

Running head: DIETER

The Dieter as Model Citizen

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Paper Presented to the

53rd Annual Conference of the International Communication Association, San Diego

May 2003

Abstract

Research indicates that a third of the U.S. populace is medically overweight and that approximately 15 to 30 percent of Americans are on a diet at any given time of the year. The Surgeon General's office is actively promoting weight loss for all Americans. This emphasis on weight indicates that, in the United States, dieting and fatness hold special symbolic significance beyond public health arguments that being overweight poses a personal health risk. This paper argues that the act of dieting parallels that of model citizenship. The dieter, like the model citizen, practices self-surveillance and self-discipline, observes a secular form of the Protestant work ethic and practices a "moral" lifestyle. In contrast, fatness symbolizes a lack of self-surveillance and self-discipline; as well as illness, laziness, and a number of other stigmatized characteristics. These symbolic meanings, rather than health concerns, contribute to anti-fat prejudice in the United States.

The Dieter as Model Citizen

Introduction

Carnevale means “farewell to flesh,” and historically the carnevale was the last big celebration of feasting and freedom preceding Lenten fasting. Today, however, the rite is reversed, and the fast occurs before the celebration.

Contemporary rites of fasting promoted by the state have become the norm for 60 percent of the U.S. population as they try, and fail, to bid farewell to their own fleshiness. “At any given time of the year, an astonishing 15 to 35 percent of Americans are trying to lose weight” (Kassirer & Angell, 1998). Yet despite research indicating that dieting only works in the short term, that many forms of dieting can cause health problems, that limited caloric intake is not necessarily the key to successful dieting, and that being overweight may not cause health problems, the Surgeon General’s office and the U.S. public health establishment—and the country’s approximately \$40 billion dieting industry—continue to encourage citizens to fast and exercise in order to melt away a significant portion of their flesh. The size-acceptance movement, which seeks to counter anti-fat prejudices, thus faces opposition both on an individual and institutional level.

Why is it in the state’s interest to encourage what is most certainly an unpleasant, and arguably a pointless, regime of self-abnegating self-discipline? The Surgeon General’s office emphasizes the public expense of treating obesity-related health problems; about \$117 billion in 2000 (U.S. Department of Health and Human Services, 2001). A third of the U.S. population is currently classified as obese (Flegal, Carroll, Ogden, & Johnson, 2002), which raises the specter of rising national health-care costs.

“The public health costs of this are just really frightening if the disease acts as it has in adults. It certainly portends a grave public health problem,” said Richard L. Atkinson, president of the American Obesity Association and director of the Medstar Research Institute's obesity research, about the 2002 statistic (quoted in Squires, 2002).

But concern only for public health and its expenses does not explain why dieting has become a shared cultural experience that cuts across social class and ethnicity for most women and many men. Everybody in the United States knows something about dieting; most have followed a diet at one point or another in their life. Why?

What is socially peripheral may be symbolically central, pointed out Stallybrass and White (1986, p. 23). Dieting, as unimportant in the global scheme of things as it may seem, is such a widespread rite throughout the United States that it clearly carries significant symbolic importance. This is because *in the United States, a dieting citizen follows the same practices encouraged in a model citizen.*

Dieting calls on core U.S. values and social trends: the Protestant work ethic, the medicalization of behavioral attributes, the panoptic power of the state, and the moralization of lifestyle. The dieter can be considered to personify and practice these values and is thus a symbol of the model U.S. citizen: self-disciplined, health-focused, self-surveillant, and moral. In contrast, the fat person can be considered symbolic of the undesirable U.S. citizen: lazy, disorganized, unhealthy, shameless, immoral, and possessed of a poor work ethic.

The Protestant Work Ethic

Max Weber's (1958) conceptualization of the Protestant work ethic is widely acknowledged to be, in secularized form, a core ideology of the capitalist United States.

The values of ascetic Protestantism: “self-discipline, hard work, the careful use of time, the reinvestment of one’s gains, personal honesty, creative innovation, and faith in the rewards of a just God” (Jones, 1997) are closely related to the values of the dieter. That is, the dieter believes that weight can be lost through self-discipline, hard work, the careful use of time (by avoiding sedentary activities and laziness), the reinvestment of gains (e.g., dieters argue that muscle burns more calories than fat, so the more one exercises, the more weight one loses), personal honesty (a good dieter does not cheat on the diet or exercise schedule), creative innovation (the dieter seeks to make diet menus and exercise regimes interesting) and faith in the rewards of Fitness (dieters believe that by adhering to this program, they will lose weight).

These values offer little grace to the fat¹: “The Protestant ethic dictates that those who are overweight lack the self-discipline to control their weight, deserve any negative outcomes they experience because of their weight, and are moral failures” (Quinn & Crocker, 1999, p. 403). Indeed, anti-fat attitudes in the United States are correlated with “just world beliefs, political conservatism, and a tendency to blame the poor for their poverty,” as well as with a tendency “to hold people accountable for what happens to them” (Crandall & Martinez, 1996), all also correlated with belief in the Protestant work ethic (Crandall, 1994). To be fat, then, implies to have poor self-discipline; a poor work ethic. Thus, the fat person must be a poor U.S. citizen, according to this conservative vein of mainstream U.S. ideology.

The main difference between the Protestant work ethic and the dieter’s credo is that, Weber argued, the rewards of the Protestant work ethic were measured in terms of material *gain*. In contrast, the rewards of the dieter’s credo are measured in terms of

material *loss* (of weight), although dieters may enjoy immaterial gain (e.g., of energy, of self-esteem, and of social acceptance).

The dieter literally embodies a secularized version of the Protestant work ethic. This embodiment is visible in the form of weight; a successful dieter/citizen is thin, and an unsuccessful dieter/citizen is fat.

The use of the body as a sign harkens back to the old days of physical punishment, such as the English colonists' use of stocks and public whippings to inscribe civic displeasure on a transgressor's flesh. But, as Michel Foucault described in *Discipline and Punish* (1979), this early form of embodied, spectacular signification grew less common with the nineteenth-century move to a panoptic society. In a panoptic society, externally imposed surveillance and discipline becomes less cost- and energy-efficient than an promotion of internalized self-surveillance and self-discipline.

Panopticism

Western society, Foucault argued, became a disciplinary society in part through the spread of a panoptic sensibility (Foucault, 1979, p. 216). Panopticism is all-surveillance, the making visible of traits or behaviors that were formerly unseen or unacknowledged, in order to control those "transgressive," "undisciplined" elements. Societal panopticism, with its coinciding encouragement that individuals keep themselves under constant self-surveillance, serves to tame the unruly body and render it docile without need of physical punishment. State-imposed disciplinary action is, by preference, replaced with self-discipline; and punishment, with praise. "Discipline rewards simply by the play of awards, thus making it possible to attain higher ranks and places; it punishes by reversing this process" (Foucault, 1979, p. 181). Foucault's insight

was that power does not simply repress, but also “induces pleasure, forms knowledge, produces discourse ... needs to be considered as a productive network which runs through the whole social body” (Foucault, 1980, p. 119).

Part of this complex practice of power is the definition and imposition of norms; of what is considered normal and thereby “healthy” in terms of physical and mental behavior. Foucault’s work showed how institutions of power defined and made visible/measurable states such as delinquency, madness, illness, and perversion. In this way, various state and medical institutions have defined, or made visible and measurable, the states of “overweight” and “obesity.”

Fat is an excellent disciplinary sign (Austin, 1999, p. 247), because it is immediately visible to both clinical and lay gaze. Although less permanent than skin color or gender, research has shown that weight is remarkably consistent over time, with most weight lost during a diet returning within five years (Allon, 1982). Weight is difficult to hide, relatively stable over a lifetime, and theoretically subject to change in a way that skin color and gender are not – thus permitting legal discrimination in many states because, after all, ‘fat people could lose weight if they really wanted to.’ Moreover, the fat are punished through social stigmatization, thus encouraging in individuals a desire to become thin.

Social stigmatization of the obese is a relatively recent innovation. Ascetic moral discourses have long condemned the deadly sin of gluttony, but gluttony’s link to obesity was not made explicit, so that thin people could still be labeled gluttonous by moral critics (Schwartz, 1986). The *act* of undisciplined, indulgent overeating was immoral; not the *result* that act might have on one’s weight.

Up until relatively modern times, in the United States as in some other countries, moderate fatness was a sign of affluence, and the stout man or voluptuously curved woman was considered healthy (Lowe, 1995; Seid, 1989; Banner, 1983). To be sure, dieting slowly spread as a social practice through the Grahamites' ascetic practices in the mid-1800s (Schwartz, 1986) and with William Banting's popular "Letter on Corpulence" in 1864 (Seid, 1989, p. 64), but it was still regarded with skepticism by many who equated a rounded body with good health.

However, with the twentieth century's rise of scientific discourse concerning weight loss — in particular, the application of calorie-counting to dieting, popularized by *Diet and Health, With Key to Calories*, a best-selling book in the early 1900s (Austin, 1999) — the idea that weight can and should be controlled by the individual became popularly accepted. At around the same time, after World War I, the slender, androgynous female ideal of the flapper rose to prominence, increasing female interest in dieting (Lowe, 1995; Banner, 1983). The flapper's slim, girlish look reflected the new cultural emphasis on "youthful modernity" (Lowe, 1995, p. 48), freedom and movement (Banner, 1983, p. 279). Since then, permutations of the boyish girl — linear and slim — have persisted in U.S. culture as one type of feminine beauty ideal, perhaps taken to its greatest extreme in the late 1960s and early 1970s with the popularity of supermodel Twiggy, 5'7" and 91 lbs (in Seid, 1989, p. 148).

Thus, slenderness became associated with beauty and other desirable cultural attributes in the early 1900s, and this has persisted. In the spirit of panopticism, U.S. citizens are encouraged to compare themselves to, and model themselves after, ideals of desirability portrayed on the media. As part of this constant self-surveillance, men and

women have become conscious of their weight and have participated in numerous self-disciplinary drug, dietary, surgical, and exercise regimes to control it.

An important question is whether embodied weight can be controlled by processes of self-discipline. The traditional dieter's credo, and widespread social messages, argue that it is. So does the U.S. medical establishment. And, by becoming a focus of attention for public health campaigns, weight has become medicalized.

Medicalization

By establishing norms (of criminality, sanity, sexuality or – in this case – weight), institutions of power can compare individuals to this norm, categorize them as more or less deviant from the norm, and make them visible to processes of examination and evaluation that affect individual freedom. This panoptic, disciplinary power over the individual is not centrally located in the state, but rather spread through a social network of institutions and individuals who create, disseminate, interpret, and apply knowledge. Nevertheless, it is this “more-or-less organised, hierarchical, co-ordinated cluster of relations” (Foucault, 1980, p. 198) that culminates in the system called “the state.” In Anglo-European society, the medical establishment has held a great deal of this sort of power (e.g., Foucault, 1994, 1998). Similarly, resistance to this power is similarly dispersed across society (“there are no relations of power without resistances; the latter are all the more real and effective because they are formed right at the point where relations of power are exercised” [p. 142]).

The medical model reified by U.S. society promotes an ideology in which human problems are categorized and treated as medical problems (Leifer, 2001). Called “medicalization,” this process of categorization and treatment has been analyzed and

critiqued with regard to a number of social issues, including the medicalization of phallogentrism (Tiefer, 1994), psychiatry (Chodoff, 2002), morality (Rimke & Hunt, 2002), compulsive gambling (Rossol, 2001), and attention-deficit disorder diagnoses (Russell & McLaren, 1998). Critics of medicalization argue against putting into medical terms human behaviors that are not good fits with the medical ideology; behaviors that are either not “problems” or that should not be treated with surgery or drugs. By medicalizing what may be more properly considered a behavioral, cultural, or emotional problem – if the term “problem” should be used at all – the medical establishment takes away individuals’ freedom to self-interpret their conditions and to make private choices concerning whether they should understand and treat those conditions, and instead assigns them to a category of the problematic and prescribes a recommended treatment. “From the Foucauldian perspective, power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies” (Lupton, 1997, p. 99).

Public health campaigns can both empower and limit individuals. For example, in an analysis of the Brazilian public health system, Gastaldo (1998) points out that although health education provides citizens with knowledge to make informed choices, it “is also subjugation. Many health education practices involve the imposition of ‘truths’ about health, in which the patient loses control of her or his own body” (pp. 129-130). That is, the categorized, watched, and disciplined body becomes an object, not only to the panoptic government but also to the individual him- or herself, who, operating under the medicalization model, treats his or her body as an object. This can lead to self-destructive behavior. For example, the objectification of the body with regard to weight has been

associated with the activities of female anorexics, who seek to control their objectified bodies in part as a result of culturally dominant messages that women's bodies should be thin to be considered beautiful and/or healthy (e.g., Gremillion, 2002; Eckermann, 1998). Bray & Colebrook (1998) argue that "there are no anorexics, only activities of dietetics, measuring, regulation, and calculation" – that is, activities of scrupulous self-surveillance.

The Surgeon General's recent public health campaign to encourage citizens to lose weight demonstrates the medicalization of fat. However, it is nothing new in U.S. history.²

In the nineteenth century, health reformer Sylvester Graham declared that gluttony was an American problem: "excessive alimentation is the greatest dietetic error in the United States—and probably in the whole civilized world" (in Schwartz, 1986, p. 25). Graham's concern about the U.S. diet led to a widespread (although far from universally accepted) ascetic dietary movement.

"From [the Grahamites'] letters and testimonials comes the first evidence of a coherent group of Americans conscious of exact personal weight, the first evidence of ordinary Americans weighing themselves with some regularity, and the first evidence of adult Americans occasionally weighing their food on a daily basis." (Schwartz, 1986, p. 27). That is, the Grahamites were the first American diet movement, applying self-surveillance and self-discipline to their diet in order to manage their weight. Note, however, that the Grahamites and foreign observers who commented on American physique and eating habits did not equate gluttony with obesity (Schwartz, 1986).

Obesity was first proclaimed to be the United States' number-one health problem in 1951 by Louis I. Dublin, chief statistician and publicist at Metropolitan Life Insurance Company (Schroeder, 1992, p. 117). Dublin developed The Height-Weight-Mortality Ratio Table that became the standard measurement of healthy weight. How to obtain this healthy weight, however, was a matter of some speculation. "The National Academy of Science lowered its caloric recommendations in 1957, again in 1963, and again in 1968" (Seid, 1989, p. 143). It was at this time, during the 1960s, that medical researchers began to eschew the insurance companies' scientifically flawed height-to-weight measurements and began to rely instead on a more specific measurement called Body Mass Index (BMI): weight (kg)/height squared (m²).

This societal emphasis on public health and weight control led to the assumption that anyone who was greatly overweight must be mentally or emotionally disturbed. After all, any sane person would preserve his or her health by staying slim. Obesity was classified as a sign of mental disorder until 1980, when the "Diagnostic and Statistical Manual of Mental Disorder declare[d] that "simple obesity is ... not generally associated with any distinct psychological or behavioral syndrome" (Stimson, 1993).

Although being overweight is widely considered to be unhealthy, research evidence indicates that the lowest mortality rates occurred among those of higher, not lower, weights; other studies indicating that weight causes health problems suffer a number of confounds (see review in Kassirer & Angell, 1998). In response to such research, in 1983, Metropolitan Life adjusted its weight tables upward (Schwarz, 1986, 337). Yet in 1998, new weight guidelines issued by the National Institute of Health's National Heart, Lung and Blood Institute lowered the BMI point of obesity. "Overnight,

29 million more Americans – a total of 55% of the population – can now expect a weight loss lecture when they go for medical care” reported Lyons (1998) after the change.

Thus, shifts in categorizations can lead to a person’s slide in or out of a medical category of concern, regardless of any “real” change in one’s weight. To confuse matters further, the standard medical prescription for weight loss is also subject to debate.

The key to losing weight, dieters are told, is to exercise and diet. To be sure, many products promise weight loss without effort — drugs, surgery, miracle diets, creams, and smoking have all been touted as easy ways to lose weight. All are either fraudulent or pose health risks (Berg, 1999; Berzins, 1999). In contrast, the U.S. National Institute of Health and the Surgeon General’s Office are united in recommending instead that dieters follow a healthy but low-calorie diet and increase their amount of exercise. The question is, how is this to be done? “It is unnecessary to conduct clinical trials to prove the efficacy of an energy-deficit diet ... the practical problem which requires evidence is the poor efficiency of management outside the strict confines of a metabolic one” points out Lean (2000), who then proceeds to review the problems in measuring and studying weight loss.

Simply prescribing diet and exercise as a “cure” for obesity is not useful, as many dieters have found through experience. In 1993, Consumer Reports surveyed 19,000 readers who had participated in diets and found that although the “average dieter lost 10-20% of his or her initial weight,” the dieter “regained almost half of the weight lost 6 months after ending the program and more than two thirds after 2 years” (in Berzins, 1999, pp. 372-373). Studies indicate that weight lost on diets typically returns within five years (Allon, 1982), so dieting is not the prescriptive “cure” for fatness that the medical

model would imply. Instead, those who wish to lose weight and keep it off must subject themselves to a constant regime of self-surveillance and self-discipline in terms of diet and exercise. A study examining successful weight-loss maintainers indicates that the three strategies common to long-term maintenance of weight loss were “(a) eating a diet low in fat and high in carbohydrate, (b) frequent self-monitoring, and (c) regular physical activity” (Wing & Hill, 2001). On the other hand, numerous meta-analyses of research indicate that diet and exercise “are ineffective in producing substantial long-term weight loss for a majority of the participants” (see Miller, 1999; Rothblum, 1999; but c.f. Lean, 2000). Too, the “yo-yo” effect caused by serial dieting and weight gain can have adverse effects on health (Schroeder, 1992; Johnston, 1994; Jutel, 2001; Maine, 2000).

In addition, BMI is correlated with a number of factors out of an individual's control (e.g., metabolism, age, genetics [Faith, Pietrobelli, Nunez & Heo, 1999], ethnicity, and socioeconomic status), and even when a variety of approaches to dieting are tried, overall there is no difference between groups; weight gain still increases with age (Jeffery & French, 1999). Similarly, public-health calls to lose weight do not take into account whether or not an individual takes drugs that may cause weight gain as a side effect, or suffers from an illness or physical handicap that makes extensive exercise impossible.

Given all of this, the medicalization of weight and the goal of the U.S. public health campaign against obesity seems increasingly questionable. And *it is* being questioned: the “healthy weight” movement seeks to eschew the categorization of weight as “healthy” or “unhealthy” and instead to emphasize that individuals can be healthy at any weight (Miller, 1999; Schwartz, 1986; Seid, 1989; Rodin, 1992; Schroeder, 1992;

Garrison, 1993; Johnston, 1994; Erdman, 1995; Klein, 1996; Hesse-Biber, 1996; Wann, 1998; Bernell, 2000; Johnson, 2001).

But the “healthy weight” movement assumes that it is fatness that is at issue. This is incorrect; the perceived health risk of fatness is not the reason fatness is so repellent to so many Americans. The symbolic issue at stake is that fatness is culturally associated with failure. Fat is undesirable; it is stigmatized. Fat implies immorality (gluttony, sloth) and failure to subscribe to social values such as those characterized by the Protestant work ethic. And as the U.S. health establishment increases its pressure on citizens to lose weight, fatness increasingly becomes un-American. The moralization of fatness has made it far more than a simple health issue.

Moralization

In applying Foucault’s framework to the ethics of health promotion, Coveney (1998) points out that public health promotions are examples of what Foucault called “pastoral power,” that is, they promise salvation in terms of health and well-being (p. 465). Coveney points out that “as health becomes a personal and social responsibility through the duty to be well, individuals and communities watch over their own, and each others’ habits” (p. 466). To be healthy is to be good, to be “saved,” and health evangelists keep an eye on the sinners and recidivists in their societal flock.

Rozin (1997) describes how specific forms of moral linkage develop in society. He uses the term "moralization" to describe "the acquisition of moral qualities by objects and activities that were previously morally neutral ... something is in the moral domain if the term *ought* (or *ought not*) applies to it" (p. 380). Moralization tends to occur at the

level of the populace, but is eventually adopted into the discourse of government and scientific institutions (pp. 380-381).

Fatness, initially neutral, has over the last century become increasingly morally weighted. This moralization has occurred hand-in-hand with fat's medicalization. "A ... reason for the medical campaign against obesity may have to do with a tendency to medicalize behavior we do not approve of," write Kassirer and Angell (1998). 'Lifestyle correctness' has become increasingly relevant in the new secular morality, such that those who practice unhealthy behaviors can be socially penalized and subjected to discrimination (Leichter, 1997). In other words, it has become morally acceptable to discriminate against and otherwise stigmatize the fat person, who is, after all, the secular equivalent of a sinner.

Research leaves no doubt that the fat are stigmatized in the United States. For example: Adolescent girls express a wish to be thinner (Tiggemann, Gardiner, Slater, 2000). Fat people are negatively evaluated as weak, lazy, immoral, self-indulgent, dirty, stupid, inferior, and lacking in self-control; and the obese are discriminated against in job interviews and on the job (Weber, 1994; Cossrow, Jeffery & McGuire, 2001; Kristen, 2002). Negative personality attributes and experiences are more likely to be assigned to overweight people (Hiller, 1981). Examination of 29 studies indicates a pattern of consistent weight-based discrimination against overweight employees (Roheling, 1999). Landlords are less likely to rent to obese prospective tenants (Karris, 1977). "Studies have shown that fat students are less likely to go to college and that their parents are less likely to pay for it ... a 1988 study found that students would prefer to marry an

embezzler, a cocaine user, a shoplifter or a blind person rather than an obese person," reported a New York Times article on weight discrimination (Goldberg, 2000).

Fatness, then, symbolizes much more than ill health. The fat person signifies failure on all counts. No wonder, then, that the presence of fat people in the United States is a matter of state concern; the fat symbolically pollute the social system. The fat are "matter out of place," transgressing of the cultural ideal of the thin (and therefore healthy) citizen.

Systems of social pollution are complex and not always clearly set forth in a culture (Douglas, 1966). A survey of U.S. citizens would not show any formal taboo against the overweight; there is no caste system embedded in the United States via religious or social law. In contemporary modern culture, "pollution is a matter of aesthetics, hygiene or etiquette, which only becomes grave in so far as it may create social embarrassment. The sanctions are social sanctions, contempt, ostracism, gossip, perhaps even police action" (Douglas, 1966, p. 74). But the volumes of research indicating widespread discrimination toward and dislike for fat people indicates that there is, indeed, a sense of social taboo about fatness.

The stigmatization of the overweight, in combination with the relative stability of personal weight over time, puts overweight individuals into an unpleasant situation. To avoid social stigmatization, they must lose weight; but losing weight, when successful at all, is usually only temporary. Thus the fat individual is trapped in a neverending struggle to master an intractable and traitorously visible aspect of his or her self. Yet this struggle is the prescribed ritual for regaining social acceptance. "I'm on a diet" ritually reinserts the potentially polluting fat body back into U.S. society. The phrase indicates

acknowledgement of, and obedience to, the U.S. ethic of self-discipline and attention to personal health, and thus of good citizenry.

Conclusion

A growing body of research calls into question much that has been medically assumed about fatness in the United States. The size acceptance movement has called on this research in its attempt to combat anti-fat prejudices. However, proving that fat is not necessarily unhealthy is likely to prove insufficient to counter the social stigma. Anti-fat prejudices in the United States are woven of many threads – ideological, medical, and moral — that operate primarily on the symbolic, rather than empirical, level.

Fatness is a complex cultural symbol that implies far more than lack of good health. As a disciplinary sign, weight works well to signify those aspects of behavior and character that comprise a good (or bad) citizen: observance of the Protestant work ethic, beauty, health, and moral character. Because weight is considered subject to self-disciplinary routines like diet and exercise, the thin person or the dieter is attributed those traits considered desirable in a citizen: a good work ethic and a good character housed within a beautiful and healthy body. In contrast, a fat person signifies characteristics undesirable in a citizen: a poor work ethic and poor character housed within an ugly and unhealthy body. The struggle for the size acceptance movement must be to neutralize the broader cultural meanings of thinness and fatness in the United States.

Notes

1. “Fat” is used here not as a derogative, but in the spirit intended by body-size acceptance movements that promote the term, such as by the National Association to Advance Fat Acceptance. “Overweight” and “obese” both have specific medical meanings, whereas “fat” is a medically neutral, culturally defined term still considered open to rehabilitation by activists.

2. For a Foucauldian analysis of dietetic discourses in early European history, see Turner, 1991.

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