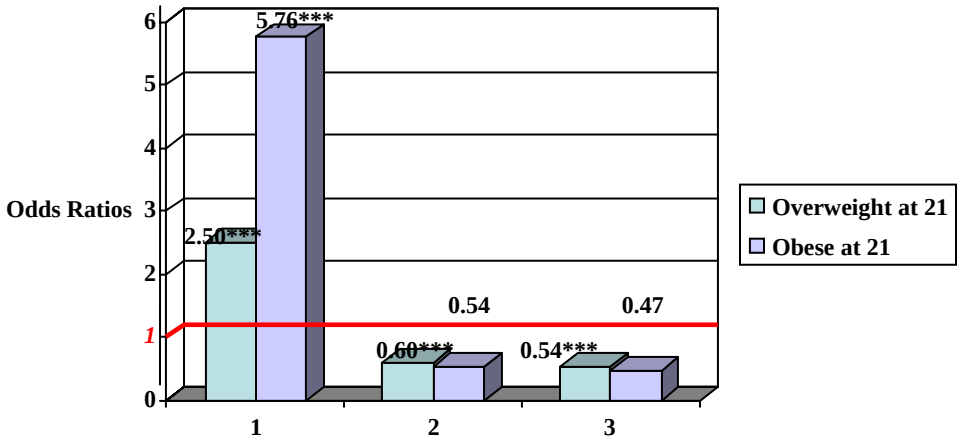
What effect does present BMI, past BMI (BMI at 21 years of age), and a history of weight loss have on perceived body size?

On the most basic level, obesity is the strongest predictor of a fat identity. The odds of one rating oneself as somewhat or very overweight as opposed to normal weight or underweight increase from 18.00 for someone whose BMI is between 25, and 29.99 to 156.47 for someone whose BMI equals or exceeds 30 (Table 3.2).[10] Also, being overweight at 21 is a significant factor in weight evaluations. The first column in Figure 3.1a shows the results for weight at 21 regressed on perceived body size without any other indicators. Those who were overweight at 21 are two and a half times more likely than people who were normal weight at 21 to assess as overweight ($p < .001$). Furthermore, people who were obese at 21 are nearly six times more likely than normal weight at 21 respondents to assess as overweight. However, both of these relationships are fully mediated by current weight (column 2, Figure 3.1a). Although the relationship between overweight at 21 and perceived body size remains significant after present weight is added to the regression, the coefficients' sign flips, leaving those who were overweight or obese at 21 to be between 40 percent and 50 percent less likely to assess themselves as somewhat or very overweight as compared to people who were normal weight at 21. In addition, as indicated in Table 3.2, model 2, young adulthood weight and weight loss indicators partially explain the BMI/perceived body size relationship, especially for obese respondents. Net of all factors, those who were overweight at 21 are

[10] Because of sample size, these odds ratios are inflated and should be taken with caution. However, they indicate a pattern that is echoed by the qualitative work reported below.

nearly 30 percent less likely, compared to respondents who were normal weight at 21, to rate themselves as presently somewhat or very overweight ($p < .05$).

Figure 3.1a. Odds Ratios of Perceiving Body Size as Somewhat or Very Overweight by Weight at 21



Notes: ***1*** indicates the reference category (normal weight at 21).
Model 2 controls for present weight indicators;
Model 3 controls for present weight and weight loss indicators.
* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

As Table 3.2 reveals, a history of weight loss is also a highly significant predictor of self-evaluated weight. Subjects who have ever lost 10 pounds or more are almost twice as likely as those who have not lost weight to report that they are somewhat or very overweight ($P < .001$), net of all other factors.

Table 3.2. Logistic Regression, Weight Indicators on Perceived Body Size, Somewhat or Very Overweight (N=3202)

	1	**2**	**3**	**4**
Overweight	8.65***	9.40***	17.75***	18.00***
Obese 1+	73.59***	90.91***	155.78***	156.47***
Past Weight and Weight Loss				
Underweight at 21		1.02	.74	.69*
Overweight at 21		.54***	.72*	.72*
Obese 1 + at 21		.47*	.53	.53
Ever lost 10 lbs		2.24***	1.93***	1.89***
Demographic Variables				
Gender (1=female)			4.46***	4.40***
Race (1=Black)			.28***	.30***
Race (1=Other)			1.65*	1.58*
45 to 65 years old			1.53***	1.63***
65 to 75 years old			.96	1.04
Never Married and Not Cohabitating			.84	.80
Formerly Married and Not Cohabitating			.72**	.70**
Presently working			.85	.87
GED or less			.70*	.69*
Some College			1.02	1.01
College Plus			1.34*	1.39*
Psychological/ Cognitive Factors				
Not/Somewhat Satisfied with Self				1.36**
Neuroticism				1.17*
-2 Log likelihood	2915.52	2839.92	2597.74	2580.61
Chi-square/df	1090.41***/2	1169.00***/6	1408.19***/17	1425.31***/19
R-squared	.29	.31	.36	.36

$p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.
Odds ratios are presented.

How do age, race, and gender moderate the BMI/perceived body size relationship?

Because demographic variables are an important part of my analysis, I ran two regressions for all demographic variables. The results of the first regression (R1) are shown in Table 3.2. This regression has present weight indicators included in Model 1 as the primary independent variables, with all other variables entered as mediators, moderators, or controls. The second set or regressions include gender (R2: Figure 1B), race (R3: Figure 1C), and age (R4: Figure 1D) as the primary independent variables added in Model 1, with all other variables, including present weight indicators, added as mediators, moderators, or controls in subsequent models.

In the saturated model of R1 (model 4, Table 3.2),[11] women are significantly more likely than men to rate themselves as "somewhat or very overweight" (Exp(b) = 4.40, $p<.001$), blacks are approximately one-third as likely as whites to rate themselves as somewhat or very overweight, and those 45 to 64 years old are 1.63 times more likely than 25 to 34 year olds to assess themselves as very overweight net of weight, demographic, and psychological factors. Alternately, being 65 to 75 years old makes very little difference on weight evaluations. Finally, college graduates are nearly 40 percent more likely than people who only have a high school degree to rate themselves as somewhat or very overweight ($P \leq .05$) (Table 3.2).

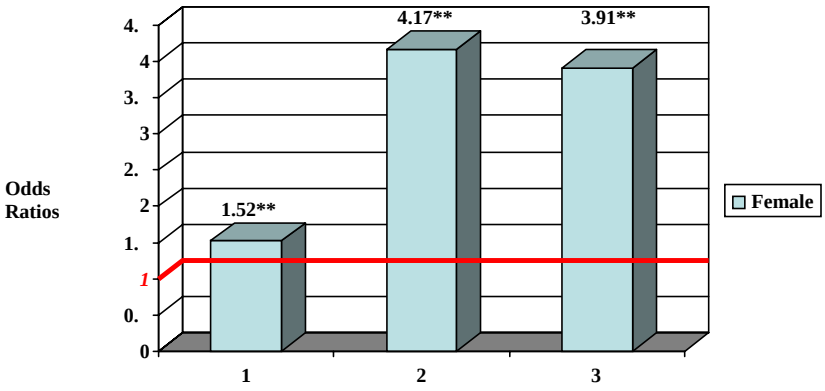
How does present BMI mediate the effects of gender, race, and age on perceived body size?

In R2 through R4, the relationship between demographic variables and perceived body size is further elucidated. In R2, gender is the independent variable and all other

[11] Regressions R1-R4 all have the same variables. The difference is the order in which they are entered into the regression. Therefore, the saturated models of R1-R4 reveal the same results.

variables are added in subsequent models. This regression reveals that gender is a significant predictor of perceived body size, net of all weight and weight loss indicators. When present weight, weight at 21, and weight loss indicators are added to the model, the odds of a woman assessing her weight as somewhat or very overweight increase from 1.52 to 3.91 ($p < .001$) (Figure 3.1b). Thus, being female is a risk factor for forming a fat identity, and this risk is independent of BMI, weight at 21, and weight loss.

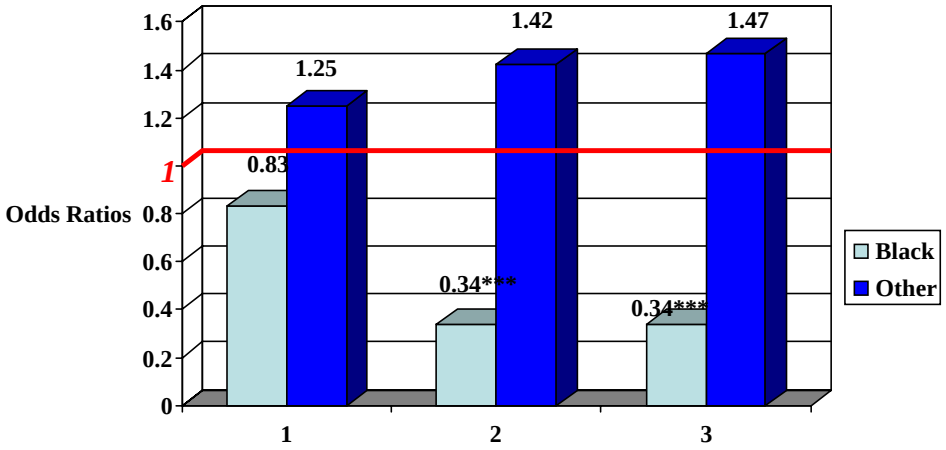
Figure 3.1b. Odds Ratios of Perceiving Body Size as Somewhat or Very Overweight by Gender



Notes: *1* indicates the reference category (male).
Model 2 controls for present weight indicators;
Model 3 controls for present weight, weight at 21, and weight loss indicators.

The race regression (R3) yields the opposite effect. Both race variables (black and other) are insignificant until present weight indicators are added to the model, after which blacks are significantly less likely than whites to assess themselves as somewhat or very overweight ($Exp(B) = .34$, $p \leq .001$) (Figure 3.1c). This suppressor effect is likely because such a small percentage of the obese sample is black (10 percent) or other (5 percent) (see table 3.1).

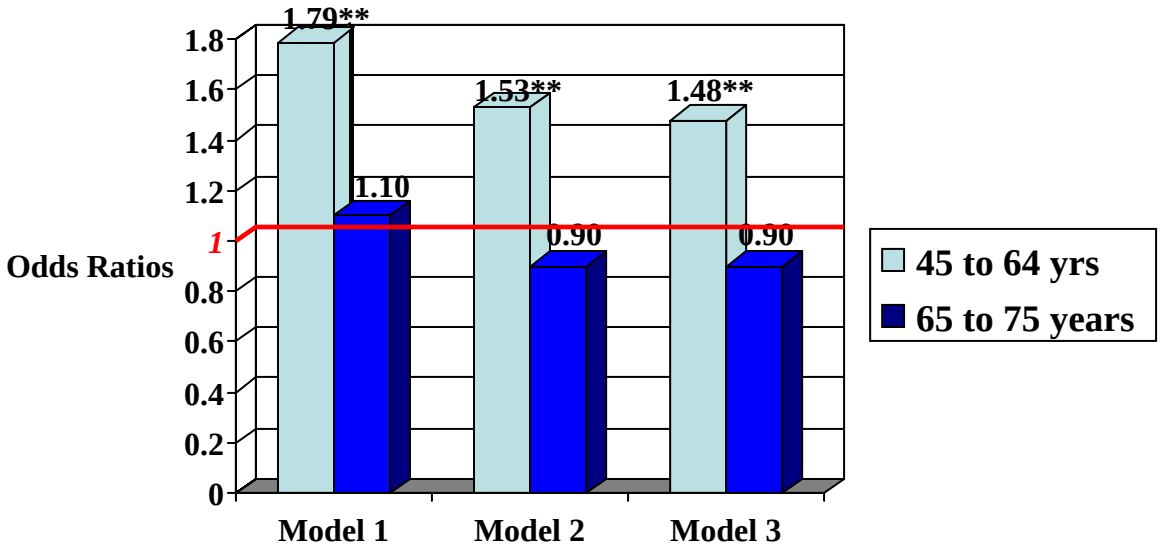
Figure 3.1c. Odds Ratios of Perceiving Body Size as Somewhat or Very Overweight by Race



Notes: ***1*** indicates the reference category (white).
Model 2 controls for present weight indicators;
Model 3 controls for present weight, weight at 21, and weight loss indicators.
*** $p \leq .001$.

R3 shows that being middle age is a significant predictor of assessing as somewhat or very overweight. Forty five to 65 year old respondents are over three quarters more likely than 25 to 44 year olds to assess as somewhat or very overweight. Although this relationship is somewhat mediated by present weight, weight at 21, and weight loss history, the relationship remains significant; middle age respondents are nearly 50 percent more likely to assess as overweight net of all weight indicators ($p < .01$) (Figure 3.1d).

Figure 3.1d. Odds Ratios of Perceiving Body Size as Somewhat or Very Overweight by Age



Notes: ***1*** indicates category (Age 25 to 44 years old).
Model 2 controls for present weight indicators;
Model 3 controls for present weight and weight loss indicators.
* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

To what extent do psychological/cognitive factors mediate the present BMI/perceived body size relationship?

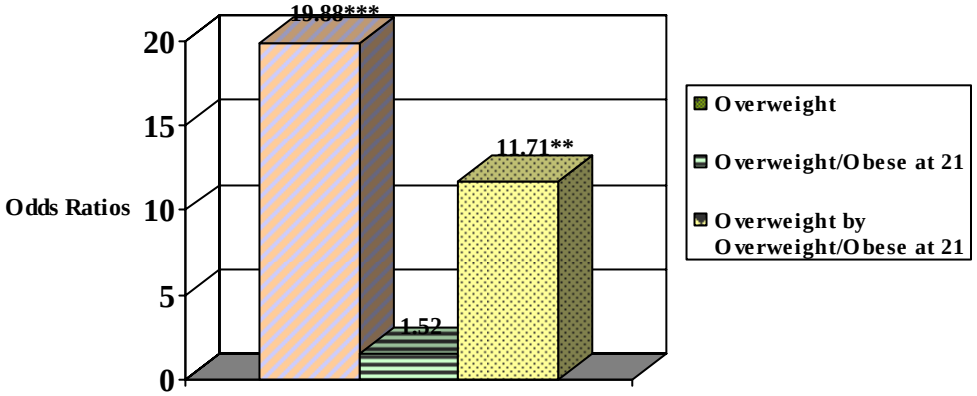
Much of identity formation is a social psychological process of internalizing external messages about personal characteristics. Literature about subjective well-being suggests that affective state is an important determinant of identity (Davern, Cummins, and Stokes 2007; Pavot and Diener 1993). Thus, it is not surprising that one's level of satisfaction with oneself affects how one assesses their weight. In the saturated model of R1, (model 4, table 3.2) those who report being "not or somewhat satisfied with self" are over 36 percent more likely than those who report being very satisfied to assess their weight as "somewhat or very overweight" ($p < .01$). Additionally, for every point

increase on the neuroticism scale, a respondent's likelihood of identifying as somewhat or very overweight increases by 1.17 ($p < .05$).

Do the effects of past weight, weight loss, and demographic variables on perceived body size vary by weight category?

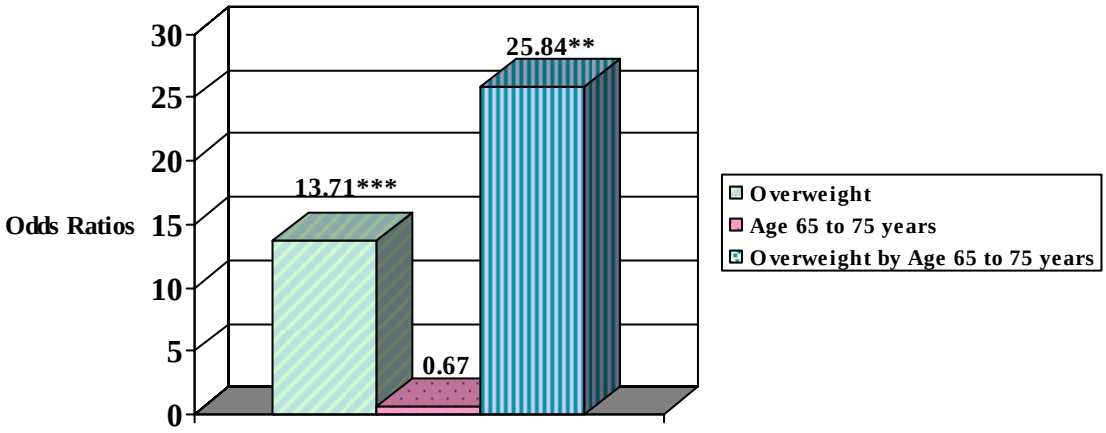
I additionally ran five logistic regressions with two-way interaction terms for presently overweight and presently obese by (1) overweight/obese at 21 (because of the strict cell-size requirements for logistic regression, I truncated the overweight at 21 and obese at 21 variables into one "overweight/obese at 21" variable); (2) ever lost 10 pounds, (3) race, (4) gender, and (5) age. Only the indicators for overweight by overweight/obese at 21 by and overweight by 65 to 74 years old reached significance. The odds of someone assessing themselves as somewhat or very overweight decreases from 19.88 ($p < .001$) for someone who is presently overweight but was normal weight at 21 to 11.71 for someone who is presently overweight and was overweight or obese at 21 (Figure 3.2). This suggests that gaining weight later in life has a greater impact on fat identities than being consistently fat since childhood. Also, older overweight adults have nearly twice the odds of assessing themselves as somewhat or very overweight as compared to overweight 25 to 44 year olds (25.84 vs. 13.71) (see Figure 3.3).

Figure 3.2 Odds Ratios for Interaction Analysis:
Perceived Body Size by Overweight * Overweight or Obese at 21



* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Figure 3.3 Odds Ratios for Interaction Analysis:
Perceived Body Size by Overweight * Age 65 to 75 Years



* $P \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Summary

Taken together, these results largely support my hypothesis that perceived body size, which in this analysis is a proxy for a fat identity, is largely affected by one's reference group and the internalization of external messages. Overweight and obese people, white people, and the well-educated are more likely to assess themselves as somewhat or very overweight than normal weight, black, and less educated people. All of these findings are consistent with past research about weight perceptions (see Paeratakul et al. 2002), and are extremely important for the research at hand. In addition, self satisfaction and neuroticism are significant indicators of negative weight evaluations. Thus, myriad factors affect how one perceives one's body size. Beyond present weight and sociocultural group alignment, past weight, weight loss, middle age, life events such as gaining an education, and psychological disposition affect how people perceive their body size. To further illustrate this point I now turn to the qualitative portion of this chapter which helps to clarify nuances that quantitative data analysis cannot: the continuum that weight evaluations exist on and the effect of current weight, gender, race, age, and weight changes on how one gains and loses "fat" as opposed to weight.

The Continuum: From Numbers to People; From Fat to Thin

Quantitative data analysis is an important social tool allowing researchers to understand social trends and patterns. However, behind every number is a person who took the time to respond to the questionnaire—each with a unique history and set of social roles, values, and identities. Thus, the rest of this chapter will bring the numbers discussed earlier alive with the words of fat people. Those who would have evaluated themselves as "somewhat or very overweight" in my quantitative analysis are the fat

people in my qualitative analysis. Regardless of BMI, they view themselves as fat based upon past weight, age, or sociocultural features. Tying the literature review and the quantitative analysis together via in depth interviews is an important path towards humanizing the fat experience. Thus, through the use of my 40 qualitative interviews, I will show how various factors affect how one identifies and brings some closer to the fat ideal type and pushes others further from it. This will help to elucidate how identities are formed and changed based upon the interaction between various personal and social characteristics that are unique to all individuals. Armed with this information, researchers will have a more acute understanding of the subgroup variations in how overweight impacts people's identities. This will hopefully lead to more informed and nuanced approaches to obesity and fat in future research and education.

Body Mass Index and Fat

The more overweight one is, the more likely he or she is to have a fat identity. In part this is because the ambiguity between fat and thin seemingly disappears when one is able to see a clear similarity between him or herself and other very overweight people.[12] It is generally more likely for a fat identity to be all encompassing for fatter people (although, this does not have to be the case). Thinner people who lie closer to the boundary between fat and thin have less clarity about their weight because at times they may be able to hide from it. Extremely fat people do not have this luxury. Maureen, who is 40 years old and "easily 300 lbs" and the most *currently* overweight person I interviewed, is the closest example of an ideal-typical fat person that I interviewed. She explained what it is like to be so overweight that it has become a part of her being: "Um, I'm always aware of it. I have such a mentality. It's part of my ego, if you will, of who I am because I know I'm

[12] See Lau (1989) who argues people are more likely to identify with groups to which they are similar.

heavy. Therefore, I enter the world as that and I know that so I'm constantly aware of it" (Maureen, 5'3 and 300+ lbs; BMI of 53+). Maureen's extreme overweight has made it impossible to hide from her weight and it has been an issue for almost her entire life. She was taught at a young age that she was fat when her mother would not allow her to wear a bikini because she was bigger than her best friend, and she is continually reminded that she is fat directly by family members and indirectly when she interacts with strangers. Consequently, she is constantly aware of how difficult her life is because of her weight and is never able to escape from her fatness even when partaking in activities such as watching television where the content often reminds her that she is not aligned with socially constructed weight norms, going on outings with friends, and interacting with perfect strangers. Strangers believe they know more about her than she knows about them because of the very visible stigma she walks around with, making it even more difficult for her to escape her fatness.

Maureen's situation is extreme. She is morbidly obese and has been most of her life. She has also felt numerous side effects that she has attributed to her weight, which I discuss in the next chapter. However, being fat is both a psychological and physical state. Because of this, when your body and experiences do not match, it is quite easy to be caught somewhere in the middle of fat and thin. Amanda, a 20 year old student and the daughter of a prominent democratic political adviser, exemplified what it is like to be in the middle of this continuum. She had what she calls a "non-specified" eating disorder in high school, and was constantly concerned with her fatness, although she was not what would be described as morbidly obese (she approximates she was about 180 pounds and 5'4 at her heaviest; BMI of 31): "I felt so fat. I was so conscious of being fat and yet I

didn't really feel like I was completely fat. If that makes sense. I was very concerned with whether people could tell I was fat or not. Like, I thought maybe some people wouldn't notice [that I was fat]" (Amanda, 5'4 and 110 lbs; BMI of 19). Although her fatness pervaded her being, because she thought that she was able to "hide" it, she was able to get a reprieve from that identity once in a while. Like Maureen, Amanda was taught at a young age that she was fat when her parents put her on a diet, yet because it was never all-encompassing, she was never "completely fat." Further into our interview she mentioned that she was able to "hide" it (or from it) depending upon whom she was around. When she was younger and went to a nearly all black elementary school in Washington D.C., her weight was less of an issue for her than when she moved to New York and went to a posh, nearly all white, private school. This is not surprising. She was older and around a demographic whose body weight ideals are much less forgiving: wealthy white people (Ross and Mirowsky 1983).

Race

Other people I interviewed had similar experiences to Amanda. For the four non-white people in my qualitative sample, depending upon their comparison group and their socio-cultural experiences, their level of fatness varied. I also heard numerous accounts from white, fat women of how it was easier to be overweight in a diverse city such as New York City rather than its suburbs. Lisa, a 48 year old white, Jewish woman who is 5'2, weighs 220 pounds (BMI of 40), and recently moved to Brooklyn from Long Island, explained that it is easier to be overweight in Brooklyn because the expectations are different: "I'm finding here in Brooklyn it's easier to be heavy. I mean it's a stereotype, but white men tend to prefer thinner women. Blacks and Hispanics tend to like heavier

women and I never got men looking at me like they do when I lived on Long Island." She later marveled that she would post on-line personal ads clearly stating she was looking for a "white, Jewish male" and only Hispanic, Catholic males responded to her ads. She conjectured this was because she was honest about her weight in the ads.

Although it is a common belief that blacks and Hispanics are either attracted to fat or do not care about it, my findings did not corroborate this assumption. It is more likely that their ideals are different. As Cara, a 22 year old administrative assistant explained, body shape is more important than weight in her native Dominican Republic where plastic surgery is currently a craze. Instead of dieting or having bariatric surgery, emphasis is placed on exercising to achieve a toned, shapely body. But Cara also explained that although you can be "bigger" as long as your stomach is flat, there is still great emphasis on weight, even among the children to whom she taught English as a second language when she lived in the Dominican Republic a few months earlier:

> [The children] are also very conscious about their weight, you know. And I worked at a preschool and I also teach English as a second language for kids in the Dominican Republic and I've worked with kids all ages up to 16 years old…and a little girl that was 4, or almost 5, "oh no, the teacher, she's fat" or whatever. It's like oh my God, I had surgery, where are you looking at this? Like come on. (Cara, 5'1 and 206 lbs; BMI of 39)

Something that is remarkable about this quote is that although Cara felt that her surgery was a success and that she had a flatter and more toned body, she still was not at a socially acceptable weight and it took the most socially uninhibited people in any society—children—to make her aware of this.

Also, three of the four non-white people in my sample have weight ideals that would put their BMIs significantly higher than the 25 that is the generally accepted standard for the boundary between normal weight and overweight—a finding that is

consistent with past research (Bennett and Wolin 2006; Fitzgibbon, Blackman, and Avellone 2000). Thus, fatness is relative. Although it depends upon one's specific history and reference group, once one varies from the norms of his or her reference group, they are generally taught about the consequences of being above the ideal weight.

Gender

Gender is clearly an important part of identity formation. There is a significant amount of literature about female body image and a growing body of literature about male body image (see Cash and Roy 1999; Kostanski, Fisher, Gullone 2004; McCabe, Butler, and Watt 2007; Muth and Cash 1997). Two of my female informants reported seeing weight loss as a vehicle to becoming truly a "girl." Amanda directly equates thinness with femaleness: "You know what, I felt like to be a real girl you had to be thin, actually." In addition, Ellen, an advertising executive in New York City who dropped from 230 pounds to 110 pounds, finally felt like a "girl" after she lost weight and was able to shop more freely.

The relationship between thinness and femaleness speaks to both gender and weight stereotypes. Women's bodies are frequently objectified and seen as a commodity (Bordo 1993). There is little doubt that women are more prone to body weight dissatisfaction (*ibid*.). And there is also little doubt that men *and* women help perpetuate the unbalanced views of what an appropriate weight is for a woman as opposed to a man (Germov and Williams 1999). Both men and women in my sample admitted they think thin bodies are more attractive and they would rather date a thin man or woman than an overweight one—although the women are more forgiving than the men. However, men have a similar relationship to the fat-thin continuum as racial and ethnic minorities.

There is empirical evidence that men are dissatisfied with their bodies in a similar fashion to women. For instance, Cash and Roy (1999) found that 78 percent of men who are dissatisfied with their weight, wish to lose weight. Although many more dissatisfied men than women would like to gain weight (22 percent vs. 3 percent), it is telling that weight dissatisfaction among men is predominantly in the same direction as women. Thus, while men are more protected than women from climbing the fat continuum, they are vulnerable to the socially constructed lines that they help to draw.

All eight men in my qualitative sample exemplify this. Although they acknowledged that they are lucky as compared to women, they also confessed that they too feel pressure to have a "decent" body. Being a male in a society that values thinness has advantages. However, the advantages are curbed once he crosses over the fat threshold. Bill, a 50 year old IT manager, demonstrates this. He recognizes that it is harder for women to be fat. However, he, more so than others, resents that it is only seen as a woman's issue. As he said: "I still have to worry about it, you know, I try and dress nice for work. I like combating the idea that if you're fat you're sloppy and slobby and you know you can still look halfway decent if you try" (Bill, 5'10 and 350 lbs; BMI of 50). Fat matters to Bill for the same reasons it matters to women—it is a stereotyped identity that requires additional energy to navigate.

Patrick, a 41 year old college administrator whose weight dropped from 502 lbs to 260 lbs via gastric bypass surgery, shed further light on this. Prior to his surgery, he was diagnosed with a binge eating disorder and bulimia. However, he had difficulty finding a treatment facility that accepted men. His story demonstrates the lack of attention and support men receive regarding their weight concerns. I queried him about this,

wondering if he felt discriminated against. His response shows the tension that many overweight men feel:

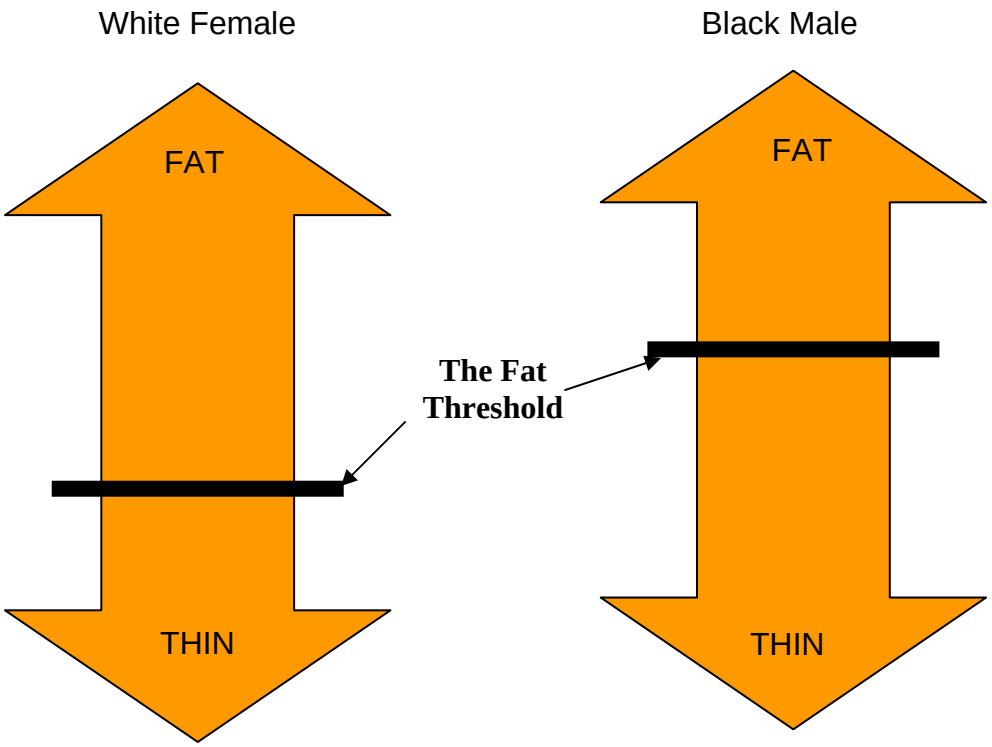
> I mean I think that within there being weight bias or obesity bias that's across the board, within it there's a gender bias—no question. I think that I got away with things that a heavy girl wouldn't have gotten away with; then, on the other hand, is that good or bad? You know, I think it enabled me. I also think the fact that I could play sports and I was fairly smart [helped]. I think if I was a dumb, fat, not athletic kid maybe the weight part would've prevented me from being successful and there would've been a bigger push to do something about it. But if you're going through and you're playing sports and doing this and that everything seems normal. I think if I was a girl I wouldn't have gotten away with all that, so what would've that meant? I would've been more miserable than I was, but would it have made me focus on it more and helped me in the long run? (Patrick, 5'11 and 260 lbs; BMI of 36)

Patrick brought up an important aspect of fat identities. As I mentioned in the first chapter, the three criteria of a fat identity—learned, trying, and all encompassing—all exist on continuums. Because he was able to play sports and was smart, he was able to identify as an athlete and a student and was able to form his social networks around these other roles. Thus being fat did not have the salience on his identity that it would have had for someone less athletic, less intelligent, or less masculine. Patrick was able to hide (from) his weight until much later in his life when it began to affect his quality of life, which I address in the next chapter. On the other hand, Patrick wondered if being able to escape the fat identity for so long, despite his corpulence, was to his benefit. Although there is evidence that obese children who grow up to be normal weight adults escape many of the health and social impacts of being persistently obese, being an obese child predisposes a person to adult obesity and the social and physical consequences of it (Ferraro, Thorpe, Jr., and Wilkinson 2003; Togashi et al. 2002). Therefore, learning you are fat early on does not necessarily lead to more positive outcomes such as thinner bodies and greater well-being later in life. Consequently, despite Patrick's questioning,

he was probably lucky that he was able to have an early reprieve from what would become a life-long struggle from his early 30s on.

In sum, similar to the relationship between weight and racial and ethnic minorities, men, like women, are part of the fat-thin continuum. The boundary between fat and thin (the fat threshold) is simply placed differently for men than it is for women (see Figure 3.4 for a pictorial illustration of how race and gender affect one's placement on the fat continuum). This exemplifies a greater point: Even though some slide up and down the fat continuum on a different scale than others, we all live on it—as I have trouble envisioning an American who has not been touched by the ideal/not ideal weight dichotomy.

Figure 3.5
Sliding up the Continuum



The Enduring Identity: Rising and Falling on the Fat Continuum

While it is beyond the scope of this dissertation to explore whether late-life weight gain is truly inevitable or not, aging is—and, as is suggested by the quantitative analysis in the beginning of this chapter, it seems to greatly affect people's weight identities. Because of this, this section is dedicated to issues regarding aging and weight changes. To this point, I have demonstrated that weight matters to varying extents for different people based upon race, gender, and level of weight, showing that fatness is relative and dynamic. In this section, I discuss fat identities as enduring identities. Although one may slide around on the continuum, once one learns that he or she is fat, it is nearly impossible to shed the imprint of a fat self.

Becoming Fat: Weight Changes and the Life Course

Physical and psychological changes that come with aging help determine and change how weight affects one's self concept. Those who gain weight later in life may not find their weight an all-encompassing part of their being because they learned they were fat later in life, when the implications of being overweight are quite different. As suggested by Markus and Nurius' (1983) and Michalos' (1985) MDT, people's happiness and satisfaction are greatly affected by how one perceives he or she is doing relative to his or her past, others, and future expectations. As such, how one identifies is inevitably tied to his or her place in the life course, and how satisfied he or she is with where they are relative to where they expected they would be. Thus, evaluating oneself relative to one's past, other people, and personal expectations plays an important role in fat identity formation and one's childhood plays a fundamental role in placing someone on his or her path to future satisfaction and happiness or dissatisfaction and unhappiness.

A major contributor to fat identities as cited by nearly all of my informants is the emphasis placed on their weight as children, usually through being placed on diets. All at once, children placed on diets learn they are fat, learn the social implications of being fat and, in more unfortunate situations, are not allowed to forget they are fat from family, friends, media, and medical professionals. For instance, Rebecca, who dropped 165 pounds via gastric bypass surgery (GBS), blames becoming a very young "lifetime" Weight Watchers member for how she first learned she was fat:

> I don't know how to put it. I never knew that I had a weight problem. I kinda learned that I had a weight problem when I was 10. My mom took me to Weight Watchers. I think I weighed 99 pounds and I got down to 86 pounds and um, became a lifetime member, and I didn't know that I was going to be a lifetime member for the rest of my life. (Rebecca 5'7 and 155 pounds, BMI of 24)

By making Rebecca's eating and weight such an issue early in her life, her mother made it very difficult for her to learn how to manage and make peace with her weight. Being forced to be constantly aware of her weight left Rebecca with an acute understanding of her fatness and the difficulties it would force her to deal with. Although inevitably Rebecca would have learned she was fat in another manner, it was the attention placed upon her weight at an early age that helped to form and solidify a fat identity that she would work so hard to dismantle later in life.

Gaining Weight

Middle age is a time of great psychological and physical transition. For instance, children in school and old enough to be more self-sufficient often send, generally mothers, back to work. It is also a time when, as much of my qualitative sample over 40 years old told me, losing and maintaining weight becomes more difficult. As such, it is frequently a time of both psychological and physical transition, which is when people

begin to question how they identify. They are no longer young, not quite old; no longer thin, not quite fat—or, no longer fat, not quite thin. Given the changes that accompany middle age, it is not surprising that for the MIDUS sample being middle age is an indicator of a pessimistic weight evaluation, net of current weight. Weight gain often accompanies middle age (Ekelund et al 2005), and those who had firmer bodies in their youth may be more sensitive to small weight gains than people who have been persistently overweight. This is suggested in part by the finding I reported above that the effect of overweight on perceived body weight decreases over 40 percent for overweight people who were overweight or obese at 21. Ellen pointed to this when she answered a question of mine regarding friendships with other overweight people:

> KJ: Did you have any overweight friends before?
>
> E: Yeah, in fact my, two of my best friends are significantly overweight, um, but neither one of them is interested in doing anything [about it]. They're fine with the way they are, but um, they're very overweight and always have been. I never was [overweight] when I was younger through high school. Like I don't know if they know what it feels like not to be [overweight] because they've always been. So, they're fine with how they are. Like even if we would go out to a bar or something. When we would walk in I would feel like you know very self conscious about my size, you know, they're fine.
>
> KJ: And they wear bathing suits?
>
> E: Yeah. They go to Las Vegas, they go everywhere and they have no problem. But I was not fine with it. And again when I was younger I was attractive and thin and I knew what that felt like and I was a popular kid and you know in school and then to get heavy I felt very aware of my [weight]. I wasn't liking how I felt. I didn't like that I didn't get the attention anymore or you know. (5'4 and 125 pounds, BMI of 21)

As Ellen implies, past weight matters a great deal for how one perceives their current weight. However, she assumes people who have never experienced thinness do not know what they are missing. As will become more clear shortly, this is not quite the case. Yet,

it is clear that the experience of becoming fat later in life is different from the experience of always being fat.

As Roberta, a 60 year old college administrator who went from 105 pounds and a size 2 in her 20s to a size 12, told me, it takes a great deal of mental energy to accept and understand this change in her body. She almost feels that she has to compensate for the fact that deep down she still feels like the "stick" of her childhood and early adulthood by being extra conscious of her size. To the average person she still looks normal weight (partially as a result of her specific body shape that still gives her a thin face and upper body, and also partially because, with a BMI of 26, she is what is generally considered overweight, but not obese). Yet in comparison to whom she identified as during her formative earlier years, she is quite heavy.

Darlene, another middle-aged college administrator, had a similar experience. As a teenager she struggled with being underweight because it was not fashionable to be so slender. However, after her pregnancies she gained weight and at 57 is now about 162 pounds and 5'2. This weight puts her right into the obese category as defined by NHLBI with a BMI of 30. Although she is quite aware of her weight, she is also unable to shed her old identity: "I still think of myself as that thin person and then you look in the mirror and you see this other person and you're like, what the heck happened." Darlene and Roberta are reminded of their weight when they buy clothing or know they are going to be weighed at a doctor's visits. This clash between their present weight and past identity is what makes their weight gain so meaningful to them.

Losing Weight and Becoming Thin?

Because a weight identity leaves an imprint on people, pounds may disappear, but the identity lingers. If one only has a fat past self to compare one's self to, it is quite hard to accept and understand a thinner present self. As the MIDUS analysis suggests, weight loss is a significant predictor of identifying as fat. My qualitative analysis supports and furthers this finding. Weight loss and attempts at weight loss frequently push people further up the continuum, making them, in essence, fatter regardless of objective weight changes. For instance, with the rise of bariatric surgery in recent years, the relationship between weight and aging has undergone its own transformation. It is no longer simply the once-thin who are having trouble accepting their present bodies; formerly obese people are as well. Although pounds may disappear, the identity lingers, leaving persons to intellectually know that they are now thin, but to still think of themselves as fat. The identities learned in childhood and adolescence are difficult to disentangle from, no matter how trying they were.

Those who have lost weight and are no longer overweight or obese frequently learn that losing weight comes with a whole new sense of self, which requires time and practice to get used to. Marsha, a 31 year old Director of Student Affairs at a prestigious urban college, spoke about her struggle to accept her new identity as a normal weight person after lowering her weight from 454 pounds to 180 pounds via gastric bypass surgery:

> You know, it's such a weird phenomenon that you're still the same person inside, but you're completely different…I still see myself as a 400 pound woman. Not all the time, I'm getting better with it and realizing when I look in the mirror I'm like, oh yeah, who's that?…A lot of it is trying to wrap your head around it. It's getting your head out of that mentality because for 20 something years I was overweight and that's the only way I knew to react to things. That's the only way

> I knew how to just do anything and now it's like, well, you're not that anymore, so you can't hold on to that, so it's frustrating. (5'8 and 180 pounds, BMI of 27).

Marsha's experience shows the two sides of accepting one's new body. On one hand, a newly thin person has to be "reminded" that they are no longer overweight or obese by looking in mirrors or reflections in windows. On the other hand, they have to accept it.

Remembering that you are now thin is not as easy as one might believe. A fat person has been taught they are fat, generally at a very young age, and their fatness has pervaded their being and experiences since then. Ellen told me a story about a recent shopping trip at a retail chain near her New York City office. She was shopping in the woman's department (this is the term used to describe sizes 18 plus) because that was where she "was used to shopping." Her weight loss really hit home when an employee came up to her and redirected her to the petite's department. Other people in my sample told me similar stories about the difficulty of going to a rack of clothing and picking out the appropriate size. Similarly, many of my subjects told me they forget they are thin until they look at their reflections in store windows or mirrors. This is similar to Roberta and Darlene who are reminded that they are no longer as thin as they once were when they go to a doctor or put on clothing that they once fit into.

Accepting one's weight gain or loss is another challenge. Christopher, a 56 year old retired school teacher and part-time actor had a similar experience to the ones cited above. It was 15 years after he shed 63 pounds and appeared quite thin that it dawned on him that he was no longer fat because a stranger in an elevator called him skinny. He explained the difficulty and consequences of remaining fat even when your body is normal weight:

> I think most people identify somehow as heavy. Like we're just here visiting in a skinny body. You know, I'm still the fat guy, but I'm visiting the skinny body. Most people who lose weight don't ever enjoy it because they never really think they're thin and that's a sad a shame, you know, that's a sad thing. (5'5 and 160 lbs; BMI of 27[13]).

Christopher eventually accepted the fact that he is now thin, and probably will remain as such for the remainder of his life (he lost the weight 40 years earlier). However, for others, by the time their identity catches up with their body, they are already overweight again. Priya, a 28 year old Indian American whose weight has fluctuated tremendously in her life, speaks of the lag in identities between varying weights:

> I feel like there's a big change that goes along with it. Because it's like you spend six years becoming fat, you know what I'm saying? And suddenly it's gone, you don't really realize it's gone until pretty much all of it's gone so here you are slim, but you don't know slim. You haven't been treated slim, you've never interacted as a slim person, you've been fat. So I didn't realize I was slim until I got fat again. So by time I caught up to my weight I had gained it back. (Priya, 5'8 and 225 lbs, BMI of 34)

Accounts of weight loss such as Priya's illustrate the difficulty of leaving a fat identity. This difficulty is a consequence of a lag between physical changes and identity.

Dieting and Becoming Fat

Beyond the difficulty with remembering and accepting newly thin bodies, voluntary weight loss enhances fat identities. This concept is difficult to exemplify through quantitative analysis alone, although the MIDUS analysis suggests that dieting plays a salient role in people's fat identities; people who have lost weight are significantly more likely to assess themselves as somewhat or very overweight. These results are not surprising. If one consciously makes an effort to lose weight, it is

[13] BMI is not a perfect measure of overweight and obesity for a number of reasons. Although, Christopher's BMI is a 27, he is not overweight. Exercising and lifting weights, has given him a toned, muscular, and slight physique.

generally a reflection of their dissatisfaction with their perceived fatness. In other words, dieting is accepting oneself as fat—whether one is overweight or not.

Once one acknowledges that he or she is fat and no longer wishes to be, it takes on a more salient role in one's identity. Thus, consistent with Stryker's (1968) conceptualization of identity salience, by placing the required attention on weight when dieting, one's fat identity begins to permeate other roles, such as work lunches, relationships with friends, family dinners and outings, etc. For instance, Cara, who has had extensive plastic surgery including liposuction, gave some insight about the obsession that frequently accompanies weight loss:

> Yeah, I'm constantly [conscious of my weight]. And I think it's just like now after I got the [plastic] surgery, I feel like I'm constantly looking at myself to see did I gain any more from this side and if I sit down, I'm like uch is anything coming out or, you know, stuff like that. Even when I'm watching TV. It's like uh, look at this, you know, it's just made me very, very aware.

Cara's weight has always been an issue for her. However, it became all encompassing after she made an effort to lose weight via plastic surgery.

Moreover, because of the visibility of fat, when diets are unsuccessful, as the majority are,[14] it has even greater implications for how people view themselves and their bodies. This is not only because frequently failed diets result in a higher weight than the pre-diet weight. It is also because a failed diet is also a public failure that places further attention on one's fatness and their assumed lack of control over it. For example, before the interview with Sari, a 62-year-old government worker who has struggled with her weight for most of her adult life, was terminated because of her discomfort with the topic, it became apparent that she had been on and off many diets that often resulted in weight

[14] The exact percentage of diets that are unsuccessful is controversial. Brownell and Rodin (1994:784-785) argue that the widely believed statistic that, on average, 95percent of diets are unsuccessful is debatable, and most probably inflated.

losses exceeding 100 pounds and gains of 10 percent to 20 percent more. While the interview did not last long enough for her to describe the feeling of gaining it back, her reaction to the topic spoke for itself.

Lynn, a 31 year old mother of two who is 5'2 and 230 pounds, took me further inside the dieting experience with her description of the steady decline a diet takes once it begins to "come undone": "It doesn't just happen in one day. It's like, well today was a bad day so I'm not going to get on the scale today. Then seven months later you get on the scale and see that you've gained more than you had lost. It's terrible" (she begins to cry). She then explained that once it has happened to you enough times you begin to think that the feeling of failure is so awful, that it is not worth even trying. As a consequence, a fat person may never try again to lose weight, or may have great difficulty succeeding at weight-loss efforts if they fear dieting will cause them to become fatter (and more overweight) at worst, and miserable at best. Dieting, failure, and being fat are intimately related because of a strong societal belief within the United States in an ethic of personal control and responsibility. Because people feel morally responsible for their weight, it leaves the physical realm of extra adipose tissue and enters the cognitive realm of self concept and cognitive schema. Consequently, dieting often strengthens fat identities.

Of course, weight loss does not always result in a stronger fat identity. Extreme weight losses of 50 to 250 pounds cause an important change in one's body and identity. When a fat person has become thin enough to control its visibility there is a marked difference in the fat identity. Taking away fat's visibility is crucial because it alleviates many of the social consequences of being overweight. There are now times that newly

thin persons can escape from their fatness, such as when in a room with strangers (contrast this with Maureen who is extremely overweight and feels the fattest in a room of strangers). In addition, thin persons have the option to take an active role in shaping their new, thin personas. As many of my informants told me, to do so they discard old pictures and, at times, old friends and acquaintances who remind them of their past. In short, the ability to get a reprieve from the physical aspects of a fat identity (the excess weight) makes it a less difficult identity to manage socially and physically regardless of age, cultural background, and gender. Although the lessons are already learned, it becomes a less trying identity and permeates fewer aspects of one's being. As such, as weight decreases, people slide down the fat continuum, although a shadow remains.

Conclusion

From the quantitative analysis that I began this chapter with, it is clear that not everyone who identifies as fat is overweight or obese, and not everyone who identifies as thin is normal or underweight. In fact, over 35 percent of the MIDUS sample whose BMI places them in the "normal weight" category assesses themselves as somewhat or very overweight, and nearly 20 percent of those who are overweight assess themselves as normal weight. Throughout this chapter, I specifically address this inconsistency by asking what makes people identify as fat? Primarily, the answer to this question is that fatness is relative. Although height and weight, the two variables that create body mass index, are objective numbers, fatness is a subjective identity that a person gains because of the experiences they have had. Individuals' specific sociodemographic configurations, such as their race, gender, and age, and their present and past weight, and weight loss history make them more, or less, vulnerable to forming a fat identity. The MIDUS data

show females to be more likely to believe they are overweight regardless of their actual weight,[15] and my qualitative sample suggests that white people and women draw the line differently than blacks and men. Although the point at which blacks, Hispanics, and men feel their fatness is at a higher weight than for whites and women, once the threshold is passed, the experience of having a fat identity is quite similar—it is taught, trying, and all encompassing.

Furthermore, we are in a constant state of social and temporal comparison. We compare ourselves with others and with our past. Thus, the MIDUS sample suggests that someone who gains weight later in life is more affected by this weight gain than someone who has identified as fat their whole life, and therefore, might be more comfortable with higher numbers on the scale (Carr and Jaffe 2007). Although this seems counterintuitive, my qualitative data lends some support to this as well. Although learning one is fat from childhood leaves a unique enduring mark on a fat person, when one listens to once thin people speak about their fat bodies, it becomes clear that they are uncomfortable with their weight for reasons beyond someone who has been overweight their entire life. Unlike perpetually overweight people, they have to learn how to be overweight, and to learn to accept themselves as such. This is strikingly similar to the fat person who has been fat since childhood and loses significant weight. We are shaped by the experiences we have in childhood, adolescence, and young adulthood, and identities formed during these formative times are enduring. It is a time when we set up our expectations for whom we anticipate being in the future. It is also at this time that we generally learn that we are thin or we are fat, and how to approach the world as a thin or fat person. Thus,

[15] In separate analyses, I ran a regression that included gender by weight variables interaction terms. Although the interaction terms are insignificant, the normal weight females are still over three and a half times more likely than men to assess as somewhat or very overweight ($Exp(B) = 3.66$, $p < .001$).

both Marsha and Darlene have to learn how to be someone new—someone who now shops in the petites department, and someone who now shops in the women's department.

In this chapter I also discussed dieting, which frequently strengthens fat identities by placing additional emphasis on one's weight. This additional emphasis causes one's fatness to permeate parts of their being that may have been protected before. Eating moves from an enjoyable, life-sustaining pastime to a time of incredible guilt. In addition, the weight cycling (losing and gaining weight frequently) that many fat people engage in has been shown to cause health problems (Tsai, Leitzmann, Willett, and Giovannucci 2006). Also, because diets are frequently unsuccessful, losing weight and regaining it reminds others about another's fatness. Hence, the social forces that teach someone that they are fat in the first place are often awoken, and the fat person is again reminded of their fatness and the moral failing that accompanies it.

Finally, throughout this chapter it has become clear that it is impossible to write about the three elements of a fat identity as fully separate entities. Persons must learn that they are fat through social messages—whether from peers, the media, educators, or health professionals; it must make their life more difficult; and it must permeate varied situations. Although it is beyond the scope of this dissertation to directly look at the specific agents that teach people they are fat, in this chapter I looked at the sociocultural factors that shelter some from the messages and make others more susceptible to the social lessons taught by a generalized other who exerts a hidden, yet powerful influence on how people identify. Once one has formed a fat identity, the consequences of being overweight disproportionately affect people based upon the socio-cultural variables

highlighted in this chapter. The next two chapters build upon this chapter. In the next chapter (Chapter 4) I ask: Do the vast medicalization of overweight, and the tangible health consequences that obese people face, make a difference with regard to fat identity formation? In Chapter 5 I ask how experiencing discrimination contributes to fat identities. I then conclude with a discussion of fat identities, tying the three analytical chapters together.

CHAPTER 4
A Trying Identity: Health, Aesthetics, and Fat

Health is a multi-billion dollar industry in the United States and the health industry has significant influence on how people come to see themselves and their bodies. One way to determine the impact of mass medicalization on the public is to study whether people with medically defined overweight or obesity are more likely to rate their health poorly net of illness or disability. To my knowledge, although obesity is used as a control in many self-rated health studies (see Ferraro and Farmer 1999 and Idler and Kasl 1991 for examples), very few studies have actually looked at the impact of overweight and obesity on self-rated health (see Ferraro, Farmer, and Wybraneic 1997; Smith, Shelley, and Dennerstein 1994; Mackenbach et al 1994; and Kaplan et al 1996 for exceptions), and only two have controlled for health conditions—only one of which did so analyzing an American population. Importantly though, both studies that did control for health conditions found obese people to be more likely to rate themselves as unhealthy compared to "normal" weight subjects who have similar morbidity and functional limitations (Manderbacka, Lundberg, and Martikainen 1999; Ferraro and Yu 1995).[16] Another way to look at medicalization is to see how the relationships between perceived body size and present BMI are affected by the addition of health variables into the model and then to ask fat people about how health concerns affect them. This study does the latter. I also seek to understand if health independently affects weight assessment, which may also indicate the effect of medicalization.

[16] Analyzing a Swedish population, Manderbacka et al (1999) only found this to be the case for people between 18 to 34 years old.

In this chapter I look at four specific research questions contained within the broader purpose of this dissertation to determine what factors cause a fat identity. The quantitative analysis seeks to directly answer the following three questions:

A) *How do normal weight, overweight, and obese MIDUS respondents' responses to health questions differ?*

B) *To what extent do perceived and diagnosed health illnesses affect one's perceived body size?*

C) *To what extent do perceived and diagnosed health illnesses mediate the relationship between present BMI categories and perceived body size?*

D) *Do the effects of perceived or diagnosed illnesses vary by weight category?*

The qualitative analysis in this work seeks to add depth to this analysis by understanding the mechanism through which health strengthens fat identities.

Descriptive Statistics

How do normal weight, overweight, and obese MIDUS respondents' responses to health questions differ?

Table 4.1 displays descriptive statistics by BMI weight category for all health variables included in this chapter. As with the prior chapter, I compared the three BMI categories by conducting factorial ANOVA and Tukey's post-hoc tests; the right hand column denotes significant contrasts between specific pairs of weight categories. This table reveals that for most health indicators there is a systematic increase in the proportion of respondents who report ill health as weight category increases. This is the case for self-assessed health ratings of fair or poor and good, for four or more obesity-related health conditions, and diabetes. Alternately, the proportion of respondents who

rate their health as very good or excellent and the proportion of respondents who report having only one health condition decreases as weight category increases.

As weight category rises, so too does the proportion of respondents who report higher levels of limitations to intermediate activities of daily living. The mean for normal weight respondents is 1.39, 1.56 for overweight respondents, and 1.97 for obese respondents (the scale ranges from 1 to 4; all category means are significantly different at the $p<.001$ level). Similarly, with each weight category, a significantly higher proportion of respondents report being short of breath when conducting basic tasks such as walking; only about a quarter of normal weight subjects report having shortness of breath, while a third of overweight respondents and over half of obese subjects are impeded by this. Finally, it is worth noting that although the ad-hoc comparisons yielded insignificant results, as weight category decreases, means for control over health decrease slightly. Together these results are consistent with both epidemiological and social science research with regards to weight and health. The heavier one becomes, the more symptoms one feels, and the less healthy one suspects him or herself to be.

Table 4.1. Means and Proportions for Dependent and Independent Variables by BMI Categories

	Total	Normal Weight[a]	Overweight[b]	Obese 1+[c]	F-statistic (df=2)	Significant Subgroup Differences
Self-Assessed Health						
Physical Health, fair or poor	.14	.10	.13	.25	39.42***	ac,bc
Physical Health, good (reference)	.35	.28	.36	.43	24.72***	F
Physical Health, very good or excellent	.51	.62	.51	.32	83.29***	F
Obesity-related Health Conditions						
No Conditions	.29	.33	.31	.20	19.32***	ac,bc
One Condition	.25	.26	.24	.23	.88	
Two Conditions	.17	.17	.16	.17	.05	
Three Conditions	.13	.11	.14	.13	2.00	
Four or more Conditions[b]	.17	.13	.15	.26	33.63***	ac,bc
Diabetes (1 = yes)	.05	.02	.06	.11	37.56***	F
Emotional Disturbance, such as Depression (1= yes)	.19	.19	.17	.23	4.27*	Bc
Intrusiveness						
Intermediate Activities of Daily Living (Scale 1 to 4)	1.59	1.39	1.56	1.97	131.52***	F
Shortness of Breath	.34	.24	.34	.53	94.67***	F
Health Belief						
Control over Health (Scale 1 to 5)	6.30	6.35	6.29	6.22	5.08**	
N	3202	1223	1264	715		
Percent	100	38.2	39.5	22.3		

[F] The means are significantly different for all weight categories.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Multivariate Analyses

To what extent do perceived and diagnosed health illnesses affect one's perceived body size?

Table 4.2 shows the effect that health variables have on people's weight assessments. First, it shows a strong relationship between health indicators and perceived body size. Second, it reveals how these relationships are affected by controlling for current weight (Columns 1 through 6). Third, it shows that health considerations are an important factor that obese people take into account when they make weight assessments (Columns 6 and 7). These latter results are supported by the interaction effects discussed in the next section.

As Models 1 and 2 (Columns 1 and 2, Table 4.2) reveal, health indicators are significantly related to perceived body size. Both subjective and objective health indicators increase the likelihood of one assessing as somewhat or very overweight. Nearly all indicators increase the likelihood that one will assess as overweight over the reference category by over 50 percent and, notably, people who have diabetes are over two times as likely to assess as such (Exp(B) = 2.36 (P<.001). In addition, having limitations to daily activities and shortness of breath when engaging in moderate activity levels significantly raises the likelihood of someone assessing as somewhat or very overweight (Exp(B) = 1.39 and 1.50 for IADLs and shortness of breath respectively, $p < .001$ for both). Yet, as columns 3 through 6 show, the strength of these relationships is attenuated by the addition of moderating and mediating variables, and most notably, present BMI.

For instance, the significant effect of one rating one's physical health as good is attenuated by the addition of present weight variables. The odds ratio decreases from 1.52 ($p \leq .001$) to 1.23. To the contrary, adding present weight variables slightly strengthens the likelihood that persons who possess chronic health conditions that researchers have linked to obesity will assess themselves as somewhat or very overweight as compared to people who do not possess any health conditions. This is most notable for those who have two health conditions. Thus, objective health conditions increase the likelihood of a fat identity, net of one's weight, while the relationship between perceived health issues and size assessment is mediated by present BMI. Also, both having diabetes and the intrusiveness factors are almost entirely explained by the present weight variables. The effect size for diabetes is nearly halved by the inclusion of weight variables. Similarly, the odds ratio for IADL decreases from 1.39 ($p < .001$) to 1.12 ($p > .05$) and shortness of breath decreases from 1.50 ($p < .001$) to 1.18 ($p < .05$).

Finally, only two factors remain even moderately significant in the saturated model (column 6). People who assess their health as "good" are almost a third more likely than people who assess their weight as excellent to assess themselves as somewhat or very overweight. Similarly, people who have two health conditions are a little over a third more likely than people with no health conditions to assess their weight as somewhat or very overweight ($p < .05$).

To what extent do perceived and diagnosed health illnesses mediate the relationship between present BMI categories and perceived body size?

Table 4.2 also shows how the relationship between BMI and perceived body size is mediated by adding health variables. As revealed by comparing columns 6 and 7, the

addition of health variables matters for how obese, older, and well-educated people assess their weight. Although overweight and obesity remained significant at the $p \leq .001$ level when both objective and subjective health variables are added to the model, the effect size decreases for both weight categories, and most notably for obese subjects; the odds ratio decreased by nearly 8 percent from 156.47 to 144.83. Even though these numbers are inflated because of the relatively small number of obese subjects, the pattern is telling. Similarly, the odds ratio for 45 to 64 year olds decreases a little over six percent, although they are still significantly more likely than 25 to 44 year olds to assess themselves as somewhat or very overweight.

Table 4.2. Logistic Regression, Health Indicators, Weight Indicators on Self-Evaluating as Somewhat or Very Overweight
N=3202

	1	**2**	**3**	**4**	**5**	**6**	**7**
Self-Assessed Health							
Physical Health, fair or poor	1.36*	.94	.72	.72	.90	.84	
Physical Health, good[a]	1.73***	1.52***	1.23	1.22	1.37**	1.31*	
Obesity-related Health Conditions[b]							
One Condition	1.27*	1.20	1.28*	1.26	1.18	1.15	
Two Conditions	1.56***	1.38**	1.61***	1.54**	1.39*	1.36*	
Three Conditions	1.54***	1.31*	1.40*	1.34	1.32	1.26	
Four or more Conditions	1.86***	1.41*	1.51*	1.37	1.24	1.19	
Diabetes (1 = yes)	2.36***	2.08***	1.20	1.23	1.42	1.48	
Emotional Disturbance, such as Depression (1= yes)	1.02	.98	1.21	1.18	1.06	.92	
Intrusiveness							
Intermediate Activities of Daily Living		1.39***	1.12	1.14	1.10	1.09	
Shortness of Breath		1.50***	1.18	1.14	1.08	1.07	
Health Belief							
Control over		1.04	1.06	1.03	1.02	1.03	

	1	2	3	4	5	6	7
Health							
Present Weight							
Overweight			8.56***	9.14***	17.31***	17.53***	18.00***
Obese 1+			65.80***	79.93***	141.86***	144.83***	156.47***
Past Weight and Weight Loss							
Ever lost 10 lbs				2.16***	1.86***	1.85***	1.89***
Underwt at 21				.94	.69*	.67*	.69*
Overweight at 21				.56***	.71*	.71*	.72*
Obese 1 + at 21				.48	.52	.52	.53
Demographic Variables							
Gender (1=female)					4.35***	4.35***	4.40***
Race (1=Black)					.27***	.28**	.30***
Race (1=Other)					1.55	1.51	1.58*
45 to 65 years old					1.44***	1.53***	1.63***
65 to 75 years old					.85	.92	1.04
Never Married and Not Cohabitating					.83	.80	.80
Formerly Married and Not Cohabitating					.68**	.68**	.70**
Presently working					.90	.89	.87
GED or less					.67	.68	.69*
Some College					1.05	1.04	1.01
College Plus					1.42**	1.45**	1.39*
Psychological/Cognitive Factors							
Not/Somewhat Satisfied with Self						1.34**	1.36**
Neuroticism						1.14	1.17*
-2 Log likelihood	3884.52	3826.95	2871.73	2802.19	2573.94	2562.11	2580.61
Chi-square/df	121.41***	178.97**/11	1134.20**/13	1203.73**/17	1431.98**/28	1443.81**/30	1425.31**/19
R-squared	.04	.05	.30	.31	.36	.36	.36

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

[a]Reference category is "very good."

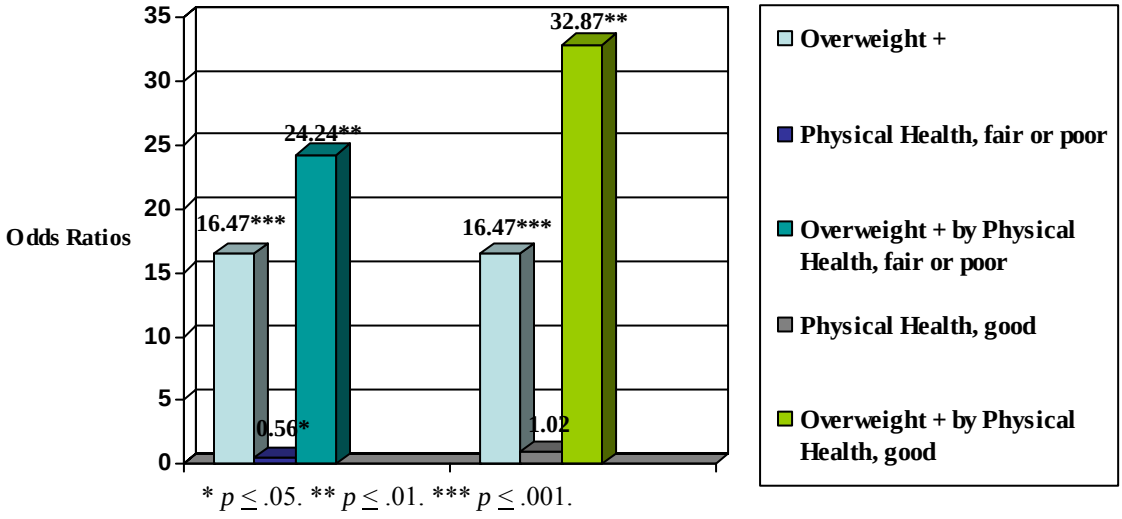
[b]Reference category is "no conditions."

Do the effect of health indicators on perceived body size vary based upon one's present weight?[17]

To understand better how health indicators and BMI affect people's weight assessments, I ran interaction terms between an indicator for being overweight or obese and all health indicators in five separate models. Figures 4.1 and 4.2 show the results for the two models that yield significant effects: present weight by self-assessed health indicators and present weight by chronic health conditions indicators. Overweight or obese people who assess their weight as fair or poor are about a third more likely than overweight people who assess their health as very good or excellent to assess their weight as somewhat or very overweight (odds ratio increases from 16.47 to 24.24). Additionally, the odds ratio for people who are overweight or obese and have either two or four weight-related chronic conditions is over 50 percent greater than the odds ratio for overweight people without a chronic condition. This suggests a cumulative effect between being both overweight or obese and subjectively or objectively unhealthy on subjective weight assessments.

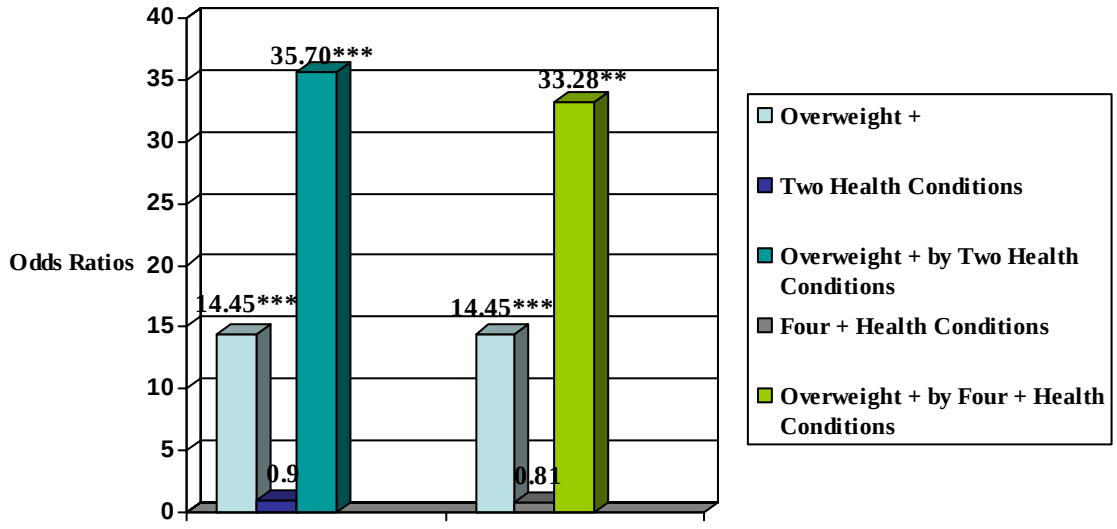
[17] For both of the perceived body size models I also ran two-way interactions between health variables and race, gender, age, and weight at age 21. None of these interactions yielded significant results.

Figure 4.1 Odds Ratios for Interaction Anlysis:
Perceived Body Size by Overweight or Obese * Physical Health



* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Figure 4.2 Odds Ratios for Interaction Anlysies:
Perceived Body Size by Overweight or Obese * Health Conditions



* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Summary

Taken together, these results suggest that *feeling* the effects of being fat is an important way people learn to identify as such. For all models I evaluated, the results tell a consistent story. Although being overweight or obese is the primary building block for a fat identity, adding the layer of either perceived or objective health conditions (that research has linked to obesity) is a way people learn to assess themselves as overweight. This eliminates the ambiguity some may feel about whether or not they are overweight. Health conditions also decrease the effect of age on perceived body size, further showing the importance of health on weight evaluations. In the next section I explain these results within the context of my 40 in-depth interviews with subjects who have varying levels of health conditions. Again, these people all sit on the fat continuum; poor health helps to push them closer to the fat ideal-type because fatness becomes more and more trying and all encompassing when it affects one's physical life, mental state, and social life.

Unhealthy Fat People

Throughout this work I argue that fat identities are formed based upon the implications of having extra adipose tissue, as opposed to the tissue itself. Failing health is an implication that is dangerous to ignore and logically plays a role in how people come to identify as fat. As might seem obvious, health conditions play a very small role in fat identity formation for people who are not overweight or obese. Yet, even for the corpulent, the relationship between health and fatness is not as straightforward as one might expect. During the remainder of this chapter I demonstrate this complexity by delving into how fat people see the relationship between fat and health.

Health and Fat: It Takes a Moron

On a practical level, fat people know that being obese is unhealthy. Take for instance the response of Bette, a 60 year old nurse, to my question regarding the relationship between health and overweight:

> I don't think that there's a moron on the street that doesn't know the truth…Of course it's an unhealthy lifestyle. I mean it causes heart disease, it causes diabetes, it causes a 1000 and 12 things, and you'd have to be a total and absolute moron to think otherwise. Is that going to change your behavior? Not likely. (5'4" and 200 lbs; BMI of 34)

For Bette, the connection is obvious. Being a school nurse for over 20 year, she is acutely aware of the health implications of obesity. In a follow up interview she told me that she has seen an astonishing declining trend in her middle school and high school students' health. As she has watched the mean BMI increase, she has seen many more cases of diabetes and elevated blood pressure. Hence, from being 200 pounds (down from over 270 pounds), and being a school nurse, she has an intimate awareness of health and obesity. However, despite the clear connection between weight and health, she does not think that being armed with this information is going to make much of a difference for how people view their weight. This is an important argument that she makes and she is both right and wrong. Evidence suggests that she is correct on a national level. Despite the clear connection made within the media and by health professionals between ill health and weight, Americans' weight keeps increasing with the heaviest getting heavier (Jolliffee 2005). However, it is impossible to know how Americans would view overweight if it was not so frequently couched in medical terms. The people I interviewed show that health implications are on the back of fat people's minds.

I interviewed people who illustrated both extremes of how the health messages can be interpreted. However, they all have internalized them to some extent. For instance, Lisa, a part-time accountant, is more critical of the messages than Bette, although she does not fully dismiss them either:

> Oh, I've got friends whose stomachs hang well over and I'm at a borderline point. If I'm heavier than this, I think I'm gonna have some serious issues. But to hear people talking about you've gotta lose weight for your health, and I know that up to a certain point that's bullshit. I mean, [I] can be up to 200 lbs. and even now I'm not facing health issues. My blood pressure is good. Everything else is fine except my cholesterol—except that's familial stuff anyway. My slender mother has high cholesterol. But at a certain point it's difficult. Like I said, this girl I know is much heavier than I am and it's hard for her to walk and so I feel like I'm fine, but someone heavier than me is not. But I don't know if that would be my mindset at any weight. (5'2", 220 lbs; BMI 40, 48 years old)

Lisa shows that fatness is relative. It is relative to how people compare themselves to others and not all people are going to feel the same implications of being overweight or obese at the same BMI. Thus, there are tremendous personal differences in how weight impacts someone physically and psychologically. This fundamental aspect of fatness became quite apparent from analyzing my interviews. For some people, the health effects of corpulence are felt nearly immediately. For others, it is only when non-weight related physical disabilities are exacerbated by their weight that they become affected by it. Either way, the idea of having a "disease," as obesity is frequently cited to be, is enough for some fat people to decide that they are unhealthy.

Framing obesity as a disease as opposed to a catalyst for disease is a direct example of medicalization. It is an effective way to make a complex story into a simple message. Ellen, a 43-year-old advertising executive who had bariatric surgery[18] to reduce

[18] Bariatric surgery is surgery that assists with weight loss by decreasing stomach capacity. There are two types of bariatric surgery: gastric bypass surgery and lap band. Gastric bypass is an extremely invasive

her weight nearly a hundred pounds, repeated some of the more extreme messages one can find in the media and health journals today:

> You have to be 100 lbs overweight [to qualify for surgery], or you have to have a health reason, um, and I had a health reason. Obesity is the number one killer, I mean ahead of cancer, it's the number one killer of people. I didn't wanna die young. I mean I still have a whole life ahead of me and I really feel like this surgery has really helped me kinda get a second chance, you know. (5'4", 125 lbs; BMI 21)

From Bette, Lisa, and Ellen, one can see the various ways health messages are interpreted by fat people. While they are internalized in various manners, these examples illustrate the power of headlines linking overweight to mortality for fat identities.

Fat matters to people for a number of reasons that are not easily articulated or untangled among the massive number of reasons that being fat is difficult. To add further complexity, the reason that weight matters for identity formation and maintenance changes as people age. The remainder of this chapter demonstrates how health symptoms, minor or severe, and anticipating health symptoms affect fat identities based upon personal history and beliefs. It supports the quantitative findings above that show a relationship between weight, health, and weight identification. Health matters, but possibly other factors, such as the inevitable cosmetic concerns that accompany overweight, matter more.

Feeling Ill

In the quantitative section that leads this chapter, I found that being fat and unhealthy matters more than simply being fat or simply being unhealthy for weight-based identity formation. Furthermore, people with preexisting conditions or a propensity for ill health, whether weight related or not, are more aware of the impact of their weight on

---

surgery, yet has a greater success rate than the less invasive lap band procedure. All of my subjects who had bariatric surgery had had the gastric bypass procedure.

their health than people who are healthy and anticipate remaining so. For instance, Ross (1994) found that people with ill health and physical disability are more likely to be depressed or affected by their corpulence. Therefore, the physical experience of being fat, coupled with a decline in mobility makes people more likely to identify as fat (Launer et al. 1994).

In line with this, my interviewees frequently cited health problems as a constant reminder of why being fat matters. Bill, a male respondent whom I mentioned earlier, summed this up when discussing a non-weight related injury he suffered:

> [Weight's] not a focus of my daily life, but it's something that I deal with daily, um because of a number of medical issues that have been made worse by my weight. Um, just about 12, 14 yrs ago I ripped knee ligaments. I slipped on a wet floor, you know that could've happened to a thin person. The fact that I weighed more, aggravated the knee more, made the injury worse. The forms of treatment recommended would've been different had I been thin. The orthopedist later said, "well I would've recommended arthroscopic surgery if you were athletic and fit and had an athletic career. Since you're not, we just went with therapy," and I've always had significant knee problems since. Had I been thinner, would I have had less discomfort to deal with?

Bill is in a double bind. Because he is overweight, his knee injury is exacerbated *and* he is not eligible for the latest treatments. These types of experiences leave people with no choice but to relate their health and weight in a manner to form a fat identity. However, the exacerbation of medical issues that most likely did not originate from a person's weight makes the relationship between weight and healthy murky.

Anne, a 51-year-old nurse illustrates this. Anne identifies as fat and as unhealthy and they are inextricably tied. She has not only struggled with her weight her entire life, but her health as well. Early in our interview she insisted that her weight has only been an issue in her life because of her health. In fact, with type 2 diabetes, hypertension, and "lousy knees" she really is a poster child for the National Institute of Health's campaign

to advertise the health implications of obesity, and this knowledge certainly has shaped her experiences as a fat person. However, once one looks at the interview in its entirety, it becomes clear that while her overweight probably has not helped her health, there are other mitigating factors to keep in mind. For instance, her thin mother died of congestive heart failure, which ultimately resulted from severe hypertension that Anne accounts to her being a smoker. Thus, the propensity of Anne, a one-time heavy smoker herself, for hypertension could potentially have been a result of a genetic predisposition. Also, as a Visiting Nurse in the housing projects of New York City, she often found herself "schlepping" computers and medical equipment up numerous flights of stairs and spending time on her knees caring for people. As a result this could have worsened, or initiated, knee problems. Finally, Anne was diagnosed with diabetes after a terrible infection resulting from knee surgery gone awry. The infection then raised her blood sugars, which then triggered or exacerbated her diabetes (she is now insulin dependent). Therefore, once one starts to unfold Anne's story a bit, her weight seems to be a potentially less salient cause of her health problems. So while Anne does blame most of her health problems on her weight, she sees other potential causes:

> Do I think it's only [my weight]? No. But I think weight had a lot to do with it. Yeah but also the job, I mean I was doing visiting nursing, schlepping computers and cases down on my knees to do wound care, walking up and down stairs. Um do I think that this would have happened even if I was 50 pounds lighter? Yeah, yeah I just do because I also have osteoarthritis in there, so I really [think I would have]. So when I say is it because of [my weight], maybe not, and the weight certainly isn't the sole reason why I am diabetic. No, no, that was from the infection. The hypertension, well you be married to Allen see if you don't get hypertension. But no, the hypertension could be [from the weight], but it also could have been diet related, maybe I was eating too much salt. (5'3 and 190 pounds, BMI of 34)

Although after some probing Anne sees that there is more to her health problems than her fatness, her physician sees weight loss as the panacea for her problems. While many of her problems may be alleviated by extensive weight loss, it is also possible that even if she were thin—like her parents—she may still have health problems. Yet, perhaps her doctors see her weight as the easiest problem to solve, which has helped to further confuse Anne. Is it her weight, her being a smoker for 23 years, or simply her genetics? Probably all three, yet the ambiguity is intolerable in a society that fears shades of gray. Perhaps it is this fear that makes health rhetoric such an attractive way to discuss weight. Once people feel that their weight is slowing them down, their weight takes on a more definitive salience. Those who are unhealthy, or anticipate being unhealthy, feel they can take control of their fate through weight loss. On the other hand, others are able to use the excuse that their health is fine so a diet can wait. Thus, how overweight people project their future health is an important lens into the role health plays in fat identity formation. It illustrates the impact and limitations of medicalizing weight. It is to this issue that I now turn.

Anticipating Illness

Sociologists warn us that medicalization—couching issues in medical terms—is not quite as scientific and rational as the public hopes (Conrad 1992; Becker 1993). As Becker (1993) argues, often medical findings are rushed to the public, fear is a tactic used to convince people to listen to and depend upon premature findings, and often findings that are given media attention are those that benefit certain industries and agendas the most. As such, the media help us and hurt us at the same time. Lack of awareness of the health-related consequences of obesity prevents people from engaging in healthy

behaviors such as eating correctly and dieting. At the same time, being given false or exaggerated information can cause unnecessary worry or cause people to try to lose weight in ways that may be more risky to one's health than his or her overweight (Brownell and Rodin 1994; Conrad 1992:2; Forman and Morello 2003; Levinson, Powell, and Steelman 1986:336; Pesa, Syre, and Jones 2000). Thus, a consequence of medicalization is that fat people learn to consider themselves unhealthy before symptoms exist (see Ferraro and Yu 1995).[19] Although this protects overweight people from potential health problems down the road, it also helps to justify extreme weight loss efforts for people who are not necessarily at any medical risk for health conditions unless they gain significant weight.

This is evidenced by my sample who feel that being fat and healthy is an oxymoron. Even those who do not feel that their health is suffering anticipate that they will become unhealthy. This is largely because of messages from physicians and the media, but sometimes it is more personal than that. For instance, Patrick felt it was inevitable that he would suffer because he watched his father die of a weight-related disease. Consider this exchange we had:

> P: Yeah, I knew it was just a matter of time. I mean in terms of my blood pressure, diabetes, things like this, I knew they were all coming soon and I would be frankly dead pretty soon at 500 lbs, but they hadn't manifested themselves yet.
>
> KJ: What made you think that it was coming? Like how did you know?
>
> P: Well as much as there is a disconnect at times between myself and reality I just, um, there wasn't that much of a disconnect that I thought I could be 500 lbs and not die or not develop diabetes or high BP. You know, my dad had a heart

[19] Although it has been found that self-reported perceptions of health are generally good indicators of objective health, Ferraro and Yu (1995) point out that all respondents had similar levels of diagnosed health conditions. However, the obese respondents were more likely to perceive that they had poor health; this points to the effect of medicalization among the overweight and obese respondents.

> attack in his early 60s and he passed away. He had quadruple bypass in his 50s and… (Patrick, 5'11 and 260 lbs; BMI of 36)

This quote is particularly interesting in the context of the rest of the interview. Shortly after he mentioned his father's illness, he told me that his father actually weighed less than Patrick currently weighs when he died. Yet, Patrick has come a long way and lost a tremendous amount of weight; relative to his past self he is thin, and therefore no longer worries that he will die of a heart attack as his father did. However, he does worry about regaining the weight and exacerbating his risk. Similarly, Stephanie, a 33 year old teacher who lost 100 pounds from gastric bypass surgery was 5'7" and 332 pounds when she decided to have surgery. Her mother was 54 when she died of stomach cancer. Although Stephanie was not specifically worried about stomach cancer, she was afraid that her blood sugars were starting to creep up (a precursor for diabetes) and that she was going to get high blood pressure and high cholesterol (although she did not have either of these conditions at the time of her surgery or our meeting). She desperately wants to have a child, and the thought of dying prematurely as her mother did is extremely frightening to her. Although they had different histories, Patrick and Stephanie understand mortality and want to prevent it as best they can. Therefore, although neither specifically had conditions to worry about, they had both been taught by media, physicians, and tragedy what their future potentially holds and want very much so to avoid it—thus they both opted for bariatric surgery.

The power of medical messages becomes even more apparent when looking at those in my sample who worry about their health simply because they are fat, even though they have no diagnosed illnesses. Stacey, a 32 year old event planner, just figured that she was going to have a heart attack. She had been told by doctors how dangerous

her weight was and became hyperaware of it despite the fact that she had no preexisting conditions, she did not have a family history of heart disease, and her blood pressure was 120 over 80 on the day of her surgery:

> KJ: Before the surgery would you have considered yourself unhealthy?
>
> S: Oh absolutely. I always thought, you know, if I got any little pain I was like oh my God I'm having a heart attack. Um and that type of stuff. I thought I was very unhealthy. And yeah, that's another reason why I decided to have the surgery. I wanted to extend my life for my son, you know. Just thinking about him not having a mom just broke my heart. And that was you know me dying an early death was you know a very good chance of that happening. (5'5 and 164 lbs; BMI 27)

Stacey exemplifies the effects of medicalization. Although she had no diagnosed health conditions, she assumed that she was going to die because of her fatness. Similar to Ellen whom I discussed earlier, she saw her weight as a disease that would ultimately lead to her death. This fear is justified; epidemiological research has drawn a strong link between ill health and obesity. However, it is telling that she drew this link when the only precursor she had was her body size. Hence, for many people, a fat identity is intimately linked to an unhealthy identity.

The Great Oxymoron: Healthy But Fat, Comparison to Past Selves

Like Patrick, Lisa and Marsha do not feel fully fat anymore in comparison to their weight and health before weight loss, even though their BMIs still place them in the obese category. Lisa, who has a BMI of 40, does not feel that she is fully fat because she still has manageable health conditions and only slightly elevated cholesterol. Marsha who lost 364 pounds after weight-loss surgery spoke of a similar experience. After losing so much weight, and feeling much healthier, it is odd to her that she is still considered *obese*:

> My BMI still considers me almost obese and I'm like whoa. But I also have to think back, I'm nowhere near as bad as I was. My blood pressure is day and night; I no longer have sleep apnea. I think at one time I was sort of pre-diabetic, but every doctor was a little different, but whatever, I'm not anymore. My blood sugar is 100 percent normal. My blood pressure was actually too low at one point, which was weird. It was a completely different phenomenon. My doctor was like, you have to incorporate salt into everything. I was like, I do? So, in that sense it's very odd [that I'm still considered obese]. (Marsha, 5'7", 190 pounds—down from 454 pounds, BMI 30)

Marsha's experiences illustrate how one's slide up and down the fat thin continuum is influenced by more than scale weight. By losing many of the side effects of being extremely obese, she no longer feels that she is obese—except when the on-line BMI calculator that she uses to check how others see her reminds her that she has not arrived at normal weight yet. Thus, weight is relative. What is obese to some is normal weight to others. To determine where people lie on the fat/thin continuum, it is necessary to understand a bit about their history; information that is rarely available to strangers who judge others as fat.

This is just a small sampling of my respondents who assumed they would die one day because of their weight. For many, these fears help them to decide to lose weight or have weight loss surgery. Thus, the medical messages are having the desired effect to encourage people to lose weight. Despite this, the rate of obesity continues to grow in the United States (Jolliffe 2004; Ogden et al. 2006). This suggests health messages are not internalized by everyone in the same way. People who have begun to feel the effects by not being able to keep up with peers, or those who have watched family members die, are affected by the health messages in a more concrete way than people who simply anticipate becoming ill. In the next section, I discuss this within the context of the intersection between present health, weight, and a desire to look good.

The Universal Desire: Looking Good versus Being Healthy

"Sick and Tired of Being Sick and Tired"…and Ugly

The relationship between health and weight is complicated. Many argue that overweight and health are inseparable—the overweight are going to be unhealthy one day and the obese *are* unhealthy. Most of my informants have internalized this belief and justifiably so. Jason is a 39 year old insurance agent who was thin until he went into a deep depression after a break up with his girlfriend in his twenties. By the time he made the decision to go on an intensive medically supervised liquid diet, he was on medication for severe gastroesophageal reflux and medication for high blood pressure which was 160 over 110 (normal is considered around 120 over 80). Neither of these conditions surfaced until he became nearly 100 pounds overweight and both disappeared after he lost weight. As such, there is no ambiguity in his mind regarding his illnesses. However, that said, while he was tired of being sick and tired, he is young and single and there is more to it:

> I can't pinpoint why I decided to do it, I think it was a combination of things. I think I was sick and tired of being sick and tired. I was physically not feeling well. Um, throughout those couple years of being obese I had severe um heartburn, regurgitation, so I was taking Prevacid. By the time I went to the doctor my blood pressure was probably like 160 over 110, dangerously high. So I was on medication for that, um, and I think also, *the other element of which most people find plays a big part, I really felt like I really couldn't meet people, whether it be a woman, without losing [weight]. Being in that condition, you know I think I was naïve to think I could meet someone because basically I wasn't gonna be attracted to a woman similar to my stature. I think my answer is definitely a combination of all those things. The desire to feel better physically, the desire to look better physically, and being sick and tired of being sick and tired.* You know it's very hard, people don't understand, that amount of weight eats your energy so much and I was having sleep apnea so I wouldn't get a good nights' sleep, you know [I was] tired all day, your hips hurt your back hurts. (Italics added for emphasis) (5'10 and 221 pounds, BMI of 32)

Jason's doctors and body were warning him that his health was deteriorating. Yet, even among all of this evidence, he spoke of an urgency within himself that had nothing to do with his health: he was not getting any younger and he was still single. This tension between knowing that your health is suffering because of your weight and desiring to lose weight for social reasons (such as attracting a partner) is a prominent theme within my interviews. As I have discussed in previous chapters, overweight is fundamentally visible (although, I argue, fat is not—fatness is a state of mind. Overweight is a state of body). As such, this visibility plays an important role in how overweight people identify. Listening to people's reasons for either losing weight, or wanting to lose weight, illustrates this tension and helps to explicate how and why weight becomes a part of one's identity.

Bette has never had any serious complications related to her fatness except recent knee deterioration. She has also shied away from associating her knees with her weight because even though her knees are quite bad, this is a more recent development in her life. Alternately, she has always been overweight and has dealt with the aesthetic implications of her fatness for nearly her entire life. When I asked her if she ever felt fully comfortable as a fat person, she answered "no" because she "didn't like the rolls and the flab" and she never really felt "pretty." Although she admits that since she lost weight she has more energy and feels better, her main discomfort with her fatness was that it looked ugly and that she had trouble fitting into mass-produced clothing and public spaces such as airplane seats. Potentially this is because she is one of what Anne would call the "lucky" ones who as of yet has not suffered major health complications because of her weight.

It is also possible that she is in denial of the implications of her weight on her health. Although her knees were badly deteriorating, before she lost weight she never allowed herself to see the benefits of weight loss. Is this because this admission would have caused significant cognitive dissonance? In other words, she did not want to go on a diet. Thus, admitting that her knees would improve with weight loss would force her to face an inconsistency between two "cognitions"—knowing that her weight is causing physical deterioration, and not wanting to endure the pain of dieting—which would leave Bette to justify the incongruence between her beliefs and behavior. Research indicates that these types of discrepancies are prevalent in many of the decisions we make and how we compare ourselves to others; yet, we manage them in the most self-protective way possible, which at times requires delusion (Festinger 1954; Taylor 1983). However, it may simply be that she was never fully confined by her health, but was very much so limited by the size of public spaces and clothing; therefore, it was in this realm that she felt burdened by her fatness. Either way, her breaking point was no longer fitting into clothing size 4X, and being prevented from being able to take airplane rides unless she was willing to "fork over" significantly more money for first-class seats. Therefore, when her weight was preventing her from living "the good life" she finally decided to diet. Her diet brought her down to 200 pounds, and she is therefore still considered obese by medical professionals. To her, though, she is no longer fat because she can shop in a mall, she can take a plane ride, and her knees feel better. Thus, health complications do matter, but not independently of the overall fat experience—a finding that directly maps to how the MIDUS respondents come to view themselves as fat.

Jason and Bette, two of the interviews that I collected the earliest, helped me to understand the complicated interplay between health and beauty with regards to how fat identities are formed. Of the people I interviewed, respondents lie near both extremes—some claimed that their weight bothers them for health reasons only, and others claimed it is purely an aesthetic discomfort; however, most lie somewhere between these two poles. In essence, how health messages are going to affect people is largely a function of the specific exposure one has to them. The greater the exposure, and the more personal the exposure, the more likely one is to see fat in medical terms, and to take health into consideration when assessing his or her body. For instance, Cara argues that in the Dominican Republic weight matters for aesthetic reasons only.

> Well, it's not like [the United States] where they're like I should eat vegetables because I'm gonna get high cholesterol and high blood pressure if I'm doing this. It's not all about health with us. It's all about how you look and you know and how you're gonna be or feel if you go outside and you see somebody else that looks like that. (5'1 and 206 pounds, BMI of 39)

This lack of health consideration likely results from numerous factors. The Dominican Republic is a warm climate. People tend to wear less clothing there than they do in New York, where Cara currently lives. Also, possibly fewer public health messages regarding weight in the Dominican Republic have prevented people from intellectually understanding that when everything begins to feel like a "drag," it may be doing more physical damage than they realize. Thus, the "silence" of serious health conditions in the making decreases their salience within the repertoire of fat-identity makers that all fat people possess.

Jason would agree with this assessment. He argues that health symptoms are frequently silent because others do not know about them and the person who feels them

can frequently mask them with medications for quite a long time, if not forever. Thus, as he explains, extra weight hurts for aesthetic reasons first:

> When you're 250 [pounds], 280 [pounds], chances are you don't feel it. Someone says something derogatory, your jeans don't fit you notice. You see the bigger issue is that the health risks are not something that you feel. Heart disease as you know is the silent killer. Cholesterol is a silent killer. Blood pressure is a silent killer for most of us. So it's not like someone's knocking on our heads saying kill me now. No, it's more like hey, your ass is fat and you're huge. That stings. That's why I think it is.

Stephanie took this one step further when she explained to me that she would worry that people would notice when she was out of breath before she lost weight. She never wanted to be in a rush, because she wanted to have time to catch her breath before having any face-to-face contact. Consequently, her health symptoms became a part of her presentation of self, morphing her aesthetic and health concerns into one.

Being Fat and the Intersection of Aesthetics, Health, Age, and Temporal Comparisons

When analyzing my interviews, I found an overwhelming sensitivity to the visibility of fatness for each person I spoke with, no matter their age, ethnicity, or gender. However, health concerns surface in every interview as well. Yet how these concerns are expressed varies depending upon the respondent's age. How one identifies, and what identities will take salience is highly dependent upon values, past experiences, social connectedness, and comparisons with past selves and others (Albert 1977; Festinger 1954; Michalos 1985). Logically, the older one is, the more expansive a repertoire of selves to compare oneself to, and the more social experiences to guide one's social comparisons. Also, although research indicates that people evaluate their current selves more highly than their past selves (Rickabaugh and Tomlinson-Keasey 1997; Wilson and Ross 2001), worries that are specific to varying age groups color self perceptions. As

Steve, a 28-year-old law student whose weight fluctuates quite regularly recognized, health is generally more of an issue for older people than it is for younger people when considering the consequences of overweight (see Hurd Clarke 2002). As he said, "…the bottom line is that probably people want to be attractive and feel attractive themselves, they want other people to think they're attractive…Health comes into play as well, but I think maybe for older people. For younger people, image comes a lot more into play." On the surface this makes sense. Younger people are generally healthier, and feel further from their own mortality than older people.

The younger people in my sample (< 40 years old) are concerned about their weight today and compare it to different, but somewhat recent, points in their life, such as college or their wedding day. They are also concerned with their weight in comparison to their peers and siblings. However, they are not concerned with their own health. Francine, a 25 year old Latina social worker, believes that "all of America needs to get on a diet" so that Americans can be healthier. She was referred to me from a friend of mine who knew I was writing a dissertation about weight identities. She was always the thinnest of three female siblings in her family and was worrying about losing her place in the family as the thin one. Her two sisters have recently lost weight and her twin, especially, is getting significant attention for this weight loss. Although she is still thinner than her sisters, Francine feels that she is losing her place in her family as the thin one. Francine spent a considerable amount of time during her interview speaking about the health problems associated with overweight in a global sense, but not for her personally. As with many of my respondents, health is on the back of her mind. But being young, and perhaps because her BMI is just over the obesity threshold and she has

not suffered from any health problems, being fat is a visual comparison with others for her. As she explains, although she sees overweight as a health problem, she is healthy so for her it is a just a theoretical concern:

> Primarily I think [fatness is] a health concern. I think that people are generally focused on the aesthetics of it, I don't look good and I don't feel good, I think that's a good motivator to be more healthy. I know I joined a gym and I pay monthly to be fit and be at a good weight, but I haven't gone for a month. The thing is, I'm healthy, there's nothing wrong with my blood pressure, there's nothing wrong with [me] so I think that it's primarily a health concern, [but] actually I worry more about what I look like and what clothes will fit me. (5'5" and 185 lbs; BMI of 31)

Francine wants to look good in comparison to her sisters and her past self. This suggests that despite the message that fitness, dieting, and health are correlated espoused by popular magazines that cater to audiences in their 20s and early 30s and news programs that cater to an older audience, until one is personally afflicted by health problems, one's weight is meaningful for social and aesthetic reasons instead of health reasons.

Conversely, for my informants who are over 40, health concerns are becoming a reality as they age; as such, they are much more hesitant to make sweeping statements such as Francine's and Steven's for whom weight is primarily a cosmetic concern. Older people not only have their past weight to compare with, but their past health and functional mobility. They imagine their possible selves, which are their potential future selves informed by their past and present selves (Markus and Nurius 1986). Hence, when Bette's and Bill's knees began to deteriorate, and Anne was unable to walk and was contending with a series of very debilitating conditions, weight took on a greater salience; they began to fear even greater debilitation in the future. Despite this, even for older people, weight's visible effects trump its health consequences. This is evident from how the older people in my sample speak about why weight impacts them. For instance,

although Anne sees a large connection between her health and her weight, when reviewing the reasons for why she has dieted it becomes apparent that aesthetics has been the ultimate motivator for most of her weight loss endeavors. Her first intentional effort was to lose weight for her wedding because as she says "no one wants to get married in a size a million." In order to lose weight that time she used diet pills, which ended up severely damaging her thyroid. After that, most of her other weight-loss attempts were in preparation of something such as a Bar or Bat Mitzvah, wedding, "somebody's something," or because a friend was going to begin a diet and asked her to join. As a matter of fact, only her most recent weight-loss attempt is fully motivated by health. She asked her doctor to prescribe the weight loss medications Meridia and Xenical because she has had a great deal of trouble walking since her last surgery and often finds herself in the house for an entire week, giving her little opportunity for exercise. Thus, while her health has clearly been an issue in Anne's life and her dieting history, not until recently has it really taken the primary role in her desire to lose weight.[20] All of the older subjects in my sample had a similar story. Weight loss efforts were entirely motivated by aesthetic and social incentives until they reached their 40s or 50s, when health incentives became a part of their decision making.

Aging, Health, and Loss of Control

The older people in my sample not only evaluate their present weight against their past weight, but their present health versus their past health, and intertwined with this is the fear of losing control of their weight and future. With aging, most people gain

[20] Although Anne seems often torn between health and aesthetics, for her daughter who is overweight she says that her only concern is that she will have the health problems that she has had. It is interesting to contrast this with Bette who mainly worries that her very overweight daughter will have to go through the social difficulties of being overweight that she has experienced, such as stigmatization, loss of job opportunities, lack of confidence, etc.

illnesses and chronic conditions to which they were less vulnerable as younger adults, leaving one to wonder if their recent health conditions are a result of aging, overweight, or both. Because there is a tendency to hold the more obvious and more controllable characteristics responsible, people tend to blame their fatness (and therefore themselves) for their deteriorating health. Some also feel that that they can slow down the aging process by losing weight. This enables them to take some control over the most uncontrollable aspect of life.

Yvonne Burgess provides a more extreme example of how health, weight, and control intersect.[21] By the time Yvonne reached her late 50s she no longer hoped to get married, but she was growing increasingly concerned about the health implications of her weight. When I interviewed Yvonne three years ago, she was 58 years old and a devout Mormon who has been overweight her entire life. It was considered a great tragedy within Yvonne's religious community as her teens and 20s passed and she remained unmarried; throughout this experience she knew this was largely because of her weight, something she figured she could control and was expected to control. Her first diet was prompted when she was in her late teens by a date that told her "if you don't care enough about yourself to do something about it, how can I care about you." This struck a chord in her as she strongly believes that your "body is a temple," and should be treated as such. However, this dieting effort ended, as did many others after that.

Incidentally, while Yvonne struggled with her weight in the 1970s, her overweight sister with a heart condition died after undergoing bariatric surgery. About 30 years later, Yvonne found herself faced with the same decision to make about having

[21] Burgess is a sociologist at Merrimack College and I met her at the 2005 Eastern Sociological Society Meeting in Washington, D.C. In this section I quote from her presentation and a telephone interview that followed a few weeks later.

surgery. She has a "strong heart" whereas her sister had a "weak" one, and Yvonne decided to go forth with the procedure simply because her health was beginning to suffer. In her presentation she labels her surgery her "journey to health" (Burgess 2005)—yet when speaking with her, one is left believing that it was a journey to control. When explaining her motivation for the surgery she discussed an embarrassing experience on an airplane and a recent diagnoses of type II diabetes. The diabetes startled her, but not necessarily because she saw her immediate mortality:

> I'd had [type II diabetes] for about a year when I had the surgery and that was probably part of the breaking point. The idea that it was out of control because I couldn't eat correctly and um I knew I had to eat correctly or my health would just deteriorate so um that was really scary for me. (5'3" and 194 lbs; BMI of 34)

When I pressed her further about why her weight was so disturbing for her, she framed it in terms of her strong religious beliefs:

> Well, I think uh because in my religion I believe my body is a temple and that I need to take care of it and so I felt like I wasn't and so I felt badly from a religious viewpoint as well as I just didn't look right. You know, I felt like I wasn't doing something I should be doing and uh because I didn't have the control I needed to have so it went much deeper than it does for some people I think.

Despite Yvonne's belief that she was unique in that her lack of control disturbed her, I argue that she is not unique. The ethic of personal control and responsibility is a belief that many Americans hold dear, and it is a significant part of how their weight affects them.

Control is an important issue on both the personal and societal level, as is further exemplified by Anne. One of Anne's many attempts at weight loss was as a long-time member of Overeaters Anonymous (OA)—a weight-loss method that takes the blame from the person and places it on the eating addiction. A fundamental part of (OA's) mission is to help people "to abstain from compulsive overeating"

(http://www.oa.org/is_oa.html). Thus, they help people to take control of a compulsion that is seemingly out of their control. On a personal level, Anne has tried to do just this. Her doctor has tried to take control of her health problems in another way: he suggested gastric bypass surgery although she is not the 100 pounds overweight that most insurance companies deem necessary to cover this surgery.[22] With Anne's history of infection and the risky nature of gastric bypass surgery, it seems logical that it may be more dangerous for her than her weight. While Anne's health is clearly suffering, the drastic measure her doctor recommends for solving her problems may be more problematic than the weight itself. So why would a health professional recommend such a risky solution? Using Douglas' (1966) assertion that anomaly is a danger that society needs to be ridded of, one can begin to understand the benefits of blaming her problems on her fatness. Eradicating her fat is the clearest answer to the more difficult questions of why one person's health has suffered so much for so long. Consequently, although the thought of gastric bypass surgery scares her greatly, even Anne sees it as a potential cure-all: "…somehow, in the back of my mind I feel ok because I figure that's [gastric bypass surgery] always an option"—and it will ultimately come down to what is scarier for her and her doctor: the lack of control she has over her health and eating or surgery.

Historically Americans have turned to medicine to explain the unanswerable (Turner 1984). Thus, it is not surprising that people have leaned on the medical community to help treat their weight problems and if one were to ask many of my informants their view, they would agree with the benefits of this. Three of my

[22] The insurance cutoff is not actually this straightforward. Because Anne is experiencing so many conditions that are considered comorbid with obesity, she actually would in all probability qualify for insurance to pay for this surgery, while a friend of hers who, as Anne put it, "ate" herself to the necessary 100 pounds overweight did not qualify because she did not suffer from any other health conditions.

respondents told me that they wake up every morning thanking their physicians for giving them a "new lease on life" by helping them to control their weight either through surgery or diet. In this vein, Patrick's pediatrician thought he was doing him a favor. He tried to teach him that he was fat, so that he might do something about his growing weight. In Patrick's words, this is how the 8 year old learned:

> Yeah and I can remember when I was very young going to the pediatrician. He was trying to scare me into losing weight. He [had me] come in because he was like you have to lose weight [and to] tell my mother I have to lose weight. When I came in the next time and I had gained weight, so he went over to this intercom—which I realized later wasn't turned on—but he went over like he was announcing it because the nurses' station was out where the public waiting room was. So if the nurses could hear it everyone could hear it. So he was like well I have to let the nurses know that you gained weight, so he goes to the intercom and all he said was "Patrick Parker, weight gain" like that and I was literally afraid to go back to the doctor because I knew I had gained weight.

This happened over 30 years ago. The messages today are hopefully more tactful, if not more subtle. Medical programs today teach classes about how to discuss weight with patients; it is a sensitive topic that affects all people to varying degrees. In Patrick's case, he got over the embarrassment, if not his fear of doctors. Yet there is no doubt that the rampant messages are controlling how people come to understand their fatness. Using health rhetoric, people hope to control their weight; using those same messages, physicians and the media hope to control fat people. Those exposed to more health messages are more affected. Thus, unhealthy overweight people are fatter than the simply corpulent and the simply unhealthy. They lie closer to the ideal-typical fat identity because they feel their fatness more acutely. It is more trying and more encompassing because it is not simply an aesthetic concern to them. It is a health concern, a cosmetic concern, and a concern about losing control and being controlled.

Conclusion

The boundary between fat and thin is fuzzy. Not all people place it at the same point or use the same measurement and not all people internalize the varying media and scientific messages regarding weight the same way. This chapter illustrates this point by looking at the various ways that health strengthens fat identities. I began this chapter with a quantitative analysis of health indicators on self-perceptions of weight. This analysis suggests a cumulative effect of ill health and overweight and obesity on weight identification. Unhealthy people do not assess themselves as overweight independently of their BMI. However, for those who are overweight or obese, health concerns reinforce their likelihood of identifying as somewhat or very overweight.

The qualitative section of this chapter examines the nuances involved with how health helps to form fat identities. On the surface, if people feel that their weight is slowing them down, whether they have a diagnosed illness or not, their weight takes on greater salience than it does if people are not feeling limited in comparison to their thinner peers. However, it is not simply feeling health consequences, it is also anticipating them. The messages relating weight with health consequences are prevalent and available to anyone who will listen. These messages are generally adaptations from medical research that connects weight to numerous health conditions. At times they are accurate, at times they are exaggerated, and at other times they are simply false. Yet, they are available, understood, and internalized by people in varying ways depending upon their level of overweight, their age, history, race, and beliefs.

Older people who have both past weight and past health to compare with their present selves are more likely to be affected by health concerns. While they have

frequently identified as fat for years, if not their entire lives, the reason that their weight matters to them changes as they get heavier and less healthy—leaving them to worry that their health is as out of their control as their age. Control is a fundamental premise of medicalization which seeks medicine to explain the inexplicable. Thus, health rhetoric is a method for both motivating people who wish to lose weight and for encouraging people to lose weight who may not want to. Yet, although health is an important factor for reinforcing one's fat identity—i.e., by making being fat more trying—it may be more of a way to understand and control something that has bothered them for longer than the health concerns: the aesthetic challenges of overweight. My interviews suggest that regardless of age and health the aesthetic piece continuously plays a fundamental role in fat identity formation. Alternately, health concerns play a role in more specific circumstances.

In sum, we hear the media's and medical community's messages and are of course affected by them. Ultimately, though, we make decisions based upon personal experiences, day-to-day living, age, and self-protective cognitive biases, such as down playing information that is inconsistent with one's being or behavior or engaging in self-enhancing social comparisons that may mask how unhealthy one is becoming or how overweight one has become (Taylor 1983; Crocker and Major 1989). In the next chapter, I look at discrimination's role in pushing people up and down the fat continuum, and I investigate the techniques in which people engage to protect themselves from the devastating effect discrimination can have on one's self concept.

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CHAPTER 5
A Taught Identity, Trying Identity, and all Encompassing Identity: Discrimination and Fat Identities

In this chapter I explore how being subject to discrimination contributes to fat identity formation. In the quantitative section of this chapter I set out to replicate the extensive findings that suggest that overweight people are subject to discrimination at greater levels than thinner people (Carr and Friedman 2005). Next, I explore whether all forms of interpersonal discrimination affect weight identities or if the relationship between BMI and perceived body size is mediated by specific types of interpersonal discrimination. Alternately, I explore if it is simply the intensity of the discrimination that matters. I then attempt to interpret these findings with an in depth look at the ways discrimination strengthens fat identities and the different physical and psychological techniques fat people use to combat the effect of discrimination on their self concepts.

Descriptive Statistics

Does perception of discrimination increase as weight category increases?

Table 5.1 displays means by BMI weight category for the three discrimination scales—*Lack of Respect, Blemish of Character, and Harassment/Teasing* and for rating in the top 25 percent of the interpersonal discrimination scale. As with the prior chapters, I compared the three BMI categories by conducting factorial ANOVA and Tukey's post-hoc tests; the right hand column denotes significant contrasts between specific pairs of weight categories. For the total sample, across all three discrimination subscales which range from 1 to 4, 4 denoting the highest level of discrimination, respondents perceived their level of discrimination to be below the median (2.00). However, as weight category increases, scores also increase. Obese respondents' perception that they have been

treated with lack of respect is significantly higher than both overweight and normal weight respondents' perceptions (1.96 for obese respondents vs. 1.81 and 1.78 for overweight and normal weight respondents, respectively). Both overweight and obese respondents are significantly more likely to report discrimination regarding their character than normal weight people (1.59 and 1.66 for overweight and obese respondents, respectively, vs. 1.47 for normal weight subjects). As with lack of respect, obese respondents score significantly higher on the harassment/teasing scale than normal weight and overweight respondents (1.60 for obese respondents and 1.44 and 1.48 for normal weight and overweight respondents). Thus, the ANOVA analysis suggests that although no group scores above the median, the more overweight one becomes, the more vulnerable he or she is to being a victim of discrimination, or perceiving himself or herself as such. Also, 11 percent of the normal weight sample, 14 percent of the overweight sample, and 16 percent of the obese sample scores in the top 25 percent of the interpersonal discrimination scale. Although a significantly higher proportion of obese respondents than normal weight respondents do so, only a small proportion of any weight category reports being a victim of a considerable amount of discrimination.

Table 5.1. Means and Proportions for Discrimination Variables by BMI Categories

	Total	Normal Weight[a]	Over-weight[b]	Obese 1+[c]	F-statistic (df=2)	Significant Subgroup Differences
Lack of Respect	1.83	1.78	1.81	1.96	9.30***	Ac, bc
Blemish of Character	1.56	1.47	1.59	1.66	13.42***	Ab, ac
Harassment/Teasing	1.49	1.44	1.48	1.60	9.15***	Ac, bc
Top 25 % of Interpersonal Discrimination Scale	.13	.11	.14	.16	5.54**	Ac
N	3202	1223	1264	476		
Percent	100	38.2	39.5	22.3		

[F] The means are significantly different for all weight categories.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Multivariate Analyses

Does discrimination predict perceiving one's weight as somewhat or very overweight?

To gain a better understanding of the extent to which interpersonal discrimination helps to form fat identities, I ran four different regressions for six different indicators of interpersonal discrimination: 1) *The daily interpersonal discrimination scale*; 2) A dummy variable indicating *ever experiencing interpersonal discrimination*; 3) a dummy variable indicating an average response rate in the *top 25 percent of the interpersonal discrimination scale*; 4) three subscales including measures of (a) being treated with *lack of respect*, (b) being treated as if one has a *blemish of character*, and (c) being *harassed or teased*. Regressions 1 through 3 also included an indicator for *weight/appearance based discrimination*. All regressions included indicators for present weight, weight at 21, weight loss, demographics, and psychological/cognitive disposition. Only one of the discrimination variables is a moderately significant indicator of perceived body size. Additionally, an interaction between gender and blemish of character was moderately significant. Because these findings are inconclusive at best I will spend a limited amount of time speaking about the multivariate regression analyses. However, they may suggest

pathways to which people, and especially women, form fat identities, so I will briefly discuss these findings.

Only the discrimination indicator that signifies a considerable amount of discrimination is reaches significance at the $p < .05$ level. Scoring in the top 25 percent of the interpersonal discrimination scale is a moderately significant predictor of assessing one's weight as somewhat or very overweight (Exp(B) = 1.44). Also, breaking the interpersonal discrimination variables into subscales indicating lack of respect, blemish of character, and harassment does not provide any greater clarity as to how people come to form fat identities, as not one subscale yielded significant results. However, one interaction term suggests that females are specifically affected by perceiving discrimination based upon a characterological flaw. With each one-point increase on the blemish scale, females are over 50 percent more likely than males to assess there weight as somewhat or very overweight ($p < .05$). Moreover, the addition of the blemish by gender interaction term decreases the predictive value of a women assessing as somewhat or very overweight by 40 percent [the odds ratio decreases from 4.68 in the model without the interaction term to 2.81 in the model that includes the interaction term ($p<.001$ in both models)].

Summary

In sum, obese respondents report higher levels of lack of respect, being treated as if they have a blemished character, and being harassed or teased than overweight and normal weight respondents. In addition, a higher proportion of those who perceive that they have been a victim of considerable amounts of discrimination are obese than overweight or normal weight. Of the six indicators for discrimination I tested in separate

regressions, only the variable that indicated extensive exposure to discrimination (top 25 percent of the interpersonal discrimination scale) was even moderately predictive of perceived body size assessments.

Also, to gain a better sense of why these variables were largely insignificant I ran interaction analyses to see if discrimination perhaps mattered for woman as opposed to men, blacks as opposed to whites, or the elderly or the middle aged as opposed to 25 to 44 year olds. Of the many interaction terms I tested, only one reached moderate significance.[23] This result suggests that women who perceive being discriminated against because of a flawed character are more likely to perceive themselves as somewhat or very overweight than men who report being discriminated against based upon a blemished character. This directly speaks to two of my main arguments throughout this work—that moral concerns shape how people view weight and fatness in the United States, and that fat is on a continuum that is dependent upon sociodemographics to determine where on the continuum one will lie. Hence, women, who are more sensitive to how their weight and changes in their weight are perceived are also more likely to believe that it is their moral responsibility to adhere to social norms for ideal bodies (Bordo1993).

Stigmatized Fat People

Many assumptions are made about fat people before they exchange words with others. These assumptions include both micro- and macro-level characteristics that are attached to fat individuals and fat groups. On a personal level society views them as "less active, intelligent, hardworking, attractive, popular, successful,…athletic," and moral than people who are not fat (Harris, Harris, and Bochner 1982:511; Lebesco 2004). On a global level, they are seen as a drain on the health care industry and on any industry

[23] I also tested interactions for both weight categories. These were insignificant as well.

that considers space money, such as airlines and movie theaters. As Goffman (1963:5) aptly noted "[W]e tend to impute a wide range of imperfections on the basis of the original one." As such, being fat is not simply a characteristic or a category—it is an identity that hosts a range of negative feelings about fat people and, often, negative feelings about oneself. In this chapter I discuss both aspects of being a discriminated fat person, beginning with the experience of being discriminated upon and ending with the in-group and self-stigmatization that many fat people engage in.

As I conducted and analyzed my interviews, the stories about discrimination were the hardest to endure and the most telling about what it means to be fat. These stories support many of my findings thus far, and add a layer to my analysis of how fat identities are formed. In Chapter 3 I argued that a fat identity is formed by first being overweight, then by being fat in comparison to a thinner, younger self. I also argued that being female and white makes one more vulnerable to a fat identity at a lower weight. In Chapter 4, I argued that there is a tension between health and aesthetics that exists in all fat people, and generally a combination of ill health (or perceived or projected ill health) and cosmetic concerns build a fat identity. Together, these building blocks make being fat a trying identity that is learned by comparing oneself to his or her past self and others and from media and medical messages about the consequences of being corpulent. Here I argue discrimination is a vital aspect of the fat experience that makes being overweight, and especially very overweight, a learned, trying, and all encompassing part of one's life that unmistakably turns a characteristic (i.e. having extra adipose tissue) into an identity (i.e. being fat).

Keeping Silent

The results I reported earlier in this chapter cannot be ignored. They are seemingly counterintuitive. Why doesn't discrimination predict a fat identity? Discrimination is an effective method of social control. It reminds people that they are not adhering to social norms and often highlights the characteristics people are most insecure about. However, although there is a vast body of literature that points to the institutional and interpersonal discrimination that overweight people are subject to, overweight people do not like to discuss it. This is likely because of the impression management many fat people constantly engage in. Take for instance how Maureen explained why she does not like to use the word fat, and does not like anyone else to use it either:

> The way I describe myself, I would probably use overweight. And, what does that mean to everybody? Well, I'm not going to say grossly [obese]. I would just say overweight. I don't refer to myself [as fat], unless I really want to get disgusted with myself. Then yes, I will call myself fat or something like that. But I don't like to encourage that with others who know my size because then it locks you into a mental state that keeps you very down and you can't go forward and that really does affect everything you do outwardly and your attitude. When you're thinking like that then people perceive you like that, and then they treat you like that. (Maureen, 5'3 and 300+ lbs; BMI of 55)

Maureen is cognizant of her ability to control her external identity to a small extent and feels that she needs to do so. She has little control over her external appearance and, therefore, takes advantage of the self-protective benefits of controlling how she refers to herself and her attitude toward her own weight. By doing so, she hopes to set a more positive tone than she may otherwise be subject to.

Most of my interviewees reported in engaging in a similar type of self-protection from discrimination. Rebecca, a social worker, is one of my most self-aware

respondents. She explained the obsession she had with her self presentation and the mind games she would play to psychologically cope with her fatness before she lost over 150 pounds via gastric bypass surgery:

> So I don't know, I kind of did myself a disservice in one sense like that I overcompensated so much. Like when I would go out on an interview I'd pretend that I didn't have a weight problem and I would make sure that I had the prettiest friends, I put so much energy into making sure that I wasn't the normal, typical overweight person, that I mean it's so much energy to do that. Make sure my hair looks a certain way, make sure my face looks good, make sure I'm not associated with this person, make sure I'm assertive, make sure I could exercise, make sure I do everything that everyone could do so that no one could say anything, and it took so much energy for me to go through that. As long as I had things actively going on, as long as I had good friends then I wasn't too bad, you know. Like I don't usually talk about this outside because it's not things that I'm proud of, you know it's kinda like things that I've done to cope with it and kind of like twist my mind so I can function. [5'7 and 155 pounds (down from 320 pounds), BMI of 24]

To have a fat identity is to navigate a fat identity. This process takes significant mental effort and requires that one puts on a facade that will convince him or herself, and others, that he or she is like everyone else, or, as Rebecca calls it, "normal."

Dan, a 48 year old medical practitioner, provides an even more direct example of ignoring discrimination to protect one's self concept. He recalled a time when a patient of his called him a "chunky faggot." Dan was not terribly hurt by this, reportedly because the patient was merely acting out of frustration. However, acknowledging that his teenage patient had the power to define for him who he is (fat and homosexual) and how he should identify would have been devastating to his self esteem. Thus, he chose to disregard the behavior's sting. Through these experiences, whether they are admittedly hurtful or not, overweight people learn how they are seen and learn how to see themselves. Admitting to discrimination runs contrary to this intense psychological work

that fat identity management requires, making it a bit less surprising that fat people may not report discrimination in the straightforward way surveys often require.

Being a Minority Group Member: A Master Status

Fat people are subject to discrimination in almost every area of their lives from family, to work, to daily outings. Although, my respondents frequently do not frame it as "discrimination," per se, it has a tremendous impact on their self concept and helps to solidify a fat identity. Being constantly subject to discrimination pushes one further up the fat continuum. As Maureen illustrates, it prevents fatness from being anything but a master status:

> It's so funny because even still with my accomplishments, or so I think, I was the only one in my family who graduated high school. I'm the only one who graduated from high school. I'm the only one who went to college, and yet, all I get here is but you're so heavy. Like I have no accomplishments in my life because they're talking only about the outer, the exterior…I'm not saying I'm the most intelligent, but the fact that I accomplished that does prove I have intelligence and perseverance and that's unaccounted for from family which is pretty amazing to me. That's sad actually, you know. So that's a huge thorn in my side. (5'3 and 300+ lbs; BMI of 55)

For being corpulent, Maureen is treated as a fat person who is not worth the same respect and treatment as others. Consequently, she is unable to identify as anything but fat although she is an educated, accomplished woman—the only one in her family. Her family is not the only group of people who discriminates against her. Her best friend did not include her in her wedding party. When Maureen asked her why, she told her that she was afraid she would "ruin the pictures." At work, her boss was very uncomfortable around her until she confronted him about it. When she walks down the street she is subject to distasteful comments from strangers, and when she walks into stores she is generally ignored. It is difficult to be Maureen. In fact the only comfort she takes in her

fatness is the fact that she does not fear walking down the street alone; she is convinced if she were to be mugged, she would not be raped. As she sees it, who would rape her?

Throughout this dissertation I frequently revisit weights' visibility. In Chapter 4 I argued that aesthetic concerns are a fundamental part of fat-identity formation. Because of the visibility, although one does not tangibly "feel" that they are aesthetically displeasing, once one steps into a social setting, they psychologically feel the weight of their fatness. Maureen stated this most eloquently in response to my query regarding when she is most aware of her weight:

> Oh God. Walking into public brings [your weight] to your attention mostly. Or meeting new people, or um, anything like that, for me…When do I feel self conscious about it? Um, usually, any time of day meeting public, usually people you don't know versus people that you do.

She then gave an example of what types of occurrences cause her to be on guard when she is in public:

> I remember walking down the street in my 20s. I was with two people and somebody yelled something and—uh, as you can tell I'm a really outward person, so I'm not really shy—and somebody just yelled something about my weight. I was so embarrassed because of who I was with. Of course, it would still hurt if I was alone; but I was so embarrassed. It just ruined my whole evening. It didn't matter that those were strangers passing by and people say things all the time. And people do feel free to say things to you about your size. Would they feel free to say things to someone who is handicapped, physically, outwardly? Because you're heavy they feel very comfortable say[ing] anything rude, lewd, and whatever to you because of what you look like.

It is notable that what disturbed Maureen the most about this case of overt discrimination is that she was with other people when it happened. By being with others, it was doubly embarrassing. Bette had a similar experience. When a few children called her fat at the beach she simply wished that her husband and granddaughter were not there to witness it. These experiences help to explain why fat people underreport discrimination. As

Maureen explained, when she is alone she has the luxury of "being conscious, but not self conscious." However, once in public overweight people have an "abomination of the body" (Goffman 1963) which they cannot hide—especially being as overweight as Maureen is. Similar to racial and ethnic minorities who are unable to hide their minority group status, fat people who have overweight bodies are constantly in a state of impression management and anticipate being discriminated against.

My respondents compared their situation with that of other minority groups frequently, indicating that part of identifying as fat is also identifying as a minority. Yet, because fat is visible and widely seen as a "characterological flaw," many fat people perceive that it is more difficult to be fat than a member of another minority group. Consider, for instance, Rebecca's comments:

> Um, black people are disabled because they have an outward thing that people can notice that they were different. Women are at a disadvantage because they're a minority and they're seen as second class. Fat people are…it is the freest prejudice out there. You can outwardly joke about them wherever you want and no one's going to stop you to say "no, that's not the proper term to use, they're actually they are morbidly obese." There's nothing that monitors anyone's feeling about it. And it's a prejudice that you can't hide and it's like, until I fit into society's norms I won't feel like [normal], you know? That's why I see it as a disability, because it prevents me from getting everything that I want.

For Rebecca, before she lost 150 pounds, her identity was formed around the limitations that her weight placed on her. Having a visible stigma that she likened to that of blacks and women increased the effect of the physical and spatial limitations (for example, she told me that she could not go skiing because she could not fit into the ski gear) that her size placed on her. The limitations that result from being a minority group member further pushed her up the fat continuum, making her weight more trying and all encompassing.

Stacey, the 32 year old event planner mentioned in the previous chapters who lost over 100 pounds via gastric bypass surgery has an interesting perspective on the comparison between being a racial minority versus being fat. Her husband is black and she has seen him victimized because of his race. However, she feels that there are more places that he is able to feel comfortable as a black man than she could as a fat woman before her surgery:

> [M]y husband's black, so I've seen first hand you know a lot of the discrimination that he goes through. He goes through discrimination, [but] it's not across the board. You know there may be racial profiling by police officers, or there may be a store clerk that may discriminate against him. I think overweight people are discriminated against in many more ways. You know, I think the airline industry is very discriminatory. I just think people across the board are much more discriminatory against overweight people. I think you just find it more often, more public. I'm not black so I can't speak on behalf of blacks, but if a black person were to go into a McDonalds, they would have less of a chance of being discriminated against than an overweight person would be, just the way people look at you or ask you questions. (5'5 and 164 lbs; BMI 27)

Notice Stacey's choice of words. She never makes it personal, yet her awareness of the widespread discrimination is what makes it meaningful to her. If one assumes that it is everywhere and inescapable, he or she is more likely to identify as fat, and make decisions because of this perception regardless of if he or she has personally experienced it. These decisions range from the seemingly mundane, such as ordering two drinks at McDonalds to make the server believe the large portion of food ordered is for two people, to the serious such as choosing a partner simply because it is the only person who they believe will have them. This is possibly another reason why the quantitative analysis found experiencing discrimination does not predict a fat identity. This is similar to the connection between illness and fat identities. Simply anticipating discrimination or illness determines how weight will impact one's identity.

Discrimination through the Life Course

Many of my respondents who are frequently subject to insults find it remarkable how upfront people are. As touched upon in Chapter 3, my respondents who have been fat since childhood cite childhood taunting as the experiences that were most apt to teach them that they were fat. Stephanie explained that she was "was tortured" as a kid, and she is still scarred from being called "fat" in the halls of school. For Bill, as a male, the teasing he faced as a child was different. As he described it, it was less personal, perhaps less advertent than what a woman might have been subject to, but it had the same effect to teach him that he was different and less valuable than someone who was thinner. As with many of my respondents, not fitting into standard clothing sizes, was a constant reminder and continues to be a constant reminder, of how Bill does not fit into society. His jerseys in gym class were always a shade off and team uniforms never came in his size. Merely the space he took up during dodge ball gave him a severe disadvantage; because he had more surface area he was more easily struck by the opponents' balls. These experiences taught Bill that he was different and fat as early as kindergarten, and this message has stuck with him.

Similarly, Marsha is still marked from the discrimination she has faced. Teasing does not end in grade school. Although my respondents expect taunting from children and even can accept it to a point, being taunted as an adult from adults is even more difficult to justify. Marsha who had lived with weight-related insults her entire life, learned that the teasing would continue in college, and likely for the rest of her life:

> [E]ven as an adult, people are cruel, oh God, I'm trying to think. We were in college they used to have the parties in the basement and stuff like that and they used to, you know, oh be careful of the stairs they're gonna break, and just stupid shit, you know and looking back on it you gotta shrug your shoulders; this shit

> hurt and it doesn't go away. I mean I can remember faces, places, names, that shit like it happened yesterday, I mean this stuff that happened sometimes 20 years [ago], and it is as clear as day. You know, sticks and stones will break your bones, yeah I don't think so, that shit hurts, it hurts, and it's what you choose to do with it, you know. (5'8 and 180 lbs, BMI of 27)

Being a victim of discrimination teaches people who and what they are. Because of this, fat identities are formed and frequently become master statuses that are difficult to shed. Marsha, who has lost a tremendous amount of weight via bariatric surgery, struggles with accepting her new self every day because of the scarring from wounds that were continually opened over 30 years of fatness.

The Look

Although I was told about a few other cases of overt teasing from adults, generally, as adults the discrimination is a bit quieter—sometimes soundless. For instance, Jane stopped dating for four years after a blind date that left her with the understanding that she was too fat to be trying to find a partner:

> I remember going on a blind date with somebody from Match[.com] and yeah he had a picture of me so he knew what I looked like and but I guess to see somebody in person is a whole different story and I just remember seeing the look of disappointment on his face. I mean he was an asshole anyway, so our date didn't last very long. [But], I remember just seeing the look of disappointment on his face and it was the first and only time I had ever seen it and actually that was the last date I had before I went into hiding. Yeah, because I thought, I don't want to see that again. (5'6, 150 lbs; BMI 24, down from a BMI of 39)

Until she lost enough weight that she felt that her risk of having that experience again disappeared, she did not go out on another blind date. As Jane's quote demonstrates, sometimes silent discrimination is more hurtful than spoken comments. Spoken comments can be justified by the person as being inhuman, or an "asshole." Looks are frequently involuntary and therefore tremendously hurtful. As with children's taunts, they are the pre-socialization reactions to what is seen as reprehensible or grossly deviant.

Nearly all of my respondents whose BMI ever exceeded 34 mentioned this look that they have come to expect. Maureen describes this look as such: "Sometimes it's disgust actually. I can't describe it, I can't describe it. It's just a look of pity, sometimes disgust, sometimes, oh God, why me?" Fat people are subject to this look in a variety of situations, but most frequently in public places where space is limited, such as public transportation and restaurants. An airplane is the most frequently cited venue.

Sliding Down the Fat Continuum

Around the time that I conducted my first round of interviews Southwest Airlines was in the news for a seemingly discriminatory policy towards overweight people. Its policy requires anybody who exceeds the space between the two armrests to purchase two tickets. While understandable from a business perspective, this policy highlights a fear and discomfort that is persistent reminder of the difficulties of being fat. Travel is often uncomfortable and stressful under the best of circumstances, but for fat people it is often too great of a price to pay simply for a vacation. Those who have family or career obligations that require them to travel by airplane have to make a decision between seeing family or traveling for work versus the pain and discomfort of flying. By the time Yvonne Burgess reached her maximum weight of 301 pounds, she was reduced to tears on each trip. The thrill that she felt on her first airplane trip after bariatric surgery allowed her to begin her slide down the fat-thin continuum towards thinness. This realization that she now fit into places that she did not before the surgery was simply exhilarating to her:

> Oh yeah, well you talk about something that you really notice is different, definitely the plane. In fact, I remember getting up, it was a through flight and you're on the plane for about 4 and half hours so I got up to use the restroom and I was just so excited that everything fit. I went into the restroom and I came out

> and I went up, this is so unlike me, I went over to the flight attendants and I said "I am just so excited. I have to tell you what this experience is like right now," and I just said, "you know, I've lost 100 lbs and everything fits and it's just so exciting," and they're like, "yeah, yeah, yeah." They probably thought "she's a little cracked." But, you know, I was so excited I just had to tell somebody how exciting that was for me and what a relief, what a relief not to have to worry that nothing's going to fit or that I'm not going to fit in the seat. (5'3 and 194 lbs; BMI of 34)

Losing weight allowed Yvonne to reflect on how difficult life is as an extremely overweight person. As Rebecca explained to me, when you are extremely fat, denial is a vital part of maintaining your psychological health. As such, it is common for fat people to become more aware of their past fatness after they lose weight.

Similar to fat people who lose weight and become healthier, when fat people who have lost weight are given positive attention by people, especially potential partners, that is not focused around their weight, they begin to learn what it is like to identify as normal weight. For instance, although Stacey has lost over 100 pounds, she is still overweight by medical standards (her BMI is 27). Despite this, she has started living a life that she feels she missed as a very young, married mother. As such, she is separated from her husband, has begun making a new circle of friends, and is going out more frequently. Instead of being reminded that she is still fat on these outings, she actually begins to forget:

> I'll be talking to a guy at a bar and I'll forget that I'm overweight and I'll feel thin because he's showing me attention and um, you know, and I mean the reaction from people is just unbelievable, I mean that has been the hardest adjustment for me in losing the weight, because I didn't know when I was overweight how much I was being discriminated against and so now that I'm not overweight anymore I can see it. (5'5 and 164 lbs; BMI of 27)

Losing weight has pushed Stacey further down the fat thin continuum towards thinness; her weight has become less all encompassing and, at times, she gets to feel the way she always assumed thin people felt. Stacey, like many obese people who lose weight, was

also in the difficult situation of learning that she was fatter than she thought she was before her surgery. She never realized how disrespectfully she was treated as a very overweight individual, until she lost weight and was subject to less discrimination. Many of my subjects framed this as becoming visible.

Ironically, people who are so frequently accused of taking up too much space frequently cite feeling invisible. "As I took up less space I became more visible," writes Frances Kuffel in her 2004 memoir of adjusting to life as a thin person after being fat for her entire life. This sentence captures how so many presently fat and once fat people characterize what it is like to be fat. Their body is large, yet their presence is miniscule. As further explanation of why Jane "went into hiding" by dropping off of the dating scene entirely, she explained that she perceived she did not matter, and, therefore, people did not notice her: "So I think for about four years I just sort of assumed I was invisible. I'm not sure I really was, but I assumed I was because I figured you know, I'm a cow, nobody's gonna be looking at me you know." Fat people feel that they are frequently "…the only person in a crowded room" (Maureen) because by being fat they deviate from weight-based social norms leaving them devalued by the visible stigma they possess.

Discrimination from Within

There is an additional irony associated with being fat. Fat people are nearly as apt to discriminate against other fat people—frequently people whom they believe to be fatter than themselves—as are normal weight people. Their reasons are sometimes the same as might be expected from a thinner person. Take for instance Lisa's response to

my inquiry as to why she will not date a very overweight man, although she is very overweight herself (based upon medical categorization she is obese):

> I'm not attracted to them—aesthetics. But, I'm not looking for an Adonis. If the guy's a little overweight I don't care that much. But I would not want to date a man who is obese. But by obese, I mean, I consider myself getting, I'm obese now. Forty pounds ago I wasn't, I was just heavy. I will date a heavy man, I won't date you know, it's just, I'm doing the same thing [they do to women]. Because there is the aesthetic—it's the eye appeal. (5'2, 220 lbs; BMI 40)

Similar to thin people, big bodies are not attractive to fat people. Eighty percent of overweight and obese MIDUS subjects rate themselves correctly; this suggests that both fat and thin people look at the same magazines, are taught the same ideals of attractiveness, and, quite possibly, spend significantly more time obsessing about these ideals than a thinner person who does not have as far to go to reach those ideals. As such, it is not surprising that fat people such as Lisa do not have any higher regard for other fat people.

However, generally the reasons for in-group discrimination by fat people are not quite as straightforward as that. Cognitive dissonance theorists would argue that the disconnect between being overweight and being prejudiced against overweight should be so strong that by our self-protective natures, overweight people would either have to have only neutral or positive feelings towards other fat people, or would have to be in denial of their own weight (Festinger 1954). This may help to explain why nearly 20 percent of the overweight and obese respondents in my sample perceive their weight to be "normal weight (See Table 1.1 in Chapter 3). However, my research generally does not corroborate this. A fat identity is a state of mind that is informed by social realities around a physical characteristic. One can tweak their fat identity in a way that is psychologically protective if necessary, and this is frequently done through social and

self comparison. For instance, Lynn frequently compares herself with other fat people and makes self-deprecating comments about her own fatness. Yet she is even harsher on people whom she perceives to be fatter than herself. Discriminating for Lynn is a form of self protection. As long as she is not "as fat as that person" she is able to protect her self esteem. As Taylor's (1983) research demonstrates, downward social comparison is an affective tool for maintaining and enhancing one's self concept.

In the vein of self protection, in-group discrimination is also a form of impression management. This is a tactic fat people engage in both socially and psychologically to help control how they perceive themselves and are perceived by others. For instance, Rebecca spoke of how she managed the psychological component of being extremely overweight:

> I have never seen myself accurately [in the mirror]; I have no idea. I've always seen myself as thinner than I am because I've needed to do that so that I can walk down the street and hold my head up. Because when I actually get a picture or if I walk past a mirror, you know on the sides I'll be like "who is that?" And when I see it and it's real it used to shatter me.

Although she was intellectually aware of how overweight she was, to protect herself psychologically she needed to maintain control of her fat identity both internally and extrenally. To manage how she was seen, she surrounded herself with people who would not highlight her fatness:

> It's funny because as much as I don't like other people to be prejudiced to me, I'm prejudiced to others. I never wanted to be around heavier people because I felt like there would be a stereotype of look at the two big girls out together. I know it's very illogical and very silly, but when you see the things you hate in yourself in others it's really hard to watch, you know?

By doing this she sought to control the impression others would get of her. She knew she could not hide her extreme overweight, but she could mask her fatness. Thus people

manage the stigma of being overweight through either outright accepting their fatness as fat activists do, or outright rejecting their fatness and other fat people as many do.

In addition, fat people have intimate knowledge of the psychological, physical, and social burden of being overweight. Although it gives them a greater sense of empathy than someone who is not or has never been fat, it also makes them want to avoid this fate for anyone they love. As such, many of my younger informants spoke of their fear of bringing fat children into the world. In other words, although linking genetics to overweight has been shown to reduce anti-fat discrimination (DeJong 1980), this link causes fat people to be biased against other overweight people when choosing romantic partners. Patrick put this the most eloquently:

> In terms of dating, I think where [the prejudice] comes from is that when I was heavier I didn't like myself at all and so I don't like to date women that are overweight. I also think, and people are like if I end up with this person what kind of kids will I have, will they be smart? I've had such an issue with this in my life that if I do end up having kids I kind of hope that that person would genetically tend towards being thin because I wouldn't wish this on my kids. There is no guarantees or anything, but I have to say there's a part of me if I end up with someone I want it to be someone who is thin from a thin family and hopefully my kids won't have this kind of curse.

As Patrick illustrates, in-group stigmatization is a reflection of the out-group discrimination to which fat people are frequently subject. In the hope of avoiding further stigmatization, they often discriminate against overweight people.

Control, Fat People, and Failure

Although a fat identity waxes and wanes depending upon where people are physically, socially, and psychologically at any given time, once fat (as opposed to simply overweight or obese), discrimination is an important part of life. Much of this is a consequence of the prevalence of a belief in the ethic of personal control and

responsibilty in combination with the struggles fat people engage in to lose weight. The edict that hard work and controlled behavior equals morality and respectability causes fat people, whom are stereotyped to be lazy and out of control, to seem immoral (Quinn and Crocker 1999). Thus, a belief in ethic of personal control and responsibility contributes to fat identity formation for two reasons. First, being labeled as lazy or sloppy, and, therefore, immoral, permeates not only one's feelings about their level of weight, but also their self-esteem (*ibid*.). Second, and related, as a result of feeling out of control over one's eating (and oneself), someone may gain a sense that the food and the fat have taken them over. As such, because persons cannot separate the psychological and the physical implications of being fat, they *are* fat, instead of simply *being* fat.

My interviewees spoke of control and their belief that they could and should control their weight and both sides—the blamers and the blamed—are represented. Fat people, as opposed to blacks and women, can do something about the trait that causes them to be stigmatized. It has long been understood that a reduction in calories and an increase in caloric expenditure will result in weight loss. Because this seems like a logical and easy path to thinness, those who have not lived the struggle of being fat have trouble understanding those who do not follow this path. It is because of this that many of my respondents feel that overweight garners less sympathy and greater discrimination than other minority groups. Consider Patrick's take on why there is a "lack of tolerance" for overweight:

> I'm not gonna say it's equated to a handicap but the fact is if someone sees someone in a wheelchair they have no idea what the person's going through but at least they see them and they register that maybe there is some pain in the person, they have some sympathy I guess. But a heavy person, they may not even think to understand that there's any issues with being heavy. Beyond that, I think there's a lack of tolerance because it's like well all the person needs to do is stop

> eating. So even if they do have an understanding about it it's like well it's your own fault, you know, whereas someone who it's not their own fault, they may have a little more [sympathy for them].

It is the expectation that fat people should lose weight that makes being overweight such a powerful identity marker. Because it seems so logical and, therefore, so easy to fix the problem of being overweight, overweight people who are unsuccessful in their weight loss endeavors deserve the consequences of being fat. It is this (mis)understanding that makes all types of people, including fat people, discriminate against fat people.

Formerly fat people are frequently the most ardent believers in an ethic of personal control and responsibility. Although they understand the struggle, those who have lost weight have lived it and expect it from others. Consider Christopher's reasoning for why he has been so successful in his weight loss over the past 40 years, while others are not:

> They don't really [want it]. It's not really the most important thing, because whenever something's the most important thing you'll do it, you know. It's not hard to choose this coffee rather than the donut when I know I want to be thin. It's hard to choose this coffee rather than the donut when I know other people want me to be thin because at 3:00 in the morning, they're not there. So that's why I think most people who don't lose weight, don't lose weight. They have never made that decision. It's not as important to them, not critical to them. So they go to Weight Watchers, or they go on the program, because other people in society want them to do that, but [for] their personal being it wasn't critical. That's why it wasn't hard for me not to eat because it was what I wanted. You know, if you want something more than anything else you'll do that. Not that it's easy, but you can do it, it's simple, you just don't eat. (5'5 and 160 lbs; BMI of 27)

According to Christopher, self control is easy when you want something badly enough. In line with self-determination theory (Williams, Grow, Freedman, Ryan, and Deci 1996), Christopher highlights that people need to really desire to change themselves for themselves—not for others. The point where people begin to desire that change enough

is frequently referred to as an "aha" moment, which occurs when a person comes too close for their own comfort to the fat pole of the fat thin continuum and decides that they need to begin to slide down. As mentioned in the previous chapter, Jason, a 31 year old insurance adjustor who lost over 100 pounds on a liquid diet, came to this point when his health and social life were suffering and he was ready to reverse what was becoming an intrinsic part of his being. After losing such a significant amount of weight in such a drastic manner, he does not worry that he will gain the weight back, because he "really" wants it. Thus, for those who truly believe in the ethic of personal control and responsibilty, this method motivates them to keep weight off. However, a collective belief in this ethic also perpetuates the very hurtful and harmful stereotype that overweight people are simply not trying hard enough to lose weight—a conviction that the less successful dieters internalize.

The stereotype that overweight people should be blamed for their failure to adhere to social norms is hurtful for obvious reasons. Yet it is harmful for perhaps less obvious reasons. As Anne explained, the fear of failure becomes so intense and internalized that fat people are afraid to even try to lose weight, which may benefit fat people's physical and psychological health: "You get to a point, and that's what happened with me too, you get to a point, you don't even set yourself up, because if you set yourself up, you set yourself up for failure, and I remember [my friend] always saying to me, I'm not going to set myself up to fail." To combat this, fat people try to think about weight loss in less intimidating terms. For instance, on an intellectual level Lynn understands the need to reframe how she thinks of, and talks about, weight-loss efforts. Early in our interview she mentioned that she was currently on Weight Watchers, not because she needs to lose

weight, but because it might make her happy because the happiest times in her life were when she was at her thinnest. She then explained, "If I say that I need to lose weight, I set myself up for failure. If I just do it because it seems like a good thing to do, then I won't fail, it'll just end." If one does not call it a diet per se, then there is nothing to fail at. However, reframing is superficial, because although a person may call a weight loss endeavor something other than a diet, when it is unsuccessful it is hard to escape the disappointment. Hence, the constant battle to lose weight that many fat people engage in reminds them that they and other fat people are failures—reinforcing already established fat identities. As such, as already touched upon in Chapter 3, dieting can make people fatter, even if pounds are reduced.

Furthermore, those who have been successful at losing weight via bariatric surgery as opposed to "sheer desire" are frequently embarrassed by how they did it because of the belief that one should earn his successes via hard work. Bariatric surgery is frequently viewed as a forced diet because of the common side effect that causes patients to become quite ill if they overeat after the surgery. As such, to bariatric surgery patients it is a way to gain control over something that has been so out of their control for so long. Yet, to many, including over half of my sample, it is the easy way out. As such, although some who had the surgery were unapologetic about it, others keep it "like it were a nuclear secret"—so as not to be discriminated against for "taking the easy way out" (Dan).

In sum, fat people are constantly managing their fat identities so as to function in a society that reminds social actors on a daily basis that the fat continuum is extremely unforgiving. One can attempt to slide down the continuum via a diet, only to be pushed

further back up as weight is regained and the self perception of being a failure is further confirmed. As such, discrimination from others frequently translates into in-group discrimination and then into self discrimination. A negative cycle that reminds overweight people that they are fat, and may always be.

Conclusion

In this chapter I explored the varying ways that discrimination strengthens fat identities. Similar to the mechanism through which health and beauty concerns transform weight into fatness, by making weight a more trying and salient part of one's life, discrimination assigns it meaning beyond the objective state of overweight. As with the prior two chapters, I began this chapter with statistical analyses of the effect of discrimination indicators on fat identities. This analysis yielded very little in the way of significant results. However, it indicated that although overweight and very overweight people experience more discrimination than normal weight people, generally only experiencing considerable amounts of discrimination leads to negative weight assessments. I also found that for women, perceiving being discriminated against because of a blemished character is moderately predictive of assessing as somewhat or very overweight. Thus, the characterological flaws that Goffman (1963) speaks of are likely an important part of how people come to see themselves and are seen by others.

Crocker and Major (1989) note that if people attribute poor treatment from others to the discriminators own prejudice, as opposed to an internal flaw of the person, it is less likely to affect one's self concept. In light of this, it is not surprising that being treated disrespectfully or being harassed will not affect how one identifies as much as the perception that one is being treated as morally flawed him or herself. Other research

indicates that people actively engage in cognitive techniques to protect their self-esteem from discrepancies between who they are, who they think they should be, and who they are expected to be (Higgins 1989; Taylor 1983). My respondents reported using similar techniques for managing their stigmatized identity and this is a likely reason for why fat people tend to underreport discrimination. Also, many of my informants mentioned that they did not realize how poorly they were being treated until they lost weight. Thus, the self-protective measures we engage in to protect ourselves from identities that are discrepant from our values and our community's values are powerful and fundamental to identity management.

Unlike the earlier chapters, in the qualitative section of this chapter I did not find subgroup differences with regards to how discrimination affects fat identities. From analyzing my interviews, I learned that although the weight cutoffs might be different, and the experiences of discrimination perceived slightly differently for men and women, when men are discriminated against based upon their weight it is still internalized and helps them to understand how their body lies outside of socially accepted norms. Similarly, the ethnic minorities in my sample may draw the line between fat and thin differently, but when they are discriminated against it stings and their self esteem suffers. This is in line with past research that suggests discrimination is a consistently powerful predictor of lower self esteem and ratings of self acceptance across age, race, and gender categories (Carr and Friedman 2005). This supports my finding in Chapter 3 where I argue being black or Hispanic, male, or older does not protect a person from a fat identity. It simply changes the threshold for when one will gain one. Once a fat identity

is formed, as it was by all of my informants, discrimination matters and it matters for a number of reasons.

These reasons are varied and give insight into the types of experiences that inform a fat identity. In this chapter I illustrate this point by demonstrating the various ways that discrimination penetrates people's identities, making a fat identity a master identity. I did this by going from the more general experience of being stigmatized to the more acute aspects of being a discriminated against. For instance, Maureen exemplifies how her weight has become her master status. Despite her accomplishments, her family, friends, coworkers, and strangers see her as fat, and this has inevitably affected her self concept. In addition, the relationship between morality and fat identities again surfaces in this chapter. It is a widely accepted way of justifying victories and losses; overweight people are continually justifying why they are successful at losing weight and why they are not, leaving many to believe they are failures. Thus, the discrimination fat people face makes being fat an impossible identity to escape from. In public fat people are faced with other people's taunts. In private they are faced with their own.

CHAPTER 6
Conclusion

Identities

Both cognitive and social perspectives on identity focus on the symbiotic relationship between self and society, or as Cerulo (1997:385) wrote, how "interpersonal interactions mold an individual's sense of self." Though Cerulo argues that more contemporary conceptualizations focus on collective identities and future research will wed micro and macro approaches to identity, here I focus on how social definitions affect individual conceptions of characteristics (and specifically stigmatized characteristics). The symbolic interactionist perspective, such as Cooley's (1954) looking-glass self, poses that "identities are…strategic social constructions created through interaction with social and material consequences" (Howard 2000:371). Fat identities are the product of how society and social actors define weight, and are largely manifested through individuals internalizing socially constructed notions about weight.

There is a plethora of literature about identity. A small sampling of this work includes reviews of the various social-psychological conceptions of identity (see Howard 2000), the link between identity discrepancy or congruence and psychological distress (or lack of distress) (see Large and Marcussen 2000 and Higgins 1989 for examples), identity verification (Stets and Burke 2005), identity change (McFarland and Pals 2005), and stigmatized identities (Goffman 1963). In addition, numerous works address specific examples of identity formation and the difficulties and self-protective benefits of identifying as (or being identified as) a minority such as black (Killian and Johnson 2006; Mossakowski 2003) or elderly (Barret 2003; Westerhof, Barret, Steverink 2003), or an

identity formed around social roles such as parenting (see Maurer, Pleck, and Rane 2001). With such a vast amount of research regarding identities, there is seemingly little room for innovation. However, this work adds to the literature by discussing how fat identities are formed and why they are a meaningful reflection of U.S. society's view of weight. It furthers the identity literature by deconstructing a fat identity in a manner that, to my knowledge, no other research on identity has done before. More specifically, I look at fat identities as two distinct entities, the social/subjective (fat) and the purely physical/objective (adipose tissue). Although many would argue that fat and overweight are inextricable, here I argue that one is a physical reality (weight) and the other is a social reality (fat), and the two do not always overlap—although they frequently do.

All identities have these two sides. Black people are burdened and protected by the social implications of being black in U.S. society. Yet, their skin color is a physical and unchangeable marker that they identify with, and are identified by. The mentally ill contend with the physical symptoms of mental illness and the stigma attached to these illnesses. Identifying as a parent is a way a father or mother defines him or herself and is defined by others, but the children are a physical manifestation of this identity.[24] Thus, all identities have social, psychological, and physical components. This knowledge will help people to understand how varying identities are formed and how they affect people's lives.

Despite the dual (or tri) nature of all identities, fat identities are an especially good example of how identities and identifying characteristics need to be viewed as separate entities in order to understand the social, psychological, and physical effects of a

[24] If a parent is to lose a child, their identity as a parent is changed, but not taken away. The identity is now based around loss of a child and the physical reminder of the emptiness, similar to that of widows (Hastings 2000).

specific characteristic on an identity. Like gay identities and identities based around mental illness, fat identities are arguably both ascribed and achieved. Also, although all stigmatized identities lie on their own continuums, and, for instance, mental illness or a homosexual identity can be so extreme that the mentally ill and homosexuals are unable to pass for "normal" (Goffman 1963), fat people's identifying characteristic is an "abomination of the body." It is visible, and therefore fat people are unable to hide from their stigmatizing characteristic. Furthermore, similar to age identities, weight has obvious social and physical implications—a fat body, wrinkled skin for older people, and ill health for both. Also, like older people who become more acutely aware of their deteriorating health as they age (Barret 2003), the more overweight one becomes, the greater his or her likelihood of health deterioration becomes.[25] In addition, aging and weight gain are possible for all, yet people take measures to combat both. Older people may engage in acts that are traditionally associated with younger people, such as skydiving to celebrate an 80th birthday to prove to oneself that he or she is not "over the hill" yet. Overweight people will keep their "skinny" jeans to keep open the possibility they will one day be thin again. Alternately, both the non-elderly and the normal weight frequently engage in behaviors, or at the very least consider engaging in such behaviors, to slow the aging process or prevent weight gain. And, at times, people will lose weight so as to feel that they can control the inevitable physical deterioration that accompanies aging.

[25] There is an important point of departure between age and weight identities. Both are affected by socioeconomic status, yet in opposite directions. Socioeconomically disadvantaged elderly are more likely to more acutely suffer from health problems because of their poverty. Therefore, their age identities are affected by this. Alternately, lower socioeconomic status is inversely related to gaining a fat identity, despite vulnerability to health implications associated with obesity.

Fat identities are dynamic through time and context. Unlike a black person whose skin color presumably will not change through time, or a bereaved parent who will never be able to fill the physical and psychological void left by their deceased child,[26] weight changes and health changes (the physical manifestations of a fat identity) are a part of a fat identity, giving it a tremendous breadth for investigation. Furthermore, the expectation that fat people can and should eliminate the characteristic for which they are defined makes a fat identity an even richer identity to examine. On one hand, this expectation gives those with a fat identity a sense of agency—they can do something about their stigma, and this may provide psychological benefits (Crocker and Major 1989). On the other hand, it adds an element to a fat identity that is potentially similar to being homosexual in a religious community that truly believes that homosexuality can be combated. Being in contact with, and accepting of, an overweight person potentially diminishes one's "illusion of control" (Langer 1985). It seems so easy and logical to the non-fat and the heterosexual person that a fat person can lose weight and a homosexual person can become heterosexual. By not controlling one's stigmatized identity, fat people and homosexuals are frightful examples of what might be one's fate if their illusion of control is a delusion. Furthermore, unlike homosexuality and most other stigmatized identities, fatness is something that can touch anyone, but is deemed controllable. As such, it is an issue for most everyone—those who are fat and those might become fat.

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[26] This is not to support an essentialist notion of any identity. All identities change in their meaning as they develop. With these changes the identities slide up and down the identity hierarchy. Here I am arguing that weight, the physical manifestation of fat identities, changes in an objective, measurable fashion from day to day and throughout the life course. This change is expected and a fundamental part of identifying as fat.

Finally, all identities are organized around a hierarchy of salience (Stryker and Burke 2000). One person can have numerous identities, and identity salience is variable depending upon social context and personal values (Howard 2000:371). However, because fat identities are visible, seemingly controllable, relatively stable throughout the life course (why they are important changes, but generally not their salience[27]), and they are inextricably tied to their intersection with other identities such as gender and race, they have numerous avenues through which to rise to the top of the salience hierarchy. Together, these factors give fat identities a depth that can shed light on the difficulty of navigating stigmatized identities, specifically, and can inform future research on identity formation in general. To clarify why this is so, I will recap my general arguments and findings. Next I will provide suggestions for future research about fat identities and identities in general. In the final section I will offer potential solutions to the great dilemma of advancing healthy lifestyles while reducing the discrimination faced by fat people.

Terminology

In this work I speak about people who identify (and are identified) as fat. These people usually have a body mass index that would classify them as overweight or very overweight, but they are not always "overweight." In line with symbolic interactionism, scale weight comes to symbolize who a person is once it becomes associated with lessons learned from the media, medical professionals, and socialization (I argue that this is one of the three criteria for an ideal-typical fat identity, which I recap below). Thus, fat identities are based upon social definitions of ideal versus not-ideal weight. To the

[27] For the elderly, overweight may actually be an indicator of health and greater longevity and, therefore, welcomed over the alternative of extreme thinness (Bender, Jockel, Trautner, Spraul, and Berger 1999).

contrary, obesity is a medically defined condition and overweight and corpulent are adjectives I use throughout this work to denote excess adipose tissue that can result in both fatness and obesity (see Figure 6.1 for a recap of these terms). There are times when the cutoff between obese and not obese and fat and thin are at the same point, such as for those like Yvonne Burgess who decide that they are "too fat" when their health begins to deteriorate out of their control. However, for most, this depends upon their place in the life course. Older people may be more likely to place the boundary between fat and thin at a similar place to the boundary between obese and not obese. Younger people such as Francine, however, will place this line differently all but ignoring the health implications of overweight. Thus, this notion of dichotomous categories of fat and thin is greatly nuanced. No one lies solely on one side of the boundary, and how close one lies to the boundary is relative, based upon the many factors explored in this dissertation. Thus, understanding the fat continuum is vital for understanding how fat identities are formed and made meaningful.

Figure 6.1. Terminology

	Medical (Objective)	**Social/Psychological (Subjective)**
Medical (Objective)	Obesity	Overweight; Corpulent
Social/Psychological (Subjective)	Overweight; Corpulent	Fat

The Fat Continuum

Fat identities exist on a continuum. People meet the criterion for an ideal-typical fat identity when they experience the three criteria that I argue are fundamental to a fat identity. The first criterion is the "taught" criteria. In the most extreme sense, the social lessons regarding why being overweight is a negative characteristic are never ending and

they follow the fat person around everywhere. For instance, this might be the case of the svelte model who has gained 20 pounds and is photographed in a bikini when on a private vacation—only to come home from vacation to her "fat" body on the cover of internationally read magazines and on television shows. Again in the most extreme sense, the second criterion is met when a person's life is nearly impossibly difficult because of his or her weight. An example of this would be the 900 pound man who must be lifted out of his house by a crane in order to be transported to a special hospital that provides in-patient treatment for the morbidly obese. This man's central identity is based on his weight—he has been confined to his home because of it, and is now being taken to a new home that is solely centered around the one goal of losing weight. At the most acute, the third criterion is met when weight takes salience over all other identities, roles, and experiences. This is similarly experienced by the 900 pound man, or the extraordinarily socialized model whose profession is based around her extremely svelte body. I use these two different examples to demonstrate that fat identities can be paralyzing because of, or in spite of, one's true weight.

In reality most people do not fit this ideal-type. They may reach the extremes in one or two criteria, but not all three. For instance, while gaining weight makes the model fat in her professional life, in her personal life she likely far exceeds her peers in beauty, height, and thinness—hence, her fatness is escapable. Alternately, for the 900 pound man who seemingly meets all three criteria, the health implications may be so great that the social implications are overshadowed, making him more obese than fat. Or, because of his extreme weight, he may engage in a number of self-protective mechanisms that actually diminish the effect of his weight on his identity, such as engaging in downward

comparisons (Taylor 1983) or devaluing the importance of thinness (Crocker and Major 1989). Thus, while to an extent all overweight people may meet one of the above criteria, many may not meet all three criteria to enough of an extent to affect their identity. Or, they may place a significant enough amount of attention into identity management, so that although others may treat them as if they are fat, they do not see themselves as such.

For those who do meet all three criteria, where on the fat continuum they lie depends upon how extremely they are affected by the lessons, difficulty, and all encompassing nature of fat identities. Once a person crosses the threshold between fat and thin, whether it is placed closer to the fat pole, or closer to the thin pole, he or she is fat (see Figure 3.1). This work set out to illustrate what about our social world and day-to-day experiences makes this so. Doing so is an important step towards understanding how weight becomes a loaded descriptor that implies that one is not living up to social norms. Only by turning fatness back into overweight, and unpeeling the social layers under which it is embedded, can we as a society take informed and unbiased measures for not only solving the health problems caused by obesity, but the devastation to people's identities as well.

The Chapters

Chapter 1

In the first chapter of this dissertation I provided the reader with the history of the fat-thin boundary which had two points of origination—the medical, which included the insurance industry's determination of when overweight was "lethal," and the fashion communities. Although within the medical community there are five weight categories

in which one can be placed, in this work I argue that the reality is that there is just one permeable boundary. This boundary is dynamic and depends upon an individual's unique combination of sociodemographics, values, and history. Where this boundary lies is also contingent upon the five properties outlined in Chapter 1. When taken together, these properties make being fat a unique and especially difficult identity to navigate. These properties propose that having a fat identity is dependent upon one's place in the life course; it is dependent upon a belief in one's moral responsibility to adhere to the tenets of the ethic of personal control and responsibility; it is dependent upon weight's visibility; it is dependent upon a social instinct to categorize; and it is dependent upon sociodemographics. Although most other identities share some or many of these properties, to my knowledge, no other identity shares all five (although all stigmatized identities share the fourth property) and very few other identities are as universally possible—nearly everyone can gain enough weight to begin to identify as fat one day.

Chapter 2

Each analytic chapter provides an analysis of what makes fat meaningful enough to become a salient part of one's identity, which I investigated through an analysis of data from a large national survey and 40 in-depth interviews. In both the quantitative and qualitative sections of this dissertation, my sample includes people of varying weights and backgrounds. I did not filter on fat identities (meaning they assess their weight as somewhat or very overweight) in the statistical analysis because I was seeking to learn what causes people to identify as overweight, regardless of their present weight. I then added further detail to these findings with my qualitative analysis by illustrating how fat people discuss their fatness and when it takes on the most salience in their lives.

Chapter 3

Chapter 3 largely dealt with the fat continuum and how weight, past weight, weight loss, age, race, and gender affect where on it a person will exist. The most basic and unsurprising finding in this work is that the higher one's BMI category, the more likely an individual is to identify as "somewhat or very overweight." This finding from the quantitative analysis is largely supported by my qualitative analysis that indicated that the more overweight one is, the closer he or she is to the ideal-typical fat identity. Yet there is more to it. At what stage in the life course one gains weight greatly affects how a person's weight permeates his or her identity. As I found in Chapter three, gaining weight later in life enhances the potential that one will identify as "somewhat or very overweight." This result concurs with Carr and Jaffe's (2007) finding. I also found that the weight gain, which is often associated with aging (Ekelund et al 2005), is a great impetus for fat identity formation. In essence, mid-life weight gain is a crisis for how people, such as Roberta and Darlene, identify. Growing up thin, neither of these women learned to identify as fat people in youth, yet their weight gain is exaggerated in their eyes because they are comparing their present selves with their formerly thin selves. As such, older people compare their present weight to their past weight, and are frequently unhappy with the comparison that signals a downward trend in their physical selves. Multiple Discrepancy Theory suggests that people engage in numerous types of comparison when evaluating their present satisfaction and happiness (Michalos 1985). However, although presumably their peers have also gained weight, my results suggest people are more likely to engage in temporal comparisons (Albert 1977) as opposed to social comparisons (Festinger 1954) at this point in their lives. Contrary to past research

that suggests that people engage in downward comparisons as a method of self-enhancement (Taylor 1983) and most people participate in the psychologically beneficial practice of evaluating their presents selves more positively than their past selves (Taylor and Brown 1988; Wilson and Ross 2001), my research suggests that middle-aged people who have gained weight later in life compare themselves with past selves. Who they once were dictates who they feel they should be, but are not. I hypothesize that this is so because it is more psychologically trying to admit defeat—or to watch their agency (or illusion of control) escape them as they struggle to cope with their inability to stop the aging process. Thus, it may actually be psychologically beneficial for people to maintain that they can control their weight if they were to put the proper energy into it. Thus, by reflecting on past selves, people who gain weight later in life may be less satisfied with their present bodies than people who gained weight earlier in life, yet possibly more hopeful that this is a fleeting stage, and that they will be thinner in the future (Markus and Nurius 1986).[28]

Similarly, people who have bariatric surgery or engage in drastic weight loss measures when they are an adult after a lifetime of extreme overweight or obesity (meaning they had at least one weight-related illness) also find themselves in a difficult position. Although they are able to gain a reprieve from their fatness because it is less visible, they have to learn to accept their new thinner bodies and to remember that they are no longer overweight. Although they are generally more satisfied with their bodies and their selves, they have to learn how to cope with a present self that is nothing like

[28] It is interesting to note that if someone attributes another's stigmatized characteristic to factors that are out of the stigmatized person's control, the attributor is more likely to be sympathetic and kinder towards the person with the characteristic (Weiner 1993; Weiner, Perry, and Magnusson 1988). However, research has demonstrated that from a psychological point of view it is psychologically beneficial to feel that one has control over his or her fate (Crocker and Major 1989).

their past self. As such, they exist at a unique spot on the fat-thin continuum—a place where they have extensive insight into the fat end while striving for, and touching, the thin end.

In Chapter 3, I also explored the effects of race and gender on fat identities. Here I argue that blacks, whites, Latinos, men, and women are at risk for gaining a fat identity. However, where the fat threshold lies (i.e. the line on the fat-thin continuum that once surpassed indicates that one identifies as fat more often than not) varies based upon one's age, education, race, and gender. Thus, the great differences between people leads to one great similarity: all people are vulnerable to the consequences of a weight-permeated identity—although for some it will be at a higher scale weight than for others.[29]

Finally, in Chapter 3 I discussed how the ethic of personal control and responsibility strengthens fat identities. One cannot control his or her race, and one can only control his or her gender with great difficulty, but most people believe that weight is something you can easily control and should control. This is because of the very simple formula I put forth in Chapters 1 and 5: If one consumes fewer calories and expends more physical energy, he or she will lose weight. The simplicity of this formula leaves fat people who have dieted to be hyperaware of their weight and of their failure to lose weight. As a consequence of this belief, overweight people who have dieted unsuccessfully, or lost weight via surgery, are more vulnerable to identifying as fat than people who have lost weight naturally or successfully. Not only does dieting require one to place more psychological and physical energy into one's weight, but when a diet is unsuccessful, this failure is visible, leaving fat people to climb further up the fat

[29] I use the term "weight-permeated identity" to elicit the imagery of water seeping into sand. It occurs slowly, but then can end up a puddle once the sand is saturated. Thus, a weight-permeated identities are not saturated—ideal-typical fat identities are.

continuum. In addition, the unsuccessful dieter's lack of control is added to their self-schema (Howard 2000)—not only does he or she see him or herself as fat, but as a failure as well. As such, gaining weight back leaves fat people, such as Lynn, not only aware of being fat, but to blame themselves for continuing to be fat. This suggests that the ethic of personal control and responsibility, or the belief that indulgence is gluttony and only hard work should reap benefits, is a core part of my informants' belief system. This, combined with fat's visibility, helps to turn overweight into fat. Furthermore, even when fat people lose weight successfully, a fat past leaves an enduring shadow because of the formative experiences one has from being a fat person, and because a fat past self leaves the possibility for a fat future self. However, because its visibility diminishes, the social implications of having an overweight body are largely lifted.

In sum, this chapter served to show that a fat identity is not simply formed because of one's weight. It is formed because of an interaction between social and personal characteristics that come together to place meaning on weight. In Chapter 4, I built on this foundation with an example of how two fundamental meaningfulness makers fit together to strengthen fat identities: health and aesthetics.

Chapter 4, Health vs. Aesthetics

In Chapter 3, I illustrated how demographic factors and weight changes lead to fat identities. In Chapter 4, I looked at how fat identities are strengthened by health and aesthetic concerns. More specifically, I demonstrated that the effect health will have on one's fat identity depends upon one's age and history. As I argued in Chapter 1, the medical community has historically held a primary role in shaping how people view and fear weight. Even those who are quite sympathetic to the plight of fat people see health

as a fundamental part of a fat identity. For instance, Ed, a 29 year old teacher whose weight regularly fluctuates, epitomized the feeling that someone becomes fat only when they are having health repercussions. Until then, they are simply overweight:

> I would define somebody that's fat by the way that their obesity or fatness affects their lifestyle. You know, if they can't get up and do the things they want to do because they're overweight, or you know, it just affects their lifestyle and their energy level, then I would say that's fat. (5'-10" tall and 203 lbs; BMI of 29)

As Ed explains, weight only matters when it makes life more difficult. Although goals are still attainable, they are harder to achieve. For instance, commuting by train is still possible, but it is more difficult. If an overweight person is not be able to walk as quickly as a thinner person, he or she will miss the train more frequently; consequently he or she loses more time to commuting than a thinner peer does. Thus, life is harder when one is overweight, and therefore overweight persons have to make decisions based upon these limitations. This then helps to push people further up the fat continuum.

Despite the clarity that many people have about the relationship between health and fat, health concerns do not form fat identities, they strengthen them. Health only matters to fat identities if one has cause to worry about their health, and a person does not have to be unhealthy to have cause. Watching family members die because of weight-related illnesses, as Patrick and Stephanie did, makes health a meaningful part of their fatness. Beyond this, however, simply being a media consumer exposes most people to the vast medicalization of weight. These messages teach people to anticipate becoming unhealthy one day, and this places both undue and necessary focus on weight. Either way, as a consequence fatness becomes a more salient part of the self concept.

Health concerns rarely act independently to enhance fat identities. Aging and the ethic of personal control and responsibility intersect with health concerns to do this. As

already mentioned, aging is out of all people's control. Yet, people can take measures to slow down their inevitable deterioration by engaging in positive health practices, including diet and exercise. Furthermore, as people age, they become more vulnerable to all types of illnesses that may be exacerbated by weight. These illnesses leave people to reexamine why their weight is meaningful to them, or brings attention to the weight gain that they had ignored until a doctor alerted them to it. However, neither of these scenarios takes away from fat's visibility, and fat's visibility frequently trumps the generally silent physical damage obesity causes. Thus, although I propose that cosmetic concerns are more salient in younger people's minds as they generally vie for romantic partners and peer approval with greater urgency than do older people, and they are generally healthier than older people, the cosmetic concerns are always an important part of a fat person's experience.

Chapter 5, Discrimination

In Chapter 4, I discussed why fat matters by contrasting health and aesthetic concerns. In Chapter 5, I added the final layer to my analysis by further examining the social consequences of being overweight via a discussion of discrimination. Once a person possesses a stigmatized characteristic, he or she suffers from what Goffman (1963) conceptualized as a "spoiled identity." Through the discrimination that results from categorizing and labeling, fat people consciously and unconsciously come to understand that they are not properly adhering to social norms. As in the other chapters, in this chapter I found the more overweight one is, the more vulnerable he or she is to weight-based discrimination and the more all-encompassing this identity proves to be. Maureen is the closest example of this. She explained how her extreme corpulence

makes all aspects of her life more difficult to the point where her fat is her being; it is her master status.

Alternately, it is not simply level of weight that leaves a fat person vulnerable to discrimination. My quantitative results suggest that interpersonal discrimination has little effect on weight identities. The only finding that was worth noting was that women who perceive that they have been discriminated against because of a characterological flaw are moderately more likely than men who have been similarly discriminated against and women who have not been similarly discriminated against to assess themselves as somewhat or very overweight. This speaks to the intersecting identities and the prevalent moral concerns that are a part of the U.S. ideology put forth in Chapters 1 and 3.

In Chapter 5 I hypothesized that there are three possible reasons for why the discrimination indicators are not significantly related to perceived body size. First, I argued in Chapter 3 that all people lie on the fat-thin continuum even though people pass the fat threshold at different points and rates. Also, my qualitative sample that is entirely comprised of fat people all reported discrimination, indicating that it is a fundamental part of having a fat identity. Thus, perhaps, although discrimination is a large part of the fat experience, once a fat identity is formed, it may not be a specific pathway towards one. Second, it is also possible that for women, who are at the greatest risk for fat identities, the climb towards the fat-thin threshold is short enough to be reflected in the quantitative analysis, as opposed to the longer climb for other subgroups such as ethnic and racial minorities which can only be exposed in the more nuanced qualitative analysis. Finally, it may again reflect the self-protective behaviors that stigmatized people engage in. For instance, fat people may assume that other fat people experience much worse

discrimination in comparison to their own experiences, and, therefore, "forget" to report them, or consider them insignificant (see Taylor's (1983) discussion of self-enhancing social comparisons). This may explain why my qualitative sample, who all reported some form of discrimination, also reported experiences of teasing and lack of respect as being quite rare. In addition, my respondents often noted that they did not realize how poorly they were treated by others, or how invisible they were, until they lost weight. As Rebecca noted, it was too difficult to acknowledge the poor treatment before she lost the weight.

In Chapter 5 I also examined in-group discrimination among fat people. Members of minority groups often feel solidarity in their marginalization, which protects one's mental health in the face of the difficulty of being a minority (Mossakowski 2003). Although there is a growing movement among fat activists for a similar solidarity among fat people (Rabin 2008), none of my informants feel comforted by this. Surprisingly, many of the fat people with whom I have formally and informally discussed this feel that to manage their identities they must actively try not to be clumped together with other fat people, hence they choose thinner friends. Also, fat people who have felt the incredible physical and emotional pain of having a weight-based identity fear the genetic aspect of fatness. Although research finds genetic explanations for overweight to alleviate some of the stigma against fat people (Dejong 1980), this same argument makes fat people not want to engage in romantic relationships with other fat people. They fear having a child that will have the same struggles and heartache that they have had. Also, fat people have internalized the same messages that others have, and many fat people are simply not attracted to other fat people. This is contrary to the self-protective measures that research

suggests people take (see Crocker and Major 1989 for a review). Instead of devaluing the importance of thin bodies, they actually support the notions that draw lines between fat and thin.

Implications of this Study and Future Research

Realistically, everyone brings their biases to all interactions. Suggesting that we simply stop believing in the ethic of personal control and responsibility, or that we simply learn to find fat bodies attractive is unreasonable. However, perhaps understanding that we all lie on the fat-thin continuum, and most people silently struggle to swim against the tide towards fatness, will enable educators and policy analysts to reframe how weight is seen in the United States. It is not a failure—it is a state. It is a state that can be socially and psychologically devastating to people, leaving it an identity from which people cannot escape.

The best way to combat the stigma and health problems associated with overweight and obese bodies is to educate the public about these states of body. However, this is complicated in light of the fact fat people are frequently obese and obese people are frequently fat. Thus, combating obesity and the stigma of fat at the same time are largely conflicting goals. To clarify why this is a dilemma, take Weiner, Perry, and Magnusson's (1988) insight into the dilemma:

> What in part appears to be needed are procedures and methods of education that point out the array of determinants of the onsets of stigmas such as obesity and drug addiction that lessen the perceived responsibility of the stigmatized person. These determinants embrace both the liberal (environmental) and conservative (genetic) causes. However, this creates a dilemma, pitting the positive and negative benefits of reducing personal responsibility for the onset of a stigma. On the one hand, one would like individuals to accept responsibility for their actions. This surely promotes personal change and is the basis for many psychotherapies. However, altruistic actions from others are augmented by perceptions of uncontrollability. (P. 746)

Thus, attributing overweight to genetics or the environment takes the blame away from overweight people and places it in arenas that are out of their control. While this would be quite helpful for reducing the stigma and discrimination corpulent people frequently face, it would be counterproductive to the health messages that teach us that our health and our weight are in our hands.

In this work I have suggested that medicalization is problematic because it leaves people to believe they are unhealthy, when they may simply just be overweight. However, it is also important to educate the public in general about the connection between obesity and illness. HIV provides an example of a medical condition that has been destigmatized. By publicly changing the attribution schema of HIV from promiscuous homosexuality and drug use, to blood transfusions and children born with the disease (and also by highlighting the poverty and lack of education in communities where HIV is the most prevalent), HIV now largely elicits sympathy as opposed to distaste (Weiner, Perry, and Magnusson 1988). However, a similar approach is unlikely to work for obesity/fatness. HIV did not lose the stigma associated with it because people began to accept homosexuality and drug use. It was simply reframed as a disease that is out of the patient's control. Because of the "fewer calories, higher calorie expenditure" formula, weight loss will always be viewed as in one's control. And, in part, it should always be viewed that way. Not because it is necessarily so, but because, as the stories of weight loss that I conveyed earlier denote, if one does not see weight loss in their realm of possible selves, then he or she will give up (See Markus and Nurius 1986). For instance, Lynn and Sari who have watched the scale go up and down numerous times, yet have always been fat—their past selves are fat, their present selves

are fat, and they assume that their future selves will be fat—wonder if it is even worth trying to lose weight.

Furthermore, it is clear that not even the prevalent health messages and current policy implementations (such as eliminating soft drink machines from Connecticut schools) are entirely successful. Although research suggests that people see the link between weight and health (Jaffe and Carr 2006), other research indicates they are not listening to these messages. People are becoming more overweight, childhood obesity rates are rising yearly, and calorie consumption continues to rise, while exercise continues to decline as a more sedentary, computer-based lifestyle becomes the norm (Brownell and Horgen 2004). In addition, there is evidence that despite the rampant medicalization and openness about the health risks involved with being overweight, some doctors are still withholding valuable information about the links between weight and illness in an effort to prevent insulting their patients (Galuska, Will, Serdula, Ford 1999). As such, a serious problem lies at the juncture of obesity and fat identity. It is the medical community's responsibility to educate the public about scientific findings linking obesity to poor health and it is the media's responsibility to do the same. However, when taken too far, it turns irresponsible. This is the great dilemma of the media, exercise and dieting industries, and physicians who want to both inform and profit from medicalizing fatness (Conrad 2005). Finding the line between responsible and excessive is not a simple task. It requires us to deconstruct the taken-for-granted boundaries in U.S. society and attempt to gain a better understanding of how these boundaries can be used to help people, as opposed to stigmatize them.

In this work I begin this deconstruction process by carefully looking at the interaction between people's unique sociodemographic mappings and the varying roles health and discrimination play in turning what should be seen as an objective descriptor into negative social category. Future works in this area can hopefully further this endeavor to gain a better understanding of why weight matters to different people. By doing this we can begin to combat the serious health problems facing obese adults and children today without exacerbating the stigma associated with being overweight. By looking at cultural differences in how weight is viewed, we can help to address what causes some racial and ethnic minorities to be more vulnerable to the health consequences of overweight. For instance, I found preliminary evidence that blacks and Hispanics pass the fat threshold at a much higher point on the fat continuum than white people. Other research indicates socioeconomically disadvantaged minorities, and especially female minorities, gain more weight than men and socioeconomically advantaged whites through the life course, a trait that makes these groups particularly vulnerable to illness and disease (Baltrus, Lynch, Everson-Rose, Raghunathan, Kaplan 2005). Alternately, there is evidence that blacks are less vulnerable to the health consequences associated with weight than white people (Fontaine, Redden, Wang, Westfall, Allison 2003). Thus, future researchers and policy makers need to take a more culturally sensitive approach to educating people about the relationships between health and weight and stigma and weight. The techniques that will work for some groups will not work for others. Blacks and Hispanics may benefit from direct information about how lifestyle choices may lead to higher rates of morbidity and premature mortality. White women one the other hand, who seem to be more sensitive to the disconnect

between believing that one's body is one's responsibility and being overweight, might benefit more from information that debunks this connection.

Along these lines, further research about thin people who identify as fat and overweight people who identify as thin is necessary for uncovering the power and limitations of social messages. There has been much research on anorexia, an extreme example of a thin person identifying as fat. Anorexia can fully encompass one's being and ultimately lead to death (Neumarker 1998). Researchers have expressed a similar concern for people who are obese, yet see themselves as thin. This most frequently results from being a member of a sociodemographic category that accepts (and values) overweight. There is much to be learned from both of these discrepancies between BMI and body image.

Both of these groups of people (those who are thin yet identify as fat and those who are overweight yet identify as thin) are interesting examples of how there are tangible benefits to living within society's norms—which is largely why norms are in place and such successful forces in defining right from wrong. These groups also suggest that both the over-socialized and under-socialized are greatly vulnerable to early mortality. On one hand there are tremendous social and psychological benefits from being protected from the consequences of being fat in U.S. society. On the other hand, it leaves these people vulnerable to social and health consequences that they may ignore, or not understand how to prevent. For example, Fitzgibbon, Blackman, and Avellone (2000) express concern for Hispanic women's health because Hispanics tend to have a greater discrepancy between their body image and high BMI than black and white women. Navigating the fine line between the self protective benefits and health

consequences of BMI-body image discrepancies is tenuous because too great an exposure and internalization of social and health messages and too little an exposure and internalization of these messages can be equally detrimental.

To learn the appropriate balance, an important place to begin would be with a large-scale qualitative study of people who traditionally have a large discrepancy between an overweight body and a thin body image (or vice versa) to help to learn what factors lead to their "aha" moments—or their passing the fat threshold or what future researchers might call the "skinny threshold." What might be learned about people who have a high BMI yet do not identify as fat is that they are quite similar to overweight people who *do* identify as fat, yet do not adhere to the public health information readily available in the media and in physician's offices. Both overweight people who do and do not identify as fat simply make choices for themselves that are different from the choices that others might make or advise. Yet, learning their thought processes and decision making is an important step towards finding culturally specific and sensitive interventions for populations who are at an increased risk of developing weight-related health conditions. Studying people with low BMIs who identify as fat may equip researchers and policy makers with an understanding of when interventions go too fat.

Here I will give some general suggestions for finding the appropriate balance between intervention and distance from which all people would benefit. Instead of simply continuing with the standard education programs that center around health messages, a more nuanced approach should be taken when thinking about how to educate the public about healthy lifestyles and fat acceptance. Messages about weight should be more encompassing and should break down the myths while dispersing the facts. For

instance, it would be useful to teach middle and high school students about cultures such as the Nouakchott, Mauritania in the Western Sahara, where to be fat is to be beautiful. In fact, fatness is so valued that female children are—when the family can afford it—force fed. They are woken up in the middle of the night for feedings and psychologically and/or physically abused if they do not eat and are forced to eat their vomit if they become sick from overeating. In this culture, people believe that girls and women will be undesirable to men if they are not fat. Even when presented with the health risks associated with obesity, they respond by saying that, "Beauty is more important than health" (Mint Ethmane cited in Naik 2004:A2). This is reminiscent of how my younger informants view the health/beauty divide reported in Chapter 4. Thus, how we view weight is a social construction based upon cultural norms and mores, as opposed to nature and history.

Alternately, while highlighting the socially constructed nature of fat, researchers and policy makers need to continue to encourage healthy food choices, limited television time, and creative methods for encouraging exercise in schools, office spaces, and during off-times—something that is already being addressed by policy institutes around the country. However, it is important to stop singling out people with BMIs that exceed a 25 or 30 and give incentives to all people to be healthier. Simply linking obesity to lack of health can be discouraging and potentially counterproductive because of the law of diminishing returns. Overemphasizing the link between weight and health causes fat people to either ignore the messages, or to be discouraged by the messages. Alternately, if it is seen as a global problem, fat people will stop being blamed for their weight, giving everyone an opportunity to take a closer look at the link between their health and

lifestyle. It is everyone's responsibility *and* choice to define what risks they are willing to take in their lives. Equipping all people with equal knowledge and equal means for living a healthy and long life is where the intervention should end—beyond that it becomes excessive and a breeding ground for anti-fat attitudes. Furthermore, as this and past research suggests, weight loss is most successful when the desire to lose weight is rooted intrinsically (Williams, Grow, Freedman, Ryan, and Deci 1996). In other words, it takes a personal "aha" moment for the desire to lose weight to be strong enough for the necessary sacrifice and energy to take hold. Throughout this work I have argued that social forces influence how one identifies. As such, external messages influence when a person will reach his or her personal "aha" moment. However, it would be useful for policy analysts and researchers to understand that numerous factors are involved with one making the decision to lose weight and maintain their weight loss long term—and all of these factors are dependent upon a strong, internal desire to change external appearance. Some people may make this choice because they want to be healthier, others because they want to avoid the discrimination fat people face. However, most will do so for both reasons, giving them a sense of control over their health, aging, clothing choices, and treatment from others.

Anti-fat attitudes are extremely harmful and have been the subject of a significant amount of sociological and psychological research. As I've demonstrated in this work, all people, including fat people, can hold these attitudes. As a consequence, fat people are subject to diminished life chances. Given this reality, it is surprising that fat people are protected from weight-based or appearance discrimination in only three areas of the United States: Michigan, Washington, DC, and Santa Cruz, California. Elsewhere, in

order to be protected from discrimination, a fat person (and his or her lawyer) must argue that he or she has been discriminated against based upon a disability, which would enable him or her to be protected under the Americans with Disabilities Act (http://www.naafa.org/documents/policies/legislation.html).

This is a complex issue. By protecting fat people from discrimination another artificial boundary must be drawn. As I've argued throughout this work, fatness exists on a sliding continuum—what is fat to some people is not fat to others. Thus, legislation would simply reinforce a superficial boundary and unique situations such as the super model and the Sumo wrestler mentioned earlier would inevitably be lost in legislation that does not take the full picture of what it means to be fat versus obese in US society. For instance, can a super model who is fired for being a size 4 argue weight-based discrimination in a law suit? In other words, how can a threshold that only exists on a continuum be framed as a fixed state? By hastily drawing such a boundary, we run the risk of reifying a boundary that fat people spend their lives fighting. Perhaps this is the best way to bring discrimination to the forefront and to begin battling it. However, fatness is a unique stigma. It is visible, yet, to many fat people, psychologically manageable. By taking the right to rationalize it from fat people, it may be devastatingly harmful to fat people who, by lying on the fat continuum, have the luxury of feeling less fat at some times than at other times. As such, legislation protecting fat people from size-based discrimination has to be cognizant of the unique properties of which a fat identity is comprised, and that fat lies on a continuum with the threshold between thinness and fatness being defined for and by each individual uniquely.

In sum, we must learn how to protect people from the stigma and discrimination of being fat, while educating people about preventing the lifestyle decline that accompanies obesity. Taking the model I have put forth here and applying it to other identities would be a useful undertaking for future work. By understanding that all identities have a social and a physical component, we can further advance our understandings of how identities are formed, and why some take on a greater salience than others. Although social constructionist models are useful tools for understanding how society defines in groups versus out groups, to truly understand an identity, and how it is affected by social constructs, it is necessary to understand and acknowledge the physical starting point for identity formation. Thus, to fully understand and deconstruct fat identities we must undertake Zerubavel's (1991) challenge to "… examine how we actually separate entities from one another, whether it be humans from animals, work from hobby, official from unofficial…vulgar from refined[,]" or fat from thin (p. 3). This can only be done by understanding an identity for what it is: a mental and social mapping of who a person is based upon specific, concrete characteristics that help to shape how the person sees and is seen. In this vain, this work is a first step for providing a new way of thinking about fat and thin—not as strictly defined entities, but dynamic identities that matter based upon one's history, sociodemographics, age, values, health, *and* scale weight.

Limitations

This work has several limitations. First, in the quantitative analysis I use perceiving one's body size as somewhat or very overweight as a proxy for a fat identity. This is not an entirely accurate proxy; however, the multifaceted manner in which I

conceptualize a fat identity would be impossible to capture in a survey questionnaire. Second, in this work I pose the idea that blacks, Latinos, and men—all groups generally thought to be more accepting of their own fat bodies—simply view fatness on a different scale, not necessarily more favorably. Yet, my sample is not large enough to provide more than a suggestion about the direction future research should go. A large quantitative and qualitative sample of blacks and Hispanics would allow a researcher to truly flesh out how ethnic and racial minorities form fat identities. For instance, it would be helpful to look at the different mechanisms through which black women or elderly black women gain fat identities in relation to how white men or women learn to identify as fat. These types of research endeavors will help educators to be sensitive to subgroup differences, allowing them to educate about healthy behaviors without encouraging tighter boundaries between fat and thin within these communities. In addition, my limited sample sizes prevent me from gaining the precision necessary to make definitive statements about who is forming fat identities and why. Yet, this sample does allow me to gain an expansive view of fat identities that future researchers can draw from to gain more precise appreciation of how specific groups, such as the elderly or men, understand weight.

In addition, my qualitative sample is skewed. I specifically sought to interview fat people. My respondents are not necessarily overweight or obese, but they all identified as fat at the time of the interview. Thus, this sample did not enable me to generalize to the population at large. Instead, it gave me a snapshot into what it is like to identify as fat. It allowed me to flesh out the major themes that fat people live by, and what measures they take to manage and understand their identities—and to do this, many

of them opted to lose weight via bariatric surgery. That my sample ranged in scale weight from 100 pounds to over 300 pounds, with a few of my informants at one time exceeding 400 pounds, gave me a unique lens into what it is like to slide up and down the fat continuum while watching scale weight fluctuate. This is in many ways an ethnographic study about why weight matters for people who are entrenched in the front lines of the weight battle. My sample is entirely from the east coast, mostly middle to upper middle class, and white—a sociodemographic clustering that is especially sensitive to how bodies can symbolize gluttony or power. Consequently, although I feel that my research is valid, it may not be replicable outside of this population. I studied the extremes in order to examine what it is like to identify as fat despite what the scale says.

Another limitation of this sample is that it did not enable me to get the thin person's perspective on the issues examined here—hence there is no control group. I suggest future research focus on thin or "skinny" identities. Thin identities and fat identities are intimately connected. Fat people usually strive to be thin. Thin people fear being fat. Although opposites, they exist on two poles of the same continuum. There is also a third category that deserves future exploration: those who are unmarked. They are neither thin nor fat. Their weight simply does not impact their life in either direction. From my research, I strongly hypothesize that this is a rare category. Yet, again, this may well be a function of the upper-middle class, east coast sample, where I gained my own wise identity[30] as the only thin female in a family of fat women. Regardless, the comparison would shed a different light on fat identities—how they are formed and why they matter.

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[30] Goffman (1963) conceptualizes a "wise" identity as an identity garnered via close association with stigmatized people.

Although my samples are small and skewed, my findings demonstrate that fatness is an important identity that greatly affects people's daily lives. It is a trait that has the power to define what opportunities and roadblocks a person will face, and it is when this power is realized that an overweight person becomes a fat person. This dissertation is an important step towards putting forth an understanding of the power of fat identities. It will hopefully lead to future works on how to strip this power from stigmatized fat identities while empowering the medical community to disseminate responsible and informed information about how to protect people from the potential health implications associated with obesity.

APPENDIX A
Interview Protocol

Sociodemographic information:

1. Age

2. Height

3. Weight

4. Occupation

5. Race and Ethnicity

6. Religious beliefs (if volunteered)

7. Perceived socioeconomic class

8. Marital status

9. Children

Interview questions:

1. Do you perceive yourself as being underweight, normal weight, or overweight? Why?

2. When did you begin feeling this way?

(If overweight since childhood:)
3. Can you recall any specific experience that led you to decide that you're overweight?

(If recently became overweight:)
3b. How did you come to decide that you are overweight?

(If recently became underweight or normal weight:)
3c. What measures did you take to lose weight?

3d. Can you tell me about any experiences that you've had recently that made you realize how much weight you've lost?

4. Have you ever been on a diet? (Or were you ever on any other diets besides your most recent one?)

5. What motivated you to lose weight? Were there any specific situations?

7. Can you talk about what it was about your healthy/appearance that worried you?

8. Was weight and food a important in your family growing up?

9. Were/are your siblings or parents overweight?

10. (If married with children) Do you deal with food issues in your household now differently than your parents did when you were a child?

11. Does your husband or children struggle with their weight?

12. (If yes to children) Does this worry you?

13. (If yes) Why?

14. When you see overweight people that are not related to you, how does it make you feel?

APPENDIX B
The Flyer

PARTICIPANTS NEEDED

Are you overweight? Or have you ever lost significant weight on a diet or through surgery? Is your weight a meaningful part of your life?

If so, please be a part of my study. I am a doctoral student at Rutgers University studying what "overweight" means in American society. Your help in my study can help change the way our society views bodyweight!

If interested, please e-mail me at kjaffe@sociology.rutgers.edu

APPENDIX C
Interview Subjects

Pseudonym	Gender	Age	Race/Ethnicity	Height	Weight	BMI	Past Weight
Ally	Female	29	White	5'5	124	21	155
Amanda	Female	20	White	5'4	110-115	19	180
Anne	Female	56	White	5'3	190	34	
Belle	Female	60	White	5'4	200	34	270
Beth	Female	36	White	5'3	185	33	
Bill	Male	50	White	5'11	350	50	
Cara	Female	22	Hispanic	5'1	206	39	221
Christopher	Male	56	White	5'5	160	27	
Dan	Male		White	5'7	179	28	269
Darlene	Female	57	White	5'2	162	30	
Ed	Male	29	White	5'10	203	29	
Ellen	Female	43	White	5'4	125	21	230
Erika	Female	30	Italian/Puerto Rican	5'1	122	23	153
Francine	Female	25	Hispanic	5'5	185	31	
Georgia	Female	48	White/Greek	5’7	194	30	300
Hailey	Female	29	White	5'5	140	23	175
Heather	Female	40	White	5'9	158	23	
Howard	Male	28	White	5'8	195	30	
Jane	Female	36	White	5'6	150	24	240
Jason	Male	31	White	5'10	221	32	373
Jerri	Female	57	White	4'10	115	24	226
John	Male	31	White	6'1	250	33	
Kathy	Female	38	White	5’4	180	31	
Lisa	Female	48	White	5'2	220	40	
Lynn	Female	31	White	5'2	230	42	
Marsha	Female	31	White	5'8	180	27	about 400
Maureen	Female	40	White	5'3	300+	55+	
Molly	Female	30	White	5'2	230	42	
Patrick	Male	41	White	5'11	260	36	about 500
Priya	Female	28	South-East Asian	5'8	225	34	
Rebecca[t]	Female	35	White	5'7	155	24	320

Pseudonym	Gender	Age	Race/Ethnicity	Height	Weight	BMI	Past Weight
Roberta	Female	60	White	5'5	155	26	
Sara	Female	29	White	5'1	134	25	160
Sari	Female	62	White				
Scott	Male	31	White	5'6	146	24	
Sharon	Female	33	White	5'4	180	31	230
Stacey	Female	32	White	5'5	164	27	292
Stephanie	Female	33	White	5'7	232	36	332
Sheryl	Female	31	Black	5’1	178	34	
Yvonne Burgess*	Female		White	5'3	194	34	301

[t]I interviewed Rebecca twice. Once shortly after she had bariatric surgery and then a year later.
*This is her real name.

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PUBLICATIONS

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Jaffe, Karen and Deborah Carr. "Body Weight and Perceived Risk of Chronic Illness among American Adults." (Revise and resubmit received from *Journal of Health and Social Behavior* January 2007).

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