

the world's diet, preventing obesity, and reducing weight stigma."¹⁶¹ Researchers at the Rudd Center, including Kelly Brownell and Rebecca Puhl, have published important studies documenting weight-based stigma, as well as others that frame obesity, including childhood obesity, as a medical problem and public health crisis. For instance, a 2009 Rudd Center report on school food writes, "Childhood obesity, with its many related diseases—among them type 2 diabetes, cardiovascular disease, and asthma—is one of the most serious health concerns facing children today."¹⁶² Indeed, the Rudd Center's consistent promotion of obesity and public health crisis frames has provoked the ire of many fat rights activists, eclipsing the important work the center has produced on weight-related bias and discrimination.

Fat rights activists dismiss the way in which weight-loss surgeons mix fat rights and medical frames as co-optation. The American Society for Metabolic & Bariatric Surgery evokes "widespread negative attitudes that the morbidly obese adult is weak-willed, ugly, awkward, self-indulgent and immoral" under its "Rationale for the Surgical Treatment of Morbid Obesity."¹⁶³ While the problem identified (weight-based discrimination) draws on a fat rights frame, the solution (surgery-induced weight loss) draws on a medical frame. If this ploy angers fat rights activists, it is because it serves to supplant political resistance to injustice with medical efforts to change individual victims of oppression. Similarly, the children's book *Maggie Goes on a Diet*, discussed in the introduction, resolves the problem of Maggie being teased about her weight with the solution of Maggie's weight loss. In the same spirit, "discrimination" is listed as one of the "hazards of obesity" in most current reviews and consensus statements on the issue, including the "Healthy People 2010" report.¹⁶⁴

Whether the perceived problem of obesity can or should be solved with dieting, surgery, or corporate regulation or some other means speaks to the issue of who or what is to blame and what, if anything, should be done. This, too, turns out to be best understood as encounters between different ways of understanding fatness. It is to these *blame* frames that we now turn.

from Abigail Saguy, *What's Wrong with Fat?*

CHAPTER 3



Blame Frames

In the previous chapter, we saw how the very term *obesity* marks fatness as a medical problem and public health crisis, as opposed to a primarily aesthetic or moral issue. We saw how some people reject the medical and public health crisis frames (and associated terminology), insisting that one can be fat and healthy, that fatness is beautiful, or that discrimination against fat people is wrong. As we saw, these different problem frames do not have equal standing in the contemporary United States. That is, the idea that fatness represents a medical problem and a public health crisis is largely taken for granted.

Among those who take the public health crisis framing for granted, there are nonetheless lively debates about who or what is to blame for the alleged crisis. An article on an online parenting forum, entitled "Obesity Epidemic in America: Who Is to Blame?," provides an illustration of this. The article considers who and what is to blame for childhood obesity without ever questioning whether "childhood obesity" should be considered a problem in the first place.¹ The author and most commentators in the accompanying forum overwhelmingly emphasize personal responsibility. According to the article's author, "just because [fast food companies] make it, I don't have to eat it," a sentiment with which the overwhelming majority of the 100 forum commentators agree.² A handful of respondents, however, suggest that the food industry, cultural factors like eating on the run and a heavy reliance on automobiles, or biological/genetic factors also play a role. "I don't think people are totally responsible for bad foods that they eat," opines one commentator, arguing that food labels are often incomprehensible and that "you don't have many options when you go out to eat or buy packaged meals to cook at home." Another notes that "healthy food is

EXPENSIVE,” while “junk food” is cheap, convenient, and tasty, and that this severely limits the choices of the working poor. A couple of commentators implicate yo-yo dieting in weight gain, and one notes that certain fetal environments can predispose people toward obesity as adults. I refer to these different ways of assigning blame for obesity as *blame frames*.

As anthropologist Gayle Rubin has noted of homosexuality, “The search for a cause is a search for something that could change so that these ‘problematic’ [phenomena] would simply not occur.”³ In other words, discussions about what causes homosexuality or obesity are driven by the assumption that it would be better if these phenomena did not exist at all. Stated differently, heated debates over the relative validity of various blame frames tend to reinforce the understanding of fatness as a medical problem and/or public health crisis. Some fat rights activists weigh in on these debates, asserting that genetic and biological factors largely determine body size. They hope this will help counter the entrenched idea that fatness is a product of sloth and gluttony, while establishing it as a legitimate basis for making rights claims. However, other fat acceptance activists are loath to engage in these debates at all precisely because they recognize Rubin’s insight that the search for a cause implies that the phenomenon itself is undesirable.⁴ Yet particular blame frames have their own distinct logic that has political and social implications, making them important objects of study.

Drawing on in-depth interviews with leading obesity researchers and fat rights activists, qualitative and quantitative analyses of hundreds of U.S. and French news media articles, and secondary research, this chapter shows that a personal responsibility frame largely dominates discussions of obesity in the United States, although a sociocultural frame is gaining traction. By contrast, and despite the rise of genetic and biological explanations in other areas of life, biological explanations of obesity are much less common.⁵ Like the problem frames discussed in the previous chapter, these three blame frames, including personal responsibility, sociocultural, and biology frames, are ideal types.⁶ They are not exhaustive, in that one could identify additional blame frames and subframes.⁷ In actual debates, people often draw on more than one of these frames. Nonetheless, these three frames capture many of the major cleavages in contemporary debates.

The dominance of a personal responsibility framing of obesity is not random. Powerful economic and political interests, including the food industry and politically conservative U.S. politicians, have promoted a personal responsibility frame. This frame also taps into deep-seated U.S. political and cultural traditions of self-reliance and the increasingly

powerful political-economic ideology of neoliberalism, in which costs are shifted from the state to individuals and families.⁸ Left-leaning academics and policymakers have increasingly pushed a sociocultural frame, which draws on a competing political tradition of collective responsibility and social justice.⁹ Biologists and geneticists, as well as some fat acceptance activists, have insisted that genetics and other biological factors explain the bulk of variation in individual body weight. However, this line of argument, which has not been pushed by powerful economic or political interests, has been dwarfed by the emphasis on individual responsibility and, to a lesser extent, sociocultural factors.

This may not seem to be especially surprising or unique to the topic of fatness. After all, previous research has shown that the news media typically individualize social issues, treating them as morality tales, rather than focusing on impersonal and complicated social factors.¹⁰ Yet, as we saw in the previous chapter, fatness has carried a particularly negative moral valence in the United States for some time. To examine the extent to which an emphasis on personal responsibility and blame is greater for fatness than for other issues, I conducted systematic comparative analysis of U.S. news reporting on obesity with U.S. news reporting on the “thinness-oriented” eating disorders anorexia and bulimia. While fatness is more common among the American poor and minorities, anorexia and bulimia are diagnosed most often in middle-class white women and girls. As I show in this chapter, U.S. news reports are more prone to blame individuals for being overweight or obese than for having anorexia or bulimia. In other words, it is not simply that the U.S. news media treat all issues in terms of individual responsibility. Rather, they are more likely to treat fatness, than “thinness-oriented” eating disorders, as an issue of personal responsibility and moral failing.¹¹

To capture the extent to which this is a specifically U.S. phenomenon, I conducted a second comparative analysis, this time between obesity news reporting in the United States and obesity news reporting in France. I found that the tendency to frame overweight and obesity as issues of personal responsibility is indeed greater in the United States, which has entrenched political and cultural traditions of personal responsibility. In France, where there are stronger traditions of social solidarity and collective responsibility, news media reports emphasize sociocultural factors to a far greater extent than do the U.S. news media.¹² Before turning to the news media analysis from which these three frames emerged, let us begin by sketching out the contours of each of these three blame frames. These are also summarized in table 3.1.

Table 3.1. BLAME FRAMES

	Personal Responsibility	Sociocultural	Biological
Blame	Bad personal choices	Toxic food and exercise environment, poverty, national and subcultural attitudes and practices	Biological or genetic factors
Solution	Getting individual people to make better personal choices	Change the food and exercise environment, change attitudes and practices within affected groups	Identify biological and/or genetic factors responsible for obesity
Master frame	Personal responsibility	Environmental justice	Biology/genetics
Analogy	Smoking	Pollution	Height
Proponents	Food industry, right-wing political actors	Left-leaning academics and policymakers	Biologists, geneticists, fat rights activists

A PERSONAL RESPONSIBILITY FRAME

A *personal responsibility frame* assumes that bad individual choices are to blame for obesity and that people need to learn to take more personal responsibility for their weight. Like the immorality frame discussed in the previous chapter, the personal responsibility frame focuses on individual failings. However, the immorality frame sees fatness as merely a symptom of an underlying problem of sloth and gluttony, whereas a personal responsibility frame portrays sloth and gluttony as the cause of the *medical* and *public health crisis* of obesity, as in the following news excerpt: "Obesity is largely the responsibility of individuals' choices concerning diet and exercise. Americans are becoming fatter because they are becoming more slothful and self-indulgent."¹³ Every reader of this book is familiar with this line of argument and in fact could probably recite it with their eyes closed, as it has a ubiquitous and repetitive presence in newspapers, magazines, and public health messages. Its omnipresence in the media landscape is not accidental; it forms the core of the rhetorical strategies adopted by many actors who have stakes in promoting personal responsibility in one form or another.

According to a personal responsibility frame, changing individual behavior is the key to reversing the alleged obesity epidemic. Thus, Republican-appointed Secretary of Health and Human Services Tommy Thompson launched a 2004 government-sponsored advertisement

campaign as part of a larger effort of his department to "spread the gospel of personal responsibility."¹⁴ This ad campaign told viewers they could "lose midsection love handles and double chins one step at a time if they eat less and exercise more."¹⁵ Such approaches are characterized by an emphasis on individual behavioral changes as the key to weight loss: "Skate to work instead of driving. Fetch the newspaper yourself. Eat off smaller plates. Take the stairs instead of the escalator. Get a dog and walk it. Eat half your dessert and more celery sticks."¹⁶

As is shown in table 3.1, the personal responsibility frame for obesity draws on a master frame of personal responsibility that, in turn, is linked to deeply seated U.S. beliefs in the value of self-reliance and suspicion of government intervention in the "private" sphere.¹⁷ A personal responsibility frame is consistent with the tenets of neoliberalism, which has guided policy efforts in the United States, United Kingdom, and elsewhere to privatize public resources and spaces, to minimize labor costs by defanging unions; to reduce public services; to remove health, labor, and environmental protections on the grounds that they are bad for business; and to lower taxes on the wealthy.¹⁸ "Do you really want the health police shouting 'Drop the chalupa!' in your kitchen?" a typical U.S. news article asks its readers, warning that "Americans will lose more than pounds if we give up responsibility for our own choices, and for the consequences that ensue."¹⁹

Supporters of a personal responsibility frame liken obesity to smoking, a behavior that is a recognized risk factor for lung cancer. This is an extremely common rhetorical strategy among the leading obesity researchers I interviewed. For instance, Theodore VanItallie drew on this analogy when asked if it was discriminatory to charge people who would be categorized as obese a higher health or life insurance premium: "I mean the same thing is true of smokers. Why should I have to pay a high life insurance [premium] because of all the deaths that are caused by cigarette smoking?" Comparing obesity to smoking implies that weight is a behavior rather than a trait that is largely beyond personal control. A highly cited 2004 study published in the *Journal of the American Medical Association (JAMA)* relied on this same logic when adopting a methodological approach that had been used to calculate the annual deaths due to smoking to compute "annual deaths due to overweight." The authors assumed that calculating the number of deaths associated with overweight and obesity would allow them to "assess the impact of poor diet and physical inactivity on mortality," implying that overweight is poor diet and physical inactivity.²⁰ Indeed, tobacco research, policymaking, and lawsuits against tobacco companies have provided a model for much research and policymaking on obesity.

Given this, it is not surprising that doctors, obesity researchers, and official health reports typically evoke individual responsibility. A survey of 89 general practitioners (GPs) with medical practices throughout the United Kingdom showed that, on average, GPs considered their patients' tendency to eat too much, to eat the wrong foods, or not to get enough exercise as greater contributors to their obesity than genetics, glandular/hormonal factors, or metabolism.²¹ Another study of 255 British health care professionals arrived at a similar conclusion, finding that providers believed that physical inactivity, overeating, food addiction, and personality characteristics were the most important causes of overweight.²² A study of 600 general practitioners in France found that 30 percent considered overweight and obese patients to be lazier and more self-indulgent than normal-weight people, and 60 percent considered lack of motivation to be the most common problem in treating overweight and obesity.²³ In another study of 620 primary care physicians in the United States, more than 50 percent reported viewing obese patients as awkward, unattractive, ugly, or noncompliant. One-third of the sample further characterized these patients as weak-willed, sloppy, and lazy.²⁴ Similar patterns have been found in Australia and Israel.²⁵ Studies have shown that nurses also assume that obesity is the product of their patients' bad personal choices.²⁶

Walter Willett, a Harvard epidemiologist who is often quoted in the news media and who is coinvestigator of the Nurses' Health Study, a longitudinal health study of more than 100,000 nurses, says in an interview with me that he's "yet to be convinced that there are very many people that if they are really serious about controlling their weight, can't get their weight down under a BMI of 25." Similarly, JoAnn Manson, also a Harvard epidemiologist and coinvestigator of the Nurse's Health Study, says in an interview with me that people "know if they were to get up off the couch and do some more walking... it would be helpful to them, but they just don't feel like it." Every day, she says, they make a choice to buy "the Big Mac and French fries instead of a salad or roasted chicken." The 2000 World Health Organization report similarly describes obesity as "largely preventable through lifestyle changes."²⁷

When asked to comment on studies showing that weight-loss diets have extremely low success rates over the long term, these and other obesity researchers emphasize that even a 5 to 25 percent success rate means that weight loss is possible, even if it is difficult.²⁸ A group of obesity researchers have even established a "National Weight Control Registry" to follow "over 5000 people who have lost significant amounts of weight and kept it off for long periods of time," in order to show that permanent

weight loss is possible and to identify why some people are successful at long-term weight loss.²⁹

The Republican Party has championed personal responsibility as a means of reducing public expenses. Thus, in discussing the HealthierUS program, which focused on providing information and empowering individuals to take responsibility for their health, President George W. Bush discussed the importance of individual people "making healthy choices [in order to] do the right thing for our future."³⁰ Republican Senator Tom DeLay said in 2004: "If you eat a lot of food and you get sick, it's your responsibility, and not the restaurant's."³¹ Democratic First Lady Michelle Obama has also emphasized personal—as well as parental and community—responsibility in her *Let's Move* campaign to combat childhood obesity.

The Center for Consumer Freedom, a food and restaurant industry advocacy group, has evoked "personal responsibility" and "consumer choice" in an attempt to discredit efforts to regulate the food industry.³² It has published a series of advertisements poking fun of lawsuits targeting the food industry, initiatives to regulate food distribution, and food labeling. An advertisement that ran in 2004 features a close-up photo on a white man's protruding belly, on which black letters ask: "Did you hear the one about the fat guy suing the restaurants?" At the bottom of the ad it says: "It's no joke. He claims the food was too cheap so he ate too much!" Below that, it says: "Learn more about the erosion of personal responsibility and common sense. Go to: ConsumerFreedom.com."³³ Another advertisement that ran as early as August 2002 and as recently as September 30, 2009, told readers that the New York Department of Health's campaign against soda is saying to consumers: "You are too stupid... to make good personal decisions about foods and beverages." After asking if "food cops and politicians" have "gone too far" in "attacking food and soda choices they don't like," the ad says, "It's your food. It's your drink. It's your freedom."³⁴

SOCIOCULTURAL FRAME

A sociocultural frame represents one reaction to the personal responsibility frame, in which people's choices are viewed as constrained by social factors, including the food industry, the urban environment, poverty, or cultural factors. A growing number of activists, researchers, writers, and filmmakers, including Michael Pollan, Eric Schlosser, Marion Nestle, Greg Critser, and Morgan Spurlock, and a burgeoning alternative food movement attribute increasing obesity rates to American food production, distribution, and

economic policies.³⁵ At its most basic, the argument is that Americans are fat because the United States produces too much food. A corollary of this argument is that U.S. policies subsidize unhealthy higher-calorie food (e.g., corn, soy, sugar, wheat) relative to lower-calorie foods (e.g., fresh fruits and vegetables). A further variation of this argument focuses on how industrial capitalists have replaced ingredients with cheaper and more fattening industrial substitutes, such as high-fructose corn syrup in place of cane or beet sugar, to maximize profits. Some critics blame the country's growing waistlines on the advent of "supersizing" and "value meals," in which customers are charged a small additional amount for receiving a much larger portion.³⁶ Others point to the power of food advertising to induce desire for unhealthy foods, especially in children.³⁷ Nutritionist Marion Nestle has powerfully argued that the food and agriculture lobbies, particularly meat and dairy interests, have hijacked government regulation of food, to the detriment of American health and waistlines.³⁸ Some researchers and policymakers refer to these various factors as an *obesogenic* or *toxic food* and *exercise environment*.³⁹ Rather than portray consumers as freely making choices, this frame stresses induced demand.

Less common is an argument that environmental toxins, or *obesogens*, may be the cause of increases in population weight. This perspective emphasizes the interaction of social and biological factors and thus also draws on the biological frame, discussed below. According to this theory, toxins are thought to be found not only in food additives but also in pesticides, dyes, perfumes, cosmetics, medicines, plastics, fire retardants, solvents, and so on. It is thought that the human organism may produce additional body fat as a way to store industrial toxins away from vital organs.⁴⁰ Even exposure to small amounts of these toxins is thought to have large and irreversible effects if exposure happens at certain critical times, and genetic variability is thought to make some people especially susceptible. Moreover, it is thought that there can sometimes be a huge, even intergenerational, lag time between exposure to these chemicals and a response in terms of weight gain. According to this theory, the increases in population weight observed in the United States in the 1980s and 1990s could be partially a delayed effect of exposure to endocrine-disrupting chemicals in the United States during the postwar period.⁴¹

The well-funded and influential International Obesity Task Force (IOTF) at times has, although not exclusively, evoked a sociocultural frame, as in its position paper "Waiting for a Green Light for Health? Europe at the Crossroads for Diet and Exercise," which cites the need to protect children "from the 'aggressive' advertising and marketing techniques that sustain the pressure to adopt unhealthy patterns of consumption and activity."⁴²

News reports often acknowledge how "decisions about whether to smoke, how much to drink, how much and what kinds of food to consume, and activities in which to engage are the result of strong cultural and commercial signals,"⁴³ thereby blending a focus on personal responsibility with a recognition of sociocultural constraints. Discussions of sociocultural factors often emphasize the specific role played by the food industry, as in the following news media excerpt: "Experts cite various causes for the obesity epidemic, ranging from super-size portions at fast-food restaurants to lack of physical activity."⁴⁴ In that these discussions identify the food industry as a "demon industry," this may help mobilize social support for government intervention.⁴⁵ Specifically, this line of argument provides a justification for greater government regulation of food production and distribution, as when a news article discusses sociocultural factors in the context of calling for the removal of soft drinks from schools, restricting food ads aimed at children, and mandatory calorie labels at restaurants.⁴⁶

By stressing how poor families are especially vulnerable to this toxic food environment, some commentators tap into concerns about social justice. Thus, economists point out that the high cost of fresh fruits and vegetables puts these out of reach for poorer households, while people living in low-income neighborhoods in the United States have limited access to facilities for physical activity.⁴⁷ Some news reports echo this concern, as in the following, quoting the coordinator of a food pantry who serves many poor families on Milwaukee's south side: "It's hard to eat healthy when you don't have the gas on or you're sleeping on the floor and you don't have a refrigerator."⁴⁸ Other scholars have argued that gender roles related to food acquisition, food preparation, and child-rearing mean that the toxic food and exercise environment has the greatest impact on women, and specifically on poor women and women of color.⁴⁹ A few scholars point out that the poor and people of color, including agricultural workers, are more exposed to chemical toxins that may be to blame for increased body mass at the population level.⁵⁰

Together these arguments draw upon a master frame of environmental justice, which seeks to redress inequitable burdens of pollution, crime, and other hardships. Environmental justice social movements have been especially critical of how U.S. environmental pollution and industrial facilities are disproportionately located in poor neighborhoods where there is a high concentration of ethnic minorities.⁵¹ Those who use an environmental justice frame treat obesity as analogous to pollution, which harms people without their consent and has a disproportionately negative impact on the poor and minorities. The analogy works best in the case of environmental

pollutants, as people have no choice but to ingest these.⁵² It is harder to argue that “less healthful eating and physical activity patterns in some demographic groups” are “substantially due to social and physical environmental differences,” in that people conceivably can make better or worse food choices even in the face of strong environmental constraints.⁵³

Some emphasize that U.S. cultural practices, including eating on the run and multitasking, contribute to obesity. These discussions are compatible with, and often blend into, discussions of personal responsibility, as in the following 2003 news article: “We buy our kids Oreos and Nintendos, eliminate gym classes to improve math scores, sell pizza at school fund-raisers, use the TV as a baby sitter and drive kids everywhere in minivans equipped with cup trays to hold milkshakes and Slurpees. As a society, we have let kids down,” said Dr. Robert Bonow of Northwestern Memorial Hospital.⁵⁴ The use of the collective *we* and reference to *society* shifts some blame away from individuals on to the collective. It suggests that changing broader cultural values and practices may be necessary to change individual behavior. However, changing individual behavior remains a goal.

Differences in subcultural attitudes about body size and eating are also evoked to explain higher rates of “obesity” among African American women and Mexican American women and men. Specifically, an alleged preference for bigger female bodies among African Americans and a taste for fried food among both African Americans and Mexican Americans are often cited as reasons for higher rates of obesity in these groups. While potentially shifting some blame away from individuals, this argument risks treating minority cultural practices and values as themselves pathological.

BIOLOGY FRAME

According to a biology frame, obesity is highly heritable, determined by genetic and other biological factors. For instance, molecular geneticist and MD Jeffrey Friedman likens body weight to height, arguing that the former is as tightly regulated by genetic factors as the latter. He concedes that people can often lose 10 pounds or so but insists that it is exceedingly difficult to lose large amounts of weight and keep it off. In other words, each person has a “set point,” or a certain weight range, to which his or her body naturally returns. While people can diet and lose weight temporarily, their weight inevitably drifts back up to where it started. This theory is consistent with studies of weight-loss programs, which show that people often lose a lot of weight at first but typically regain it within a year or two and, at best, are able to sustain a 5 to 10 percent loss. “In trying to lose

weight,” Friedman says, “the obese are fighting a difficult battle. It is a battle against biology, a battle that only the intrepid take on and one in which only a few prevail.”⁵⁵ Discussing Friedman’s work, *New York Times* journalist Gina Kolata concludes, “Free will, when it comes to eating, is an illusion.”⁵⁶ Studies showing that identical twins reared apart have extremely similar BMIs and that identical twins are twice as likely as fraternal twins to have the same degree of overweight lend support for a biological frame.⁵⁷

A common objection to such arguments is that our genes have not changed in the past 30 years and therefore cannot explain the current “obesity epidemic.” To this, Friedman argues that the genes that make people fat need an environment in which food is cheap and plentiful, just as the genes that make people tall need an environment in which people are well nourished. He points out that Americans today are at least three inches taller on average than they were in the Civil War era because, unlike in earlier periods, American children today almost always get enough food for their genes to direct them to grow to their maximum height. Friedman argues that the situation is likely to be the same with weight. Today, children and adults in the United States can easily get enough food for their genes to direct them to grow as fat as they can be, a point of view widely popularized in Gina Kolata’s 2008 book.⁵⁸ He and others further point to the fact that not everyone has gotten fat in the contemporary environment as evidence that genetics or other factors mediate the effect of environment. Some see the leveling of obesity rates in the first decade of the twenty-first century as evidence that those who have the genetic tendency to get fat in the contemporary Western environment already have.⁵⁹

Friedman is credited with the discovery in 1994 of leptin, a hormone made by fat tissue that plays a key role in regulating weight. The idea is that, just as a thermostat monitors heat in a home, producing more heat when the house is cold and less when it is warm, so a fat thermostat in the brain monitors leptin levels. High leptin levels signal high amounts of body fat and reduce appetite, while low leptin levels signal insufficient body fat and increase appetite. Some believe that fat people might have the equivalent of a thermostat set too high or that is malfunctioning so that it takes more leptin than normal for the brain to respond.⁶⁰ In extreme cases in which children have no leptin, they are insatiable no matter how much they eat. One girl who had no leptin weighed 190 pounds when she was just eight years old; her parents had put a lock on the pantry to stop her constant eating. At nine years old, she began receiving injections of leptin, and the results were dramatic. After a week of injections, she ate no more than her siblings and at the same speed, rather than quickly devouring her food as

before. Her weight plummeted. Other children and adults with no leptin had similar responses to leptin injections.⁶¹

When leptin was initially discovered, many thought that it provided the key to a miracle weight-loss drug, and the pharmaceutical company Amgen paid Rockefeller University, where Friedman was employed, \$20 million for the rights to the leptin gene. Amgen agreed to pay many times that amount if the hormone proved successful in producing weight loss. Yet a preliminary study in 1997 produced disappointing effects. It turned out that very few fat people actually lack leptin.⁶² More research is ongoing that is examining the precise role leptin and other genes play in determining body weight and appetite.⁶³ This points to the way in which a biological frame invites pharmaceutical and surgical solutions.

If highly effective weight-loss drugs were available, one would expect them to be marketed as a solution to the *biological* or *genetic* problem of obesity. Yet available or recently available weight-loss drugs only produce very small amounts of weight loss, typically by reducing appetite, as in the case of Meridia (Sibutramine, withdrawn from the market in October 2010), or by blocking the absorption of fat, as in the case of Xenical (Orlistat). Moreover, both of these drugs are meant to be used in combination with a weight-loss diet and physical activity, thus still requiring people to make behavioral changes. Similarly, weight-loss surgery, in which part of the stomach is stapled or amputated, is best understood as facilitating dieting, by reducing appetite and making it physically uncomfortable (even gastrointestinally excruciating) to overeat, rather than surgically correcting a faulty stomach or metabolism. Indeed, a surgically altered stomach is less effective in absorbing nutrients, one of its primary functions.⁶⁴ Thus, while we might expect pharmaceutical companies and weight-loss surgeons to promote a biological framing of obesity, this potential has not yet been realized.

Nongenetic biological factors have also been shown to shape body weight. For instance, the Dutch Famine Study is often cited as evidence that prenatal environment influences body size. The Dutch famine of the winter of 1944 to 1945 was created when a German blockade cut off food and fuel shipments from farm areas to the densely populated western provinces. During what was called Hungerwinter, rations were as low as 400 to 800 calories a day, or less than a quarter of the recommended adult caloric intake.⁶⁵ There have been scores of studies examining the effects of prenatal malnutrition and calorie deprivation on the babies born soon after the Hungerwinter. For example, a 1976 historical cohort study, of 300,000 19-year-old men examined at military induction, showed that exposure to the famine as a fetus during the first half of pregnancy resulted

in significantly higher rates of obesity.⁶⁶ A 1999 study among 50-year-old men and women found that maternal malnutrition during early gestation was associated with higher BMI and waist circumference in the 50-year-old women but not in the men. The authors argued that these findings suggest that “perturbations of central endocrine regulatory systems established in early gestation may contribute to the development of abdominal obesity in later life.”⁶⁷ This type of research is at the intersections of biology and social factors and is used to demonstrate the limits of individual choices.

Some scientists have argued that certain viruses may result in weight gain, which constitutes another sort of biological argument that, if it were to gain traction, could potentially shift blame away from individuals as well as spur research into prevention and treatment of the relevant viruses.⁶⁸ Yet, in that viruses are contagious, it could also worsen fear and stigma of fat people as sources of contagion. For instance, in a 2012 Newsy report on a study showing obesity and liver disease were contagious in mice, the news reporter said that this “seems potentiality pretty scary. Just by being near someone who’s overweight, you could be too,” as the camera showed images of “headless fatties.”⁶⁹ Others have argued that certain pharmaceutical drugs, including many of those prescribed for mental illness, may be responsible for some proportion of the U.S. (and world) population becoming “obese.”⁷⁰ This is another sort of biological argument that complicates accounts solely stressing individual factors.

Fat acceptance activists often emphasize the heritability of body size in order to counter stereotypes of fat people as lazy gluttons and to argue that fatness is like other protected legal categories, including race and sex category. For instance, one member of the National Association to Advance Fat Acceptance (NAAFA), a 57-year-old nurse, says she tells women in NAAFA workshops that they should not be blamed for their weight because they “were born to have this tendency.” She tells them: “Society wants to blame it on you. It’s not your fault. If it was your fault then everybody that overate would be big, and that’s not true because you see tons of people who eat constantly and remain thin. It’s their genetics and their metabolism, and you look at them scarfing down stuff all the time and they never seem to gain an ounce, whereas you have to just smell the fumes and you put on ten pounds.” By analogizing fatness to disability, race, sex, and height, fat rights activists shore up the biology frame.

It is not surprising that fat rights activists would pursue a strategy of insisting that fatness is an ascribed characteristic, like race or (many cases of) disability, rather than a behavior, like smoking. With the important exception of religion, U.S. law grants rights to people based on being

members of “protected classes,” which at the federal level include ascribed characteristics such as race, sex, and national origin. Since the civil rights movement, several identity groups—including women, gays, and the disabled—have “bridged,” or likened, claims of discrimination against their group onto more established forms of discrimination in an attempt to gain legitimacy.⁷¹ Thus, the term *sexism* was chosen to evoke the preexisting term *racism*, thereby conveying the similarity of these forms of discrimination. Claiming difference as innate is a common political tactic in the U.S. legal context, in which race provides the starting point for theorizing other forms of inequality.⁷² The gay rights movement has similarly latched on to arguments about the genetic basis of sexual orientation to argue that sexual orientation deserves the same group protections as race or gender.

Yet a biology frame, on its own, does not challenge the underlying assumption that fatness is a problem. In fact, by participating in a discussion about possible causes of fatness, fat rights activists may inadvertently shore up the idea that fatness is a problem. Communications scholar Kathleen LeBesco argues that “allowing oneself to engage” in debates about the extent to which body size is under personal control “drains pro-fatness rhetoric of its power.”⁷³ By painting fat people as the victims of biology (or any other external force), LeBesco argues that one also “paints them as incompetent and powerless.”⁷⁴ Moreover, this line of argument implicitly suggests that only those who have not chosen their condition deserve protection from discrimination.

DOMINANCE OF A PERSONAL RESPONSIBILITY FRAME

A biology framing of obesity remains relatively marginal. Moreover, when invoked, it tends to be subordinated to a narrative of personal responsibility. If you tune into a television show or pick up a newspaper article on obesity, you will most likely be told that body size is under personal control. If you watch the popular reality show *Biggest Loser Couples*, you may hear a doctor ask a 20-year-old male contestant: “You have so much to live for. What are you doing?” to which the shamed contestant responds: “Throwing it away.” You may hear another contestant confess to this doctor, after being told that his death is imminent due to his weight: “I realize how selfish I’ve been,” to which the doctor replies: “It’s in your control.” Later in the season, you may hear a muscularly toned and Hollywood-looking physical trainer explain to viewers: “To get in shape and to change your life doesn’t come free; you’ve got to earn it. And if they want it bad enough, if they can change themselves mentally and emotionally right

here, the rest will follow,” a theme with which contestants echo: “You’ve got to make it a battle to make yourself better.”⁷⁵ Illustration 3.1 provides a visual rendition of how health authorities blame individual people for weighing more than what they deem desirable.

While reality shows are especially sensationalist, the print media also heap blame on individuals, as in the following 2003 news article in the *Boston Globe*: “The two prime culprits for this expanding obesity are inactivity and overeating, and TV watching is linked to both of them. This is an important take-home lesson, now that school’s ending and children can finally relax. Too often they relax—just like adults—by spending lazy hours in front of the TV, which can be hazardous to both age groups’ health and well-being.”⁷⁶ Mentioning television watching as an example of sedentary activity simplifies the narrative of sedentary lifestyle as immoral, which may explain why television is the example of choice when it comes to discussing inactivity. I have yet to read an article about children becoming



Illustration 3.1:
Finger pointing. Illustration by Ian Patrick

obese because they are spending too much time reading, doing puzzles, or playing board games. While these activities are sedentary, they are seen as beneficial in other ways for child development, muddying the simple narrative of obesity as the product of bad individual choices or behavior.

Viewed through a personal responsibility lens, fat people are easily seen as self-indulgent, lazy, and/or ignorant, as in the description of this family: "Bruce and Lisa Smith never skimped much on food. Chips, fried chicken, canned fruit, sodas—they ate as much as they wanted, whenever they wanted. Exercise? Pretty much nonexistent, unless you count working the TV remote or the computer mouse. 'We were out of control,' says Bruce, 42. And so was their son, Jarvae, who is 5 feet 4 and weighs 176 pounds."⁷⁷ Few readers would consider working a TV remote or a computer mouse physical exercise. Rather, sarcasm is employed to convey disdain and contempt for the Smiths, who are portrayed as lazy and irresponsible individuals and parents. The press commonly blames childhood obesity on parents: "The problem [of childhood obesity] is so grave that some researchers predict that the life expectancy of today's children could shrink by as much as five years. The key to reversing the trend? Parents."⁷⁸ The fix is presented as a matter of common sense: "One simple way to get the entire family fit is to turn off the television and shut down the computer."⁷⁹ By describing solutions as "simple," those who are fat or have fat children are portrayed as stupid, ignorant, or willfully disobedient.

Food-industry lobbyists emphasize personal responsibility as a way of deflecting attacks on the food industry, as when the executive vice president for government relations at the Association of National Advertisers, an organization based in Washington, DC, whose members include food companies, says: "I don't know of any little child who jumps in the car and drives to a supermarket and buys their own food."⁸⁰ Rather, it "is the confounding truth that parents—whether distracted, oblivious or both—are ultimately to blame for what their children eat."⁸¹ According to a letter to the editor in *Newsweek*, adults "who permit their children to eat as they please (meaning anything and everything)" must be either "supremely ignorant or genuinely abusive."⁸²

Even news media discussions of weight-loss drugs tend to highlight their ineffectiveness, thus serving to further emphasize the importance of behavior modification, as in this article that quotes a professor of nutrition discussing weight-loss drugs as an elusive "magic bullet" that distracts people from making necessary lifestyle changes: "Fewer people are doing what they know they should do. Instead, everybody just wants a magic bullet."⁸³ Articles quote recognized experts, in this case director of the Center for Science in the Public Interest, Michael Jacobson, to give authority to the

assertion that: "It may be that we enjoy our slothful, gluttonous lifestyle so much that we'll just remain overweight until we come up with a drug to cure it."⁸⁴ While one might assume that discussions of weight-loss surgery would frame obesity as a biomedical problem, news media discussions of surgical intervention also tend to stress personal responsibility, evoking patients who have surgery because they "could not do it on [their] own," or quoting leading obesity researchers as saying that "it would be sad to think that people feel they can eat poorly, be inactive, and when they get overweight, have it fixed by surgery," or a surgeon saying that "20 percent to 30 percent of people who get the lap band fail to lose more than 50 percent of their excess weight" because they "cheat by eating certain types of food that limit their weight loss or cause them to gain back weight."⁸⁵

The hold of a personal responsibility frame is so powerful that even health at every size advocates sometimes emphasize it for good nutrition and physical activity. For instance, Glenn Gaesser strongly urges readers to improve their personal lifestyles by getting at least 140 minutes of exercise (including yard work and playing actively with children) each week and by eating a diet low in fat and sugar and high in complex carbohydrates. Gaesser argues that "obesity may not be a direct cause of disease, but may serve as an imprecise marker for an imprudent lifestyle," suggesting that those who do not exercise or eat poorly are irresponsible or careless.⁸⁶ In the following passage from his book, he ironically explains how individuals can choose to create abdominal fat, associated with heart disease:

Exercise as little as possible, eat fiber-depleted foods loaded with fat (especially saturated fat) and refined sugar, drink a lot of alcohol, smoke cigarettes, and subject yourself to as much stress as possible. . . . But if you can't indulge in every one of these behaviors, one or more will still be effective—especially if you choose physical inactivity and fat and sugar-laden food, the behaviors of choice for millions of Americans.⁸⁷

By Gaesser's account, even exposure to stress is a choice, as opposed to a product of social factors (such as poverty or limited job opportunities) beyond individual control.

QUANTIFYING BLAME FRAMES

My claim that a personal responsibility frame dominates news coverage of obesity is supported by several empirical studies and by systematic news media analyses I have conducted with several of my students.⁸⁸ As part of

these analyses, my students and I read and coded a random sample of 262 news articles on overweight and obesity published in *The New York Times* or *Newsweek* between 1995 and 2005. *The New York Times* has among the highest national circulation of any newspaper and is widely regarded as the newspaper of record, giving it influence over opinion leaders and policy-makers and shaping reporting in other news media.⁸⁹ *The New York Times* has a relatively high quality of reporting, biasing the sample toward more sophisticated reporting. I included articles from *Newsweek* to add longer articles to the sample, as news magazines typically publish longer articles than newspapers. Both publications have the advantage of being available in the LexisNexis database for the entire 1995 to 2005 time period. This sample misses some of the range of the news media, including women's magazines, the ethnic press, or political presses.⁹⁰ Specifically, given that the majority of readers of these papers are from the middle class and are white, these publications may be more likely, than ethnic presses or presses catering to a more working-class audience, to uncritically reproduce negative stereotypes regarding heavier people, the poor, and ethnic minorities. Nonetheless, given their cultural influence, they are important to study.⁹¹

Before looking at the relative discussion of different blame frames, let us examine the prevalence of different problem frames, discussed in the previous chapter. Almost one-third (31 percent) of this sample refer to obesity as a health crisis, and 22 percent call it an "epidemic." In comparison, only 11 percent discuss weight-based discrimination and 1.9 percent discuss the possibility of being fat and healthy. Moreover, discussion of obesity as a health crisis increases from 17 percent of the sample in 1995–2001 to 39 percent of the sample in 2002–2005. Similarly, discussion of obesity as an "epidemic" increases from 12 percent of the news sample in 1995–2001 to 28 percent of the news sample in 2002–2005. In contrast, there is less discussion of weight-based discrimination in 2002–2005 (7 percent of the sample) compared to 1995–2001 (17 percent of the sample).

Within this sample, news reports are more likely to discuss individual-level contributors to obesity than sociocultural or biological/genetic factors. Specifically, as is shown in figure 3.1, 41 percent of this sample discuss individual-level causes of obesity, compared to 29 percent that discuss sociocultural contributors and 16 percent that discuss biological factors. While only a small proportion of articles (8 percent) specifically discuss cultural contributors to obesity, 17 percent of articles mentioning blacks, Latinos, or the poor discuss cultural causes (compared to only 4 percent of articles not mentioning these groups). Discussions of responses to the alleged obesity problem similarly focus on individual-level behavioral solutions (56 percent), whereas 24 percent of articles discuss medical solutions and 21 percent discuss policy solutions. Other research has shown that,

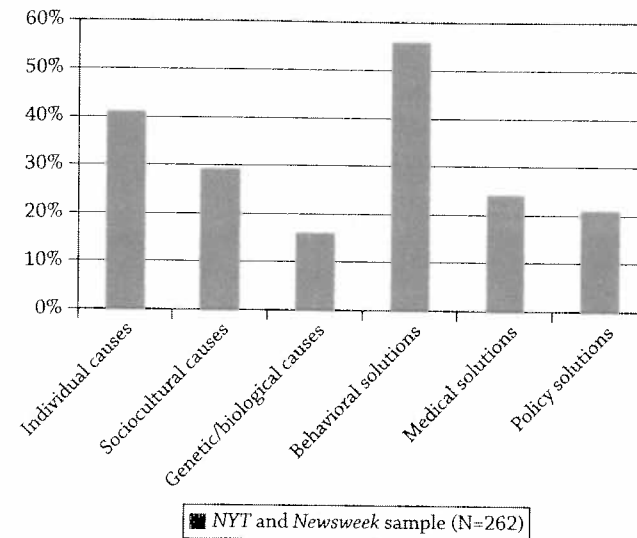


Figure 3.1:
Percentage of *New York Times* and *Newsweek* sample discussing specific causes and solutions for obesity and overweight

compared to print news coverage of obesity, television coverage focuses even more heavily on individual behavioral causes and solutions.⁹²

As can be seen in figure 3.2, however, discussions of sociocultural factors and policy interventions have increased over time. In contrast, discussion of biological factors remains low throughout the time period surveyed and discussions of individual causes and individual-level solutions remain high.⁹³ Thirty-four percent of articles published between 2002 and 2005 discuss sociocultural contributors to obesity, compared to 9 percent of articles published between 1995 and 2001. Policy interventions are discussed in 28 percent of articles in the later period, compared to 9 percent of articles in the earlier period.⁹⁴

The way in which my students and I coded the newspaper articles to include any mention of a cause does not capture the way in which, even when factors other than personal responsibility are mentioned in an article, they were often discussed alongside personal responsibility. In fact, in most cases, a personal responsibility frame dominated the discussion, as in the following 1999 article: "They're pushing these super-sized foods at restaurants, and customers want value for their dollar. . . . Am I going to go to the restaurants where I get a 3-ounce burger for \$3, or to the one where I get an 8-ounce burger for \$3?"⁹⁵ While industry pressures are identified, "customers" are still portrayed as ultimately facing a choice, rather than being passive victims, as with pollution.

Similarly, even when biological or genetic factors are discussed, they are typically subordinated to individual contributors. For instance, a *Newsweek*

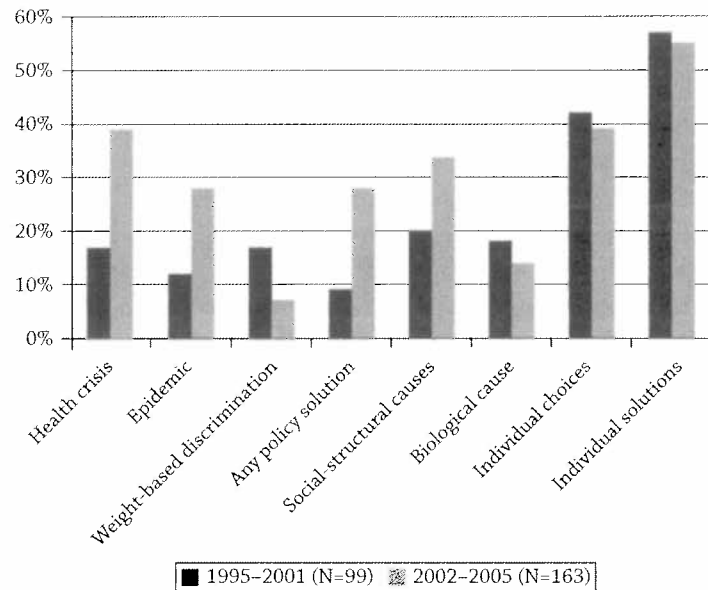


Figure 3.2:
Percentage of *New York Times* and *Newsweek* sample discussing specific causes and solutions for obesity and overweight, 1995–2001 versus 2002–2005

article discusses both biological and individual contributors to weight but ultimately emphasizes the importance of personal choices: “You can’t pick your parents, but you can pick what you eat and how often you exercise.”⁹⁶ The idea that genetics might provide an excuse for body weight is thus explicitly rejected. Rather, the article emphasizes people’s ability (and, seemingly, their obligation) to make choices regarding diet and exercise. Similarly, another article cites new research on “race and weight,” explaining that, “on average, black women burn nearly 100 fewer calories a day than white women do when their bodies are at rest,” but cautioning that “the new findings do not mean that controlling and losing weight is a hopeless task for people with lower metabolic rates, just that it may require more attention to diet and exercise.”⁹⁷ This article thus reminds readers that managing their weight is their responsibility and that a biological predisposition to weight gain requires more, not less, personal vigilance. Such reporting is also common in other countries. For instance, a French *Le Monde* article mentions “genetic” and “endocrinological” factors only to dismiss them as irrelevant “95 percent” of the time: “Only 5 percent of cases can be attributed to genetic or endocrinological factors. In the remaining 95 percent, obesity is due to bad eating habits.”⁹⁸

Is the focus on personal responsibility a generic aspect of U.S. news reporting or specific to the issue of fatness? To what extent is it specific to

U.S. news reporting? To answer these questions, I conducted two comparative news media studies, which are discussed in the remainder of this chapter. As we will see, a comparison of U.S. news reporting on overweight and obesity with U.S. news reporting on anorexia and bulimia suggests that U.S. news reports are more likely to blame people for being “too fat” than for “thinness-oriented” eating disorders. I argue that this stems from the particular moral valence and racial and class connotations of fatness versus thinness. A comparison of U.S. versus French news reporting on overweight and obesity suggests, however, that U.S. political and cultural traditions of self-reliance make an emphasis on personal responsibility for obesity especially likely in this country, compared to countries with greater cultural and political emphasis on social solidarity, such as France.

WHAT’S DIFFERENT ABOUT FAT?

The U.S. tendency to emphasize personal responsibility is not unique to the issue of fat.⁹⁹ And yet the fact that fatness has been framed as a sign of sloth and gluttony since the early twentieth century seems to make the discourse of personal responsibility even more potent in this context. Eating disorders and overweight/obesity are both medical categories related to body weight and eating. Yet, while both eating disorders and overweight/obesity are considered medical problems, anorexics are by definition “too thin,” and bulimics are often relatively thin or of average weight. Given contemporary American attitudes that being heavy is the embodiment of gluttony, sloth, and/or stupidity, while slenderness is the embodiment of virtue, I hypothesized that the press may be more likely to invoke personal responsibility in the case of obesity than in the case of eating disorders.

Indeed, my analyses suggest that the news media are more likely to portray eating disorders as a problem for which no one is to blame, while suggesting that obesity is the result of bad personal and parental choices. These conclusions are based on analyses of the news sample of 262 news articles on overweight/obesity described above and 70 articles on anorexia and bulimia published between 1995 and 2005 in *The New York Times* or *Newsweek*.¹⁰⁰ It also draws on qualitative analysis of five additional articles published in these publications in 2006 and 2007 that specifically discuss binge-eating disorder.¹⁰¹

As shown in figure 3.3, news reports on both eating disorders and overweight invoke personal choices, with more than 40 percent of articles in both categories mentioning personal choices as contributors. However, several factors are described as contributing equally to eating

disorders, while individual choice is the predominant explanation offered for overweight. Articles about eating disorders discuss sociocultural causes at the same rate as individual choices (47 percent for both), while 19 percent of eating disorder articles cite biological causes. In contrast, 41 percent of articles about overweight/obesity mention individual choices, with sociocultural and biological causes mentioned in 29 and 16 percent of articles, respectively.¹⁰²

Moreover, qualitative analysis reveals that news articles on anorexia typically evoke “complex webs of cultural factors and psychological processes,” serving to diffuse responsibility amongst several factors.¹⁰³ Moreover, articles on anorexia and bulimia tend to discuss biological factors and social constraints as working in tandem, diffusing focus away from individual blame, as in the following *Newsweek* editorial: “Good news: scientists are developing a better sense of how genetic and social triggers interact.”¹⁰⁴ When discussing both genetics and individual responsibility, articles on eating disorders often emphasize the former, stating, for instance: “Parents do play a role, but most often it’s a genetic one.”¹⁰⁵ In other words, when it comes to anorexia and bulimia there is, as the title of one news article proclaims, “no-one to blame.”¹⁰⁶ Contemporary reports on anorexia tend to portray parents as part of the solution, rather than as part of the problem, advising parents “to think of the disorder as an outside

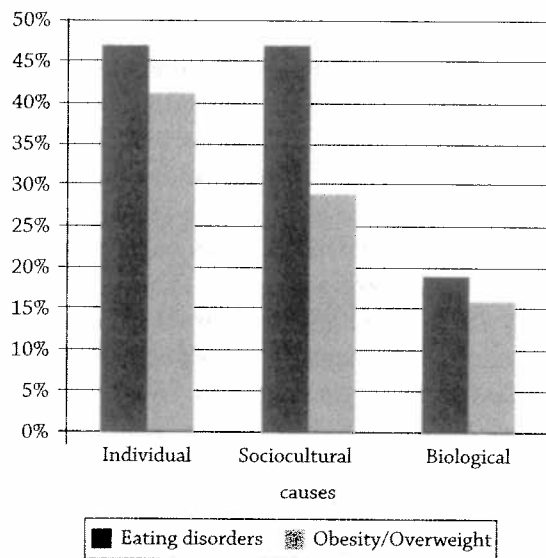


Figure 3.3:
Percentage of *New York Times* and *Newsweek* sample—on overweight/obesity compared to eating disorders—discussing specific causes

force that has taken over their daughter's life [and] to be unwavering in finding ways to feed their child.”¹⁰⁷

Even when an eating disorder is described as beginning with a choice (i.e., to start a diet), the choice is typically depicted as a “normal” response to cultural pressures, rather than as an irresponsible or self-indulgent behavior. For instance, an article entitled “When Weight Loss Goes Awry” describes a teenager's anorexia as beginning with an innocent diet: “Last summer, as friends started dieting, she decided to lose five to 10 pounds. Within a few months Amelia, now 15, was on the death-march called anorexia nervosa.”¹⁰⁸ In a society in which watching one's weight is a moral obligation, Amelia is not faulted for beginning a diet. Rather, anorexia is cast as a case in which good intentions go too far. Amelia, described as “a straight-A student and cheerleader,” is quoted as saying “in a weak but determined voice from her bed at the Children's Hospital in Denver [that she] would never want this to happen to anybody else.”¹⁰⁹ Anorexia is thus portrayed as something that “happens to” people, even model teenagers, rather than something people bring upon themselves. Similarly absolving anorexics from blame, another article explains that “for some kids, innocent-seeming behavior carries enormous risks.”¹¹⁰

Considering a host of factors from “obsessive-compulsive disorder, depression, low self-esteem and anxiety” to the “reduce fat in your diet” drumbeat, which can haunt children who already feel pressure—from gaunt models or each other—to be thin,” news articles do not blame the “intelligent, often highly accomplished kids [who] spiral into such destructive behavior.”¹¹¹ Many news articles point the finger at the narrow beauty standards of popular culture. For instance, discussing anorexia and bulimia, one article declares that “the apparent precipitant of these [eating] disorders seems to be an overwhelming desire to be thin, thin enough to walk down a Paris fashion runway, to act in a Hollywood movie or to dance with a leading ballet company.”¹¹² Yet even such blaming of mainstream cultural pressures is tempered by arguing that they only result in eating disorders among people with a biological or psychological predisposition. For example, after noting that doctors have observed a “disturbing trend: a growing group of women in their 30's, 40's and 50's who have eating disorders,” the article reassures readers that many of these newly diagnosed older women have actually had lifelong psychological problems and that “lots of people in our culture diet, [but] relatively few end up with an eating disorder.”¹¹³

Thus, not only are individual dieters not blamed for their behavior, but also the culture of dieting is normalized: “While everyone is exposed to similar societal pressures to be thin, only a small percentage develop eating

disorders. Those who succumb typically are prompted by extreme career pressures, as often happens to ballerinas, models, actresses and jockeys, or they have some underlying emotional and/or physical vulnerability.”¹¹⁴ Some articles compare anorexia to alcoholism and depression, in that they are all “potentially fatal diseases that may be set off by environmental factors such as stress or trauma, but have their roots in a complex combination of genes and brain chemistry.”¹¹⁵ Specifically, they note that “many kids are affected by pressure-cooker school environments and a culture of thinness promoted by magazines and music videos, but most of them don’t secretly scrape their dinner into the garbage. The environment ‘pulls the trigger,’ [...] but it’s a child’s latent vulnerabilities that ‘load the gun.’” By stressing the complex interplay among individual factors, biological predisposition, and macro-level environmental factors, this type of reporting mitigates blame of individual anorexics and their parents.

Even more strikingly, as shown in figure 3.4, articles are much less likely to hold individuals responsible for curing eating disorders (4 percent of eating disorder sample) than for fixing overweight (56 percent of overweight sample). Articles in the eating disorders sample discuss medical interventions at least *seven times* more frequently than they mention either policy or behavioral solutions (54 percent versus 7 percent and 4 percent, respectively). In contrast, articles on overweight/obesity are more than twice as likely to discuss behavioral modification than either medical interventions (24 percent) or policy solutions (21 percent). Forty-six percent of articles on eating disorders, but no articles on overweight, discuss only medical solutions.¹¹⁶

As victims of a complex illness, sufferers of eating disorders are not expected to “pull themselves up by their bootstraps.” Rather, they are depicted as needing medical intervention. For example, one article describes an anorexic 14-year-old who, despite wanting “to improve,” had failed to recover when going it alone: “It took a second hospitalization at Schneider, the following spring, before Molly could maintain a healthy weight.”¹¹⁷ One article describes how a young anorexic girl was only able to recover after repeated hospitalizations because she frequently relapsed when not under direct medical supervision.¹¹⁸ Such failures are not portrayed as evidence of weak will, nor are they blamed on their parents. Rather, they are used to underscore the seriousness of anorexia as a medical illness that requires medical intervention.

Even when eating disorder articles explicitly state that individuals can cure themselves, it is almost always under the guidance of a doctor. Thus, we read about new therapies for bulimia in which specially trained nurses coach bulimics to help themselves: “Many bulimics do not need traditional psychiatric therapy. Instead, he said, patients will learn to help themselves.

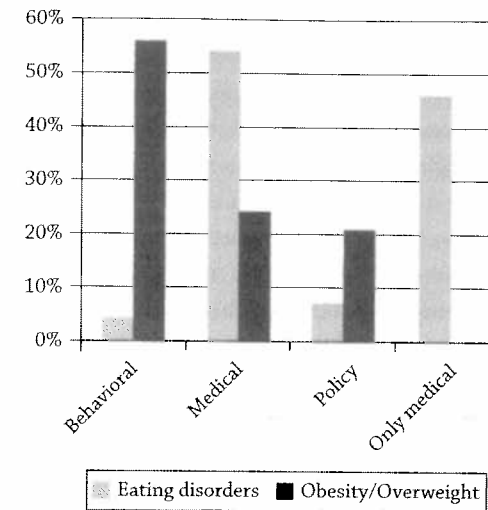


Figure 3.4:
Percentage of *New York Times* and *Newsweek* sample—on overweight/obesity compared to eating disorders—discussing specific solutions

‘What we’ve done is change the treatment into a self-help format,’ said Dr. Fairburn.”¹¹⁹ Yet, when “self-help” for eating disorders is enacted under medical supervision, curing disordered individuals is still presented as the responsibility of an expert physician.

BINGE-EATING DISORDER: A NEED FOR SELF-CONTROL

Binge-eating disorder is categorized in the *DSM-IV* as an “Eating Disorder—Not Otherwise Specified,” an umbrella category for various eating disorders that do not meet the precise criteria for either anorexia or bulimia. The American Psychiatric Association (APA) provides a “provisional diagnosis” of binge-eating disorder as bingeing without compensatory purging and/or extreme dietary constraint.¹²⁰ This “provisional diagnosis” signals that binge-eating disorder is being seriously considered as requiring its own diagnostic category in the *DSM-V* (expected in May 2013), while also providing clinical researchers with shared criteria for studying the disorder. Binge eating is likely to become the object of more public discussions, as it gains more attention from clinicians.

Articles that discuss binge-eating disorder in detail draw upon frames typical of *both* thinness-oriented eating disorders articles and of articles on overweight, underscoring the extent to which this condition straddles the symbolic space between usually polarized conceptions of body size.

Ultimately, however, binge-eating disorder is more firmly situated within an "overeating" frame, depicting sufferers as needing "self-control" more than medical assistance. For instance, in an account of her personal struggle with binge-eating disorder, reporter Jane Brody writes: "My despair was profound, and one night in the midst of a binge I became suicidal. I had lost control of my eating; it was controlling me, and I couldn't go on living that way."¹²¹ A psychologist helped Brody resist suicide but "was not able to help me stop bingeing. That was something I would have to do on my own." As with victims with eating disorders, this binge eater is presented as needing help from a doctor or therapist, but ultimately, as with overweight, it is suggested that she needs to control overeating on her own.

Two articles that discuss binge-eating disorder argue that the most important reason binge-eating disorder needs to be taken seriously is because it makes it more difficult to *succeed at weight loss*. In other words, the concern with achieving a "normal weight"—which also dominates discussions of overweight—seems to trump more general concerns about eating disorders as psychological problems. One article explains: "The importance of binge eating disorder is that people who fit these criteria do worse than others in weight management programs."¹²² By focusing on the importance of weight loss, these articles obscure or downplay the psychiatric symptoms experienced by binge eaters, which have been shown to have negative health effects independent of body size.¹²³ Another article draws upon binge-eating disorder's relationship to overweight in order to depict it as a *public* health risk: "Because of the disorder's close link with obesity...it's a major public-health burden," a theme that was never encountered in discussions of anorexia or bulimia.¹²⁴

Further, while feminist authors have identified binge eating and compulsive overeating as serious "eating problems," which—like anorexia and bulimia—often "begin as ways women numb pain and cope with violations of their bodies" and are "a logical response to injustices," this news sample describes individuals with binge-eating disorder as "overeaters" who have an "ordinary, if unfortunate, human behavior," and a few articles express concern that binge-eating disorder has been "invented" by greedy drug companies.¹²⁵ For instance, the following article quotes an eating disorders researcher who says: "Outside North America, it's basically a laugh.... No one thinks it's a serious condition.... These are overeaters."¹²⁶ In other words, there is resistance to giving binge-eating disorder the status of a full-fledged eating disorder like anorexia or bulimia, for which outside forces of biology or cultural pressures—rather than individual choices—are to blame.

In sum, the comparison with eating disorders suggests that, in the contemporary U.S. society in which thinness is highly prized, news articles are less likely to moralistically blame individuals for disordered eating that leads to thinness than they are to blame them for being too fat. It seems that the association of heavier bodies with gluttony and sloth and of thinner bodies with discipline and responsibility favors framing anorexics and bulimics as victims of cultural and biological forces beyond their control, while blaming the obese for their weight. Such frames, in turn, reinforce the original stereotypes that fuel them. This sample of news articles tends to deny binge-eating disorder, in which sufferers eat large quantities of food and tend to be heavier, the status of a "real" eating disorder, reframing it instead as ordinary and blameworthy overeating. In other words, the news media's tendency to present obesity as a moral issue of personal responsibility is not merely a generic feature of news reporting. Rather, fatness as an issue lends itself to moralizing in a way that other issues do not.

RACE, CLASS, GENDER

Historically, in the United States, the association, especially among women, of fatness with the poor and people of color and of thinness with elite whites has largely driven the negative moral valence of fatness.¹²⁷ My news media analysis suggests that this remains true today. The *Newsweek* and *The New York Times* sample discussed above was also, on average, more likely to discuss nonwhites, compared to whites, and the poor, compared to the middle class, in the context of overweight and obesity, while focusing on affluent white women and girls, rather than on the poor or people of color, in the context of anorexia and bulimia.¹²⁸ These patterns in reporting may reinforce the image of white middle-class girls and women as victims and of poor minorities as ignorant or willfully defiant of health guidelines.

Indeed, there is evidence that white middle-class women and girls are more likely than poorer women and girls, women and girls of color, or boys or men to be diagnosed with anorexia or bulimia, also referred to as "thinness-oriented eating disorders," although this may partially reflect biases in diagnosis.¹²⁹ In contrast, rates of binge-eating disorder, which are often associated with higher body weight, are similar among black women, white women, and white men, with some scholars finding recurrent binge eating to be more common among black women than among white women.¹³⁰

These demographic trends have been evoked in debates over the relative urgency of eating disorders as compared to overweight and obesity. While fat acceptance activists and eating disorder specialists have expressed concern that discussions of the danger of obesity will trigger eating disorders, those advocating for greater attention to obesity have dismissed these concerns as class biased. For instance, Greg Critser, author of *Fat Land*, argues that the news media have given disproportionate attention to anorexia because they are biased toward problems that affect the white upper middle class. Quoting a physician who treats overweight and obese girls at Children's Hospital in downtown L.A., Critser writes: "For every one affluent white anorexic you create by 'overemphasizing' obesity, you foster ten obese poor girls by downplaying the severity of the [overweight] issue."¹³¹ Quoting Judith Stern, Critser adds, "We've got to stop [talking about anorexia] and get on with the real problem."¹³² In an interview with me, obesity researcher James Hill similarly says: "Not to sound cruel about it, but one problem [obesity] is a huge problem for society. The other problem [anorexia] is a smaller problem." Similarly, in an interview with me, obesity researcher Walter Willett says: "The problem of overweight and obesity is a hundred times more of a problem than the problem of anorexia, if we look at morbidity and mortality."

This is directly related to the fact that overweight and obesity have been defined broadly to include anyone with a BMI over 25 or 30, respectively, regardless of body composition or health status, while anorexia has been defined quite narrowly. Specifically, the APA defines anorexia as the refusal to maintain body weight at or above a minimally "normal weight" for age and height (85 percent of "expected" weight), fear of gaining weight or becoming "fat," denial of the gravity of one's low body weight, and, in post-menarchal females, amenorrhea.¹³³ The APA defines bulimia as recurrent episodes of binge eating (eating extremely large amounts of food in one sitting), followed by "inappropriate compensatory" purging (i.e., by vomiting and/or taking laxatives), and an undue influence of body shape in self-evaluation.¹³⁴ Fat rights activists and health at every size scholars argue that a better comparison is between the prevalence of eating disorders and type 2 diabetes, pointing out that rates of the former among U.S. children is roughly nine times higher than the latter.¹³⁵

The following news article plays up stereotypes of anorexics as elite white girls. It describes how 10-year-old Katherine, growing up in the wealthy suburbs of Richmond, Virginia, had been diagnosed with anorexia and how her parents, in their desperation to help their daughter, promised they would buy her a pony if she would only eat. After two months of inpatient treatment at a children's hospital in a nearby town, during which she

was homeschooled, Katherine recovered and became "an avid horsewoman, sometimes riding five or six times a week."¹³⁶ When Katherine says she is hungry, her mother "has been known to drop everything and whip up a three-course meal," comments the article approvingly.¹³⁷

In contrast, another news article describes how a poor black single mother lost custody of her son, Terrell, after months of fighting neglect charges related to his body weight. He had gained weight after being released from an inpatient weight-loss program and his mother protested that she could not "watch him 24 hours a day . . . , hold his hand, take him to the Y, make him eat salad" or buy the food recommended by Terrell's doctors while working at her time-consuming minimum-wage job.¹³⁸ These two articles drive home the way in which an ideology of total motherhood puts moral pressure on mothers to protect their children from medical risk in a social context in which different mothers have unequal resources at their disposal to live up to these expectations.¹³⁹ In these articles, a white, wealthy anorexic girl is treated as a victim of a terrible illness beyond her and her parents' control, while a black, poor, obese boy is described as having a health problem that may be the result of parental neglect.

Discussions of obesity are also racialized, in that they tend to point blame at sedentary activities, such as television-watching as opposed to reading, that are associated with lower income or less formal education and more common among African Americans.¹⁴⁰ Similarly, fast food and cheap industrialized "junk food" are cited as examples of poor food choices, rather than, say, imported Brie cheese or premium ice cream. For instance, a *New York Times* editorial opines: "With more two-income families and single-parent households, more children eat at cheap fast-food outlets, where sugary drinks and high-calorie choices in enormous portions abound."¹⁴¹ The focus on behaviors associated with the poor and ethnic minorities is typical of earlier moral crusades against alcohol, which targeted immigrants, and the drug wars, which have focused on drugs like crack cocaine that have been consumed disproportionately by poor minorities, rather than the drugs like powder cocaine that are consumed by the affluent.¹⁴² In other words, even when race and class are not explicitly mentioned, these discussions are imbued with racial and class overtones. A *New York Times* editorial recognizes and resists this tendency by arguing that expensive high-caloric foods (and their elite consumers) should not get special treatment: "Another penny or two of tax on fast food is really a tax on the poor . . . if potato chips are taxed, *crème brûlée* should be too. Anybody who buys Camembert can afford an extra nickel for a childhood obesity prevention program."¹⁴³

Discussion of the risks of “dual-working parents,” in which “parents” rely on packaged foods or takeout to feed their families, obscures the fact that it is specifically working women who are expected to be at home cooking nutritious meals.¹⁴⁴ An advertisement running in newspapers in the summer of 2005 makes this explicit, blaming “30 years of feminist careers,” for a host of social ills including “an epidemic of childhood obesity and diabetes”: “With most mothers working, too few adults and children eat balanced, nutritious, portion-controlled home-cooked meals.” This advertisement echoes earlier discussions by 1830s crusader Sylvester Graham, among others, of food excesses “within the home, at table, by women.”¹⁴⁵ In that working-class women and women of color often have no choice but to work, these discussions are racialized as well.

The emphasis on breast-feeding as an antidote for obesity, despite a lack of compelling scientific evidence for this claim, further advances an obligation to “total motherhood.”¹⁴⁶ For instance, a *Chicago Sun-Times* article cites breast-feeding as the first “step to fitness”: “It’s far easier to prevent childhood obesity than treat it. And the time to start is infancy. Breast-fed babies are 22 percent less likely to become overweight adolescents than bottle-fed babies, according to a study reported in the *Journal of the American Medical Association*. Bottle-feeding parents might make their babies finish the bottle even when the kids feel full, the researchers found. Also, breast-fed babies have lower levels of insulin, which promotes fat storage.”¹⁴⁷ Given lower rates of breast-feeding among African Americans, which have been partly attributed to a rejection of a legacy in which enslaved black women were forced to nurse their masters’ children, the emphasis on breast-feeding further casts black mothers as bad mothers.¹⁴⁸

Moreover, as is shown in figure 3.5, news reports are more likely to invoke a personal responsibility, as well as sociocultural (and specifically cultural) but not biological, frame when the poor and/or ethnic minorities are discussed, compared to when these groups are not discussed.¹⁴⁹ Specifically, among articles mentioning blacks, Latinos, or the poor, 54 percent discussed individual choices, 43 percent mentioned sociocultural factors, and 17 percent mentioned cultural factors, compared to 38, 26, and 4 percent, respectively, among the articles not mentioning these demographic groups. In contrast, 15 percent of articles mentioning these groups and 20 percent of articles not mentioning these groups discussed biological factors, a difference that is not statistically significant, meaning it could be the product of chance. I found the same pattern, in which articles mentioning the poor, blacks, or Latinos were also more likely to discuss individual blame and sociocultural factors (but not biological factors), in a different news media sample.¹⁵⁰

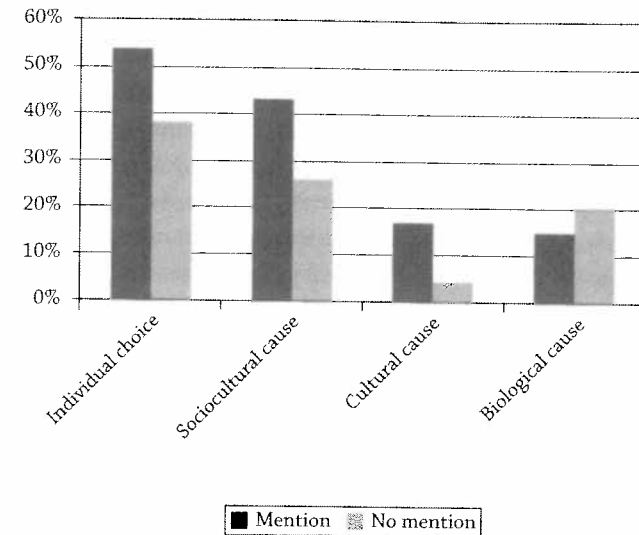


Figure 3.5:
Percentage of *New York Times* and *Newsweek* sample discussing specific causes and solutions for obesity and overweight depending on whether blacks, Latinos, or the poor are discussed

One article portrays as absurd a lawsuit brought by two black-girl plaintiffs from the Bronx against McDonald’s, arguing that it was the plaintiffs’ own fault for “gorging themselves so wantonly.” The word *wanton* refers to lewd or bawdy behavior and is clearly moralizing. Similarly, the word *gorge* means to consume greedily, thus conjuring up gluttony. The account of these girls’ unchecked desire for cheap and fattening food echoes stereotypes of black women as having insatiable sexual appetites.¹⁵¹ This article dismisses the idea that these girls could really not have known “about the nutritional shortcomings of fast food” and says that “if that’s really true, they should consider a lawsuit against their parents for endangering the welfare of their children rather than a suit against McDonald’s.”¹⁵² This article thus rejects the idea that McDonald’s has any responsibility to produce nutritional food, heaping full blame onto the girls and their parents. This is consistent with an ideology of “total motherhood,” in which mothers are held responsible for any harm that may befall their children as well as a broader tradition of denigrating black mothers as bad mothers.¹⁵³

If cultural factors are more likely to be mentioned when blacks, Latinos, or the poor are cited, it is because minority ethnic culture is often being blamed. For instance, one article, discussing the higher rate of overweight among minorities in inner cities, quotes a news source who acknowledges that “it is easier and less expensive to eat fast food and very difficult to find, in some of these neighborhoods, appropriate

foods, fruits and vegetables at a reasonable price.”¹⁵⁴ But the article then shifts to a focus on ethnic culture, quoting an activist who says that, in the end, “‘it will take a culture change’ to reverse the trend. . . . ‘Eating healthy is synonymous with whiteness for some of these kids,’ [an activist] says. ‘They’ll be like, ‘Salmon? That’s white people food.’” In contrast, “black people food” is assumed to be “unhealthy” foods. Thus, ethnic minorities are depicted as backward or ignorant and as needing to be educated in proper food choices and preparation, thereby reproducing stereotypes based on race as well as body size.

Similarly, many of the obesity researchers I interviewed evoked a contrast between weight-conscious and health-conscious elites and poor minorities who do not care about their weight or health. For instance, Xavier Pi-Sunyer, who is a medical doctor at St. Luke’s Hospital, runs his own weight-loss clinic, is on the board of Weight Watchers Inc., and is a past president of North American Association for the Study of Obesity (NAASO), says that “the average American . . . eats three cheeseburgers and a big order of French fries and a two-liter milkshake twice a week.” He vehemently rejects the idea that the contemporary United States is a weight-obsessed society, saying that “the average American doesn’t care [about his or her weight].” He acknowledges that many of the “Barnard girls” [women attending the elite Barnard University in New York City] are obsessed with weight for “cosmetic reasons” but contrasts this to the “average American woman [who gains] weight with each pregnancy and [ends] up [after] four kids, fifty pounds heavier . . . because nobody alerts her to the fact that this may happen and it may not be good for her to end up fifteen-twenty years later fifty pounds heavier.” Later in the interview, he says:

Now a lot of the obesity problem in America or more of it is in the minority groups and more in the poorer groups, and it may be that they have other priorities. You know, some woman who’s living in the housing projects and has no husband and is trying to take care of four kids and is now off welfare and has to work and has all kinds of problems. For her, diet is not [a priority]. In fact, food is the one pleasurable thing she can afford, so it’s not a high priority in their lives. I’m not saying they’re wrong, but I’m saying I don’t think they’re really connected to the idea that, that, you know, they need to lose twenty-five pounds, and so they don’t try it.

While acknowledging that a woman in this situation has social constraints that seriously limit her choices, Pi-Sunyer concludes that someone in this situation needs greater sensitization about the risks of obesity, rather than, say, better employment and child-care options.

Sometimes, an alleged aesthetic preference for heavier women among African Americans is blamed for higher rates of obesity among African American women. For instance, a 2005 article states that “more subtle societal influences, like differences in acceptable body images among different ethnic groups, all contributed to greater obesity among women with lower incomes and those in certain ethnic groups.”¹⁵⁵ A 2003 news report on a *JAMA* special issue on obesity makes the same point as follows: “The mainstream media continued to dwell on the dangers of the epidemiologically small number of the mostly white and affluent anorexics and bulimics, while heralding surveys that found a greater acceptance of overweight and obesity among African American girls as salutary signs of ‘self-respect.’ Do such attitudes contribute to the disproportionate percentages of obesity among minorities? No one seems willing to ask—much less say. But as Critser points out, ‘such sidestepping denies poor minority girls a principal—if sometimes unpleasant—psychological incentive to lose weight: that of social stigma.’”¹⁵⁶ Note how this article invokes the “obesity epidemic” as a rationale to support increasing the stigmatization of heavy African American women. A 2003 *New York Times* article discusses how Latino culinary preferences contribute to overweight among Latino children: “[Mr. Batista] says some cultural habits are simply getting the best of his people. ‘Latinos eating vegetables? Come on,’ he says, raising his hands in frustration. ‘We don’t eat vegetables. It’s rice and beans and meat. It’s very natural.’”¹⁵⁷

While black subculture is often blamed for higher rates of overweight and obesity among African Americans, an alleged preference for larger female bodies among black Americans is mentioned as protecting minority girls from anorexia and bulimia. Quoting a medical doctor, one article states that experts traditionally had thought that “anorexia and bulimia didn’t happen to black, Asian or Hispanic women, that they were somehow immune. . . . Being curvy or large was a source of pride within the African-American community.”¹⁵⁸ Those black (and sometimes Latina) girls who do develop eating disorders are often seen as being especially vulnerable to “white” pressures. One article describes how a black teenage girl developed bulimia because, as one of nine black students in a high school of three thousand, she was “struggling simply to be accepted. [In her words:] ‘When it came to body image, my perception of beauty was based on my white peers and images of white celebrities in the media.’”¹⁵⁹ Thus a mainstream diet culture is implicated in (thinness-oriented) eating disorders, while African American culture is praised as offering some cultural buffering.

Articles mentioning blacks, Latinos, or the poor are also more likely than those that do not mention these groups to discuss obesity policy

solutions (37 percent versus 18 percent in the *New York Times/Newsweek* sample). I have found this same pattern in another news media sample.¹⁶⁰ Many of these not only address issues of access to affordable fresh fruits and vegetables but also seek to educate people considered unable to make good food and exercise choices and to change minority ethnic *cultural attitudes* about food and eating.¹⁶¹ For instance, one article, describing a public health intervention in a southern black community, discusses a recipe for “low-fat catfish” developed by nutritionists as “one of a series [of new recipes] showcasing revered family recipes purged of their sins by two Auburn University nutritionists” and talks about how a leader of a public health intervention “recited a litany of virtuous eating for her largely female audience.”¹⁶² This article identifies mothers as a crucial part of the solution, recounting how these interventions recruit minority mothers as “cheerleaders for good health,” and target them as the preparers of food for their families: “We’re building on community talent with women who are cooking for their children and passing on behavior patterns to their children and their children’s children.”¹⁶³

WHAT’S DIFFERENT ABOUT THE UNITED STATES?

Explanations for ill health that focus on individual lifestyles are consistent with core American values of individualism and upward mobility. As political scientist Sylvia Noble Tesh has argued: “In some circles, it is chic not to smoke, to jog around the streets, to exercise in gyms, to eat low-cholesterol foods. Doing these things, or claiming to do them (“We hardly ever eat meat any more”; “I’ve started running again”), testifies to membership in the affluent classes. Such behavior means you are economically successful, or expect to be, or at least are very much like people who are. It has come to demonstrate a willingness to work to improve yourself and an eagerness to move up socially.”¹⁶⁴ Moreover, emphasizing personal control over illness is less threatening to economic and political vested interests than emphasizing social-cultural factors that imply a need for major changes in industrial practices, in the economy, or in the government.¹⁶⁵

Comparative research further suggests that conservative morality and an emphasis on individualism hold greater sway in the United States than elsewhere, including Europe and specifically in France.¹⁶⁶ While neoliberalism is on the rise in France, in general and in public health discourse specifically, French public intellectuals and popular opinion still tend to attribute a greater role to social factors in shaping individual trajectories.¹⁶⁷ Looking specifically at the case of body size, historian Peter Stearns has

argued that fatness has been especially moralized in the United States compared to other nations. He specifically found that the French were less likely to treat fat as an issue of morality, compared to Americans, and treated it instead as a fashion issue.¹⁶⁸

Yet Stearns published *Fat History* before the “obesity epidemic” emerged as a public health priority, raising the question: how is a country like France, where weight has historically been less moralized, framing the “obesity epidemic”? Does this greater focus on social inequalities and a lesser tendency to moralize weight specifically make the French press less likely to discuss individual contributors to and solutions for obesity and more likely to stress sociocultural determinants of obesity and collective solutions?¹⁶⁹ To examine this, I selected 108 news reports of obesity published in the French newspaper *Le Monde* and the French news magazine *L’Express*, publications that are similar in style and readership to *The New York Times* and *Newsweek*, respectively.¹⁷⁰

I found that the French news reports are as likely as American news reports to emphasize individual causes of overweight/obesity (46 compared to 39 percent, a difference that is not statistically significant). However, an emphasis on individual blame dominates U.S. news framing, while being more equally balanced by other frames in French news reporting. That is, while American articles are almost 50 percent more likely to mention individual compared to sociocultural contributors to weight, the French articles mention sociocultural factors as frequently as individual factors. This is because the French news reports are more likely than the American ones to discuss sociocultural contributors to overweight/obesity (47 versus 27 percent) and to discuss government policy solutions (44 versus 21 percent). In contrast, the American reports are more likely to emphasize individual-level solutions. The French news sample is also somewhat more likely to discuss biological determinants of weight (25 versus 15 percent). These patterns are shown in figure 3.6. The overall pattern is that, as expected, the American news media are more likely than their French counterparts to frame body size as a choice, rather than as influenced by forces beyond personal control.

Specifically, the French articles are more likely than the American articles to blame the food industry for contributing to obesity, particularly among children. Thus one article in *L’Express* affirms that the “proliferation of advertisements for products targeted at children have a direct effect on the development of obesity in France. Therefore it is necessary to manage such advertising.”¹⁷¹ Another French article similarly condemns the food industry for contributing to childhood obesity and not acting to reverse the trend: “We know that obesity is multifactorial. There is no single nutrient

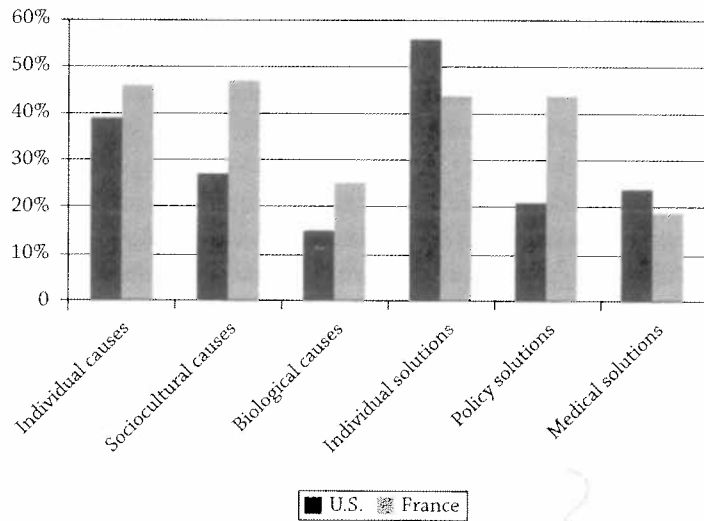


Figure 3.6:
Percentage of U.S. and French news sample discussing specific causes and solutions for obesity and overweight

that is guilty, no single type of food responsible, and no unique behavior to proscribe. But must we abstain [from action] based on the pretext that it is complicated, as the lobbies claim? Whether they represent biscuits, sugar, vending machines, fast food restaurants, cookies, soda or the food industry, they all say: 'It is not only me. Do not penalize me.' Of course. But if we listen to all of them and sanction none of them, we will stay on the same course for a long time."¹⁷²

Many of the French news articles specifically blame American fast-food restaurants and processed snack foods for expanding French waistlines: "The McDonald's food chain, a symbol of 'bad food' (*malbouffe*)... is at the center of these critiques on this side of the Atlantic.... Makers of soda, including especially Coca-Cola and PepsiCo, the latter which also owns Frito-Lay, are also in the hot seat."¹⁷³ Unbridled capitalism and corporate greed is a common theme in French critiques of the United States. Obesity provides another opportunity to strike this chord. The French press is also more likely than the American press to discuss policy solutions, which may be related to greater support for state intervention in France, compared to the United States.¹⁷⁴

There is no reason to believe that sociocultural factors are objectively more to blame for increasing body weights in France than in the United States. In fact, given the more extensive social safety net and lower levels of social inequality in France compared to the United States, the opposite is a distinct possibility. Rather, it seems that the French press is more likely

to emphasize social factors because such considerations are more accessible in French cultural and political traditions. Similarly, there is no reason to believe that individual-level solutions would be more effective in the United States or that policy solutions would be more effective in France. Rather, this difference in attention probably echoes *general* patterns in how social problems are addressed differently in each nation, with the U.S. press focusing more on individual autonomy and the French press envisaging a larger role for the state.

In addition to different national cultural lenses regarding personal responsibility and the role of government, there are well-documented differences in U.S. and French approaches to food and eating, which are reflected in news media reporting on this issue. Americans often eat alone, over a computer, in a car, or while running crosstown.¹⁷⁵ In many corporations, there is suspicion of people who take leisurely lunch breaks; they are seen as lazy. I have often heard American business people who have collaborated with French people criticize their long lunch breaks as evidence of a weak work ethic. Indeed, a common American expression for being inattentive or indolent is saying that someone is "out to lunch." American school children are typically given a meager twenty minutes for lunch. Typical cafeteria food includes pizza and corn dogs. Despite expressed consternation about childhood obesity, there is no federal mission to develop students' palates or to teach appreciation of food, although there have been some local efforts made in this direction. A growing slow food movement notwithstanding, the dominant American approach is to treat food as fuel.

Sociologist Barry Glassner has argued that, in general, Americans believe that "the worth of a meal lies principally in what it lacks. The less sugar, salt, fat, calories, carbs, preservatives, additives, or other suspect stuff, the better the meal." Glassner contrasts an American "gospel of naught" with a French emphasis on pleasure. Thus, when one study asked 1,281 respondents from France, Japan, Belgium, and the United States what words they associated with chocolate cake, the French chose "celebration," while the Americans chose "guilt." Asked about heavy cream, the French chose "whipped," while the Americans picked "unhealthy."¹⁷⁶ Reflecting these cultural differences, the American news sample is also more likely, compared to the French news sample, to discuss low-fat (12 versus 2 percent), low-carbohydrate (12 versus 2 percent), and low-calorie diets (10 versus 1 percent). In contrast, the French news sample is more likely to talk about *adding* "healthy" foods to the diet (17 versus 1.1 percent). In bemoaning the decline of French food culture, the focus is as much on a way of eating (i.e., slowly, over several courses, with others) as on particular foods consumed.

This chapter and the preceding one have examined both the opinions of obesity researchers and the content of news media reporting. Clearly both of these are important, but what is their relative importance? To what extent are news media reports shaped by scientific studies and vice versa? The next chapter addresses these questions.

CHAPTER 4



Fashioning Frames

Many people assume that if the risks of “obesity” have been exaggerated, it is the fault of the mass media. Scientists, many think, do their best to accurately present their research, which typically has important limitations and a fair amount of uncertainty. In contrast, journalists tend to sensationalize scientific findings and minimize uncertainty to produce more dramatic and compelling news stories in order to sell copy.¹ They favor imagery over content, cover research as a series of dramatic events, and report on provocative theory as if it were fact.² That science journalists typically lack scientific training and hold scientists in awe makes them unlikely to question research findings. Journalists and newspaper editors’ decisions about which studies to discuss and which to ignore have also been shown to influence public opinion.³

Yet scientists also routinely simplify and sensationalize their own results to attract news media attention, thereby boosting their visibility and attracting funding for their research.⁴ So is it journalists or scientists who have produced the received wisdom that Americans are eating themselves to death? More broadly, how do scientific studies and news reporting on such studies frame fat differently?

A brief historical examination of the emergence of the term *obesity epidemic* points to the interdependent role of science and media coverage.⁵ This term was first used by the news media in the mid-1990s, in response to a 1994 study published in the *Journal of the American Medical Association* (JAMA) showing that, between 1980 and 1991, the proportion of overweight or obese Americans jumped by 20 percent so that, by 1991, nearly one-third of the population was overweight or obese.⁶ The authors of the study concluded that overweight and obesity presented “a public health