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CHAPTER 13

Coping with Prejudice and Discrimination Based on Weight

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Imagine the following scenarios:

- Some friends of yours are going out for the evening. They ask you not to come, explaining that you are likely to "scare away potential dates."
- You go to the doctor's office with your spouse, only to discover that there is no seat that will accommodate her size. Your doctor admonishes her to lose weight, even though she is not his patient. Then the nurse draws you aside and asks in a kind voice, "Is it really fair to bring your wife out in public—where people can see her?"
- In a job interview, your would-be boss remarks, "My men need a pretty face and figure to look at, not a pig like you."
- A stranger comes up to you and says, "You're really gross! I can't believe how fat you are. I'd kill myself if I looked like you."

The above are actual experiences reported by people who are significantly above average weight—that is, people who are visibly "fat." At the office, on the street, and in the home, fat people are the targets of stares, rude remarks, discrimination, and ridicule. For fat people, weight-related stigmatization and discrimination are sad facts of life.

Consider the following newspaper account of a twelve-year-old boy who committed suicide in Florida: "Jacqueline Graham still can't bring herself to show her son's room to strangers, but you don't need to look past the photos in the living room to see who he was: He was the fat kid who didn't have any friends. The easy target. The mark . . . In the social hierarchy of fifth grade . . . that put him squarely at the bottom" ("Life and Death," 1997).

Unlike other forms of prejudice, such as racism, sexism, or ageism, prejudice against fat people is freely expressed in Western nations. In a society

that glorifies youth, beauty, and a narrowly defined "healthy" appearance, people stereotype and harass those whose bodies do not conform to this ideal. Body weight is seen as being controllable and fatness, therefore, is seen as a voluntary condition. Perhaps for this reason, people feel free to express their prejudicial attitudes without fear of social censure. Negative stereotypes of fat people include the views that they are ugly, morally and emotionally impaired, asexual, discontented, weak-willed, and unlikable. Ironically, fat people are just as likely as average-weight people to hold these prejudiced attitudes (Crandall, 1994).

Individuals who share the stigma of obesity quickly find that weight-related stigmatization affects nearly every aspect of their lives. Fat people report job discrimination, social exclusion, exploitation by the diet and fitness industries, denial of health benefits, trouble finding clothing, mistreatment by doctors, and public ridicule (Allon, 1982; Millman, 1980; Rand & MacGregor, 1990; Rothblum, Brand, Miller, & Oetjen, 1990). Fat people are less likely to be admitted to elite colleges (Canning & Mayer, 1966), or to have their education funded (Crandall, 1991). Fat people are also more likely to be of lower socioeconomic status (Sobal & Stunkard, 1989), and to lose socioeconomic status over time (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993).

THE LANGUAGE OF WEIGHT

Terms used to describe body weight can be quite confusing. The term *overweight* is most often defined in relation to tables of desirable weight, such as those published by life insurance companies. People whose weight is above the weight range deemed "ideal" according to life insurance height and weight charts are called "overweight." The term *obesity*, on the other hand, refers to an increase in the percentage of body fat relative to lean tissue (Bray, 1992). A common way of measuring obesity that considers the effects of height on weight is the body mass index, or BMI. BMI is body weight in kilograms divided by height in meters squared. Unfortunately, the United States is one of the few remaining countries that have not moved to a metric system, so this formula is difficult for the general U.S. public to use.

Because fatness is so stigmatized, words commonly used to describe it sound pejorative. *Obese, fat, hefty, overweight, massive,* and *morbidly obese* all sound equally unflattering. Fat acceptance organizations, such as the National Association to Advance Fat Acceptance, or NAAFA, have therefore advocated a strategy for destigmatizing fatness. Such organizations propose to reclaim the term *fat*, making it merely descriptive, rather than pejorative. This strategy is similar to the strategy of reclaiming words such as *dyke* or *queer* by gay and lesbian activists. It is thought that with increased use of these terms in positive or neutral contexts, they lose their pejorative power. Throughout this chapter, then, we will use the word *fat*

to describe people with high body weights, unless we are citing a direct quote.

FACTS AND MYTHS ABOUT BODY WEIGHT

Two assumptions about body weight seem to underlie prejudice and discrimination against fat people. The first is that if fat people would just eat less and exercise more, they would lose weight and thus no longer be part of a stigmatized group. The second belief is that large body size causes health problems.

In 1958, Stunkard wrote, "Most obese persons will not stay in treatment of obesity. Of those who stay in treatment most will not lose weight, and of those who do lose weight, most will regain it" (p. 79). This statement is still true half a century later. Between the 1960s and the 1980s, the rate of dieting among women doubled. In 1987, a study by Rosen and Gross (1987) found that 63 percent of high school girls were on diets, compared with 16.2 percent of boys. While dieting was becoming more prevalent, however, the average U.S. citizen's body weight was also increasing. This finding leads some researchers to believe that there is something about dieting that actually increases weight gain. In fact, dieting does seem to precede fatness, rather than the other way around. People who diet do lose some weight; however, rigorous follow-up studies find that nearly everyone regains the lost weight over the course of several months (Cogan & Rothblum, 1993). Fewer than three percent of people maintain weight loss over the long run, and after four to five years, many dieters weigh more than they did before they started dieting (Swarzc, 2003a).

There is a popular belief that Americans are more sedentary than ever before due to labor-saving devices, the increased numbers of automobiles, and a general lack of exercise. According to Szwarc (2003b), this is not true.

> Realistically, lifestyles for middle-class American adults haven't changed in line with bulging weights. Back in the 1960s, most Dads (or Grandpas, for younger readers) still drove to an office job each day and mowed the lawn on the weekend; Moms took care of the house with much the same appliances and modern conveniences we enjoy today . . . Who remembers their parents donning sneakers (hardly ever called *athletic* shoes back then) and heading to the gym every day or putting in an hour on the treadmill? Among lower socioeconomic classes where obesity rates are the highest, manual labor remains the primary employment. (p. 2)

Data collected by the Centers for Disease Control (CDC) show that exercise activity from the mid-1960s through the 1990s did not change, while other studies have shown increasing levels of physical exercise from the 1960s to the 1980s (Szwarc, 2003b).

Regarding fatness and health risks, there are three major confounds in the studies that examine the relationship between weight and health (Rothblum, 1990, 1999). First, studies that examine whole communities

for weight and health problems do not control for income. However, income is strongly related to weight in the United States. Statistics indicate that fat people are much poorer than thin people. In addition, income in the United States is strongly associated with access to good health care. Thus, comparing fat people to thin people without controlling for income is the equivalent of comparing poor to rich people. Second, health-risk studies do not control for frequency of dieting, and, as mentioned above, fat people have dieted more than thin people. Diets, even those considered "healthy," are associated with many of the same risk factors that we associate with weight, such as cravings for fat, high blood pressure, increased heart rate, heart attacks, kidney disease, diabetes, and lower mortality. Finally, researchers do not (and could not easily) control for negative physiological effects of stress among fat people, who live as members of an oppressed minority group. In fact, stress has also been shown to cause many of the health problems associated with weight.

Even if one accepts the majority opinion that obesity is unhealthy, the health risk posed by high body weight is no justification for fat stigmatization, which is the main focus of this chapter. Eating "junk food" and consuming alcohol are also practices generally considered to be unhealthy, yet people drinking beer or eating hot dogs are not routinely subjected to harassment, public ridicule, and peer pressure to change these habits. Fat stigmatization therefore appears to be a problem independent of the purported health risks of body weight.

RESEARCH ON FAT STIGMA

The stigma of being fat has been extensively documented. Much of this research has emphasized how people perceive those who are fat, rather than how fat people perceive and cope with discrimination. Existing studies have focused on attitudes toward fat people, the effects of obesity on other life experiences (such as going to college or getting a job), and the social difficulties faced by fat people. Experimental as well as survey research supports the existence of extensive discrimination and prejudice against fat people.

For example, a study of stereotyping (Larkin & Pines, 1979) asked 20 male and 20 female undergraduates to use 38 descriptive scales to "form a first impression" of three fictitious people, one "overweight," one of "average weight," and one "underweight." Participants rated these people on scales measuring traits such as "decisive versus indecisive," "neat versus untidy," "relaxed versus nervous," and so forth. On 22 of the 28 variables, the fat person was rated negatively. Specifically, the fat person was seen as incompetent, unproductive, less industrious, disorganized, indecisive, inactive, less successful, more mentally lazy, and more lacking in self-discipline.

Negative stereotypes about fat people may lead others to dislike or ostracize those who are visibly fat. This effect has been demonstrated in several studies of children, adults, and health professionals. For instance, in a classic study of children's attitudes toward fat people (Richardson, Goodman, Hastorf, & Dornbusch, 1961), researchers asked six groups of children to rank-order six drawings according to how much they liked the child depicted in each one. The drawings included a child with no handicap, a child with crutches and a brace, a child in a wheelchair, a child missing a left hand, a child with a facial distinction, and a fat child. Participants included 277 underprivileged, disabled, and non-disabled children attending a summer camp, 104 non-disabled children from a different camp, 42 low-income city school children, 113 rural school children, and 104 school children of middle to high socioeconomic status. All six groups of children rated the drawings in precisely the same order, with the fat child being least preferred.

These same negative attitudes against fat people have been demonstrated by physicians, medical students (Blumberg & Mellis, 1985; Maddox & Liederman, 1969), nutritionists (Maiman, Wang, Becker, Finlay, & Simonson, 1979), and mental health professionals (Agell & Rothblum, 1991; Young & Powell, 1985)—in other words, by the very people to whom fat individuals might go for help and support. Crandall (1994) has suggested that weight bias derives in part from the belief that fat people are responsible for their weight, and that this belief leads to fewer sanctions against fat prejudice. Crandall argues that prejudicial attitudes toward obesity today are "overt, expressible, and widely-held," similar to racist attitudes fifty years ago. He suggests that anti-fat attitudes derive from a "Puritanical morality" that values self-discipline, self-control, and self-reliance—qualities that fat people are assumed to lack. He further notes that fat people are just as likely as average-weight people to hold negative attitudes about fatness.

Providing evidence in support of the above idea, Crandall and Biernat (1990) surveyed 478 male and 594 female undergraduates on anti-fat attitudes, political conservatism, symbolic racism, sexual attitudes, religiosity, self-esteem, and miscellaneous social attitudes. They found that bias toward obesity was associated with racism, conservative attitudes toward other social issues, and authoritarianism. Being fat, in and of itself, was not associated with anti-fat attitudes, suggesting that beliefs about fatness are more related to one's ideology than one's personal weight. Predictably, fat respondents who did hold anti-fat attitudes tended to have lower self-esteem than fat respondents who did not. The authors conclude that anti-fat bias is in general associated with a conservative, authoritarian outlook on the world—an outlook that posits that "People deserve what they get." In other words, people will discriminate against fat people because of a naive perception that they choose to be fat.

ATTITUDES TOWARD FAT PEOPLE IN OTHER COUNTRIES

While negative bias against fat people certainly exists in Western nations, there is some evidence that such bias is "culture bound." For example, Cogan, Bhalla, Sefa-Dedeh, and Rothblum (1996) compared 219 U.S. college students to 349 college students in Ghana on measures of weight, dieting and restrained eating, disordered eating, and attitudes toward fatness. Between-group comparisons revealed that African students preferred a heavier body size, with Ghanaian males preferring the largest body size and U.S. females the smallest. Additionally, U.S. women were most likely to report that their weight interfered with social activities. The U.S. sample also rated thin people more positively than Ghanaians did, attributing qualities such as happiness, self-confidence, self-discipline, and attractiveness to them.

A study by Crandall and Martinez (1996) looked at anti-fat attitudes in 236 Mexican and 170 U.S. university students, who were also surveyed about their beliefs in a "just world" and political beliefs. Mexican students were found to be less concerned about their weight and more accepting of fat people than U.S. students. In the U.S. sample, anti-fat attitudes were associated with "just world" beliefs, political conservatism, and a tendency to blame the poor for their poverty. In contrast, among the Mexican students, there was no relationship between anti-fat attitudes and social ideology.

The results of these cross-cultural studies provide support for Crandall's (1994) assertion that antipathy toward fat people is related to U.S. cultural values. Crandall and Martinez (1996) point to three reasons why fatness is particularly stigmatized in the United States. First, they argue that U.S. beliefs reflect negative stereotyping of fat people. Second, because fatness is naively associated with personal control and self-discipline, they posit that fatness will be less stigmatized in cultures that do not highly value these attributes. Finally, they say, the U.S. emphasis on self-control and self-determination serves a "central organizing function" around which citizens form opinions about issues. Thus, body weight and other traits that are believed to result from a lack of self-control will be negatively valued in the United States and not as much in cultures that do not value self-control as highly.

FAT PEOPLE'S OWN EXPERIENCES OF STIGMATIZING SITUATIONS AND ATTEMPTS TO COPE WITH FAT STIGMA

Few studies have asked fat people directly about how they deal with fat stigma on an everyday basis. Furthermore, because body weight in the United States is inversely related to income, research that focuses on middle-class populations, such as college students or employees, is unlikely to come across many people who are extremely fat. Myers and Rosen (1999) sampled severely fat people who were trying to lose weight

by clinical means (weight loss surgery or medication). They found that the heavier these people were, the more they reported stigmatizing experiences and the more they employed a variety of strategies for coping with stigma. A greater number of reported stigmatizing experiences were associated with more mental health symptoms, more negative body images, and more negative self-esteem. The authors also identified 11 types of stigmatizing situations and 21 ways of coping with the stigma reported by fat people. Three of these coping strategies—negative self-talk, isolation, and avoidance—were related to poorer psychological adjustment. None were associated with better adjustment (Myers & Rosen, 1999).

In this chapter, we want to present evidence for the relationship between stigmatization, coping attempts, and psychological distress in two groups of fat people, one being a group of "fat acceptance" advocates, and the other being a group of subscribers to a weight-loss magazine (for a more detailed description of this study, see Myers & Rothblum, 2004). Thus, we will be describing the perceptions of two non-clinical samples: NAAFA members and readers of a national publication targeting dieters. These groups are both examples of "voluntary associations" created to assist people in coping with fat stigma. Yet, their approaches differ. NAAFA members purportedly favor "fat acceptance," whereas the magazine subscribers are more likely to be interested in losing weight. We wanted to investigate how members of these two groups combated the effects of fat stigma, and whether their coping efforts were associated in any way with their levels of psychological distress.

As in the study with clinical samples (Myers & Rosen, 1999), we found that for both magazine subscribers and NAAFA members, reports of stigmatization and coping attempts increased in direct proportion to body size. The most frequent stigmatizing situations that respondents faced were hurtful comments from children, other people making unflattering assumptions, loved ones feeling embarrassed to be seen with the fat person, and physical barriers (such as chairs that were too small). Respondents reported facing these situations between "once a year" and "several times in my life." Being stared at and subjected to unsolicited negative comments were also frequent experiences. Infrequent experiences included job discrimination and physical assault, which occurred, on average, less than "once in my life." We found that stigmatizing experiences were related to more mental health symptoms, more negative body images, and lower self-esteem.

The most frequent coping responses reported by these respondents were practicing self-acceptance, attempting to head off negative remarks by socially disarming people who might otherwise be critical, and making positive self-statements. Respondents reported that they used these strategies from "once a month" to "several times a year." More frequent use of coping strategies was related to higher self-esteem. People who used the coping strategies "Self-love/self-acceptance" and "Educating self and others about weight control and stigma" reported fewer mental health

symptoms, more positive body images, and more positive self-esteem. Three other coping strategies—"Seeing the situation as the other person's problem," "Refusing to diet," and "Being visible despite stigma"—were associated with more positive self-esteem and less body dissatisfaction, with no relation to overall mental health symptoms. Finally, "Positive self-talk" was associated with higher self-esteem only. Maladaptive coping strategies included "Negative self-talk," "Cry, isolate myself," "Avoid or leave situation," "Eating [more]," and "Losing weight"—these strategies were associated with greater body dissatisfaction and lower self-esteem.

An examination of group differences between NAAFA members and magazine subscribers revealed that NAAFA members were more likely to report stigmatizing experiences than magazine subscribers. The groups did not differ with regard to the number of coping attempts they made. On the clinical measures, magazine subscribers reported significantly greater body dissatisfaction. Magazine subscribers and NAAFA members had similar levels of psychological symptoms and self-esteem. One difference between these samples was their approach to dieting. Predictably, magazine subscribers were about twice as likely to report being on a diet currently than NAAFA members (62% versus 33%, respectively). Unexpectedly, NAAFA members were not more likely to practice fat acceptance strategies as a whole. When each of the coping strategies was analyzed individually, NAAFA members were more likely to report attempts to educate themselves and others about fat stigma and weight control, and were also more likely to seek social support from other fat people.

Clearly, weight-related stigmatization is a frequent and distressing experience that requires considerable coping effort. Verbal harassment and abuse, public ridicule, intrusive remarks, and geographic barriers, such as seats and clothing that are too small, are among the various types of events frequently reported by fat respondents. Additionally, while it has often been assumed that weight stigma contributes to low self-esteem and poor body image among fat people, this is the first empirical study to provide support for this conclusion. Our findings suggest that more frequent reports of stigmatizing experiences are associated with more mental health symptoms, more negative body images, and lower self-esteem. In contrast, weight alone was unrelated to psychological adjustment.

Sadly, although we read almost daily about the health risks and social problems associated with "obesity," we are never provided with effective ways of losing weight. In the absence of effective methods for weight reduction, millions of people are left to cope with health and social problems on their own. Too often, these people engage in repeated, fruitless attempts to diet—diets that most often result in no weight loss and, perhaps, in a decrease in self-esteem and body image. Our research adds to the body of evidence that suggests that weight loss—this culture's traditional remedy for stigmatization—is ineffective and associated with worse psychological adjustment among fat people.

Fortunately, our findings also suggest that at least one population of fat people has discovered ways of coping with stigmatization that are associated with lower levels of distress—among them the same forms of coping associated with better adjustment to other stressors. "Fat acceptance" as an approach to weight stigmatization therefore appears to have at least some validity and is worthy of further study. In the absence of a way to make fat people's bodies conform to socially acceptable norms, these findings are welcome news, indeed.

Suggestions for combating prejudice and discrimination against fat people appear in the toolbox for change below.

TOOLBOX FOR CHANGE

For	*Images/Perceptions*	*Strategies for change*
Individuals	Fat people are stereotyped and harassed. People believe that fatness is easily remedied by dieting or exercise. Fat people are socially excluded. Fat people are blamed for their weight. As a result, fat people (as well as everyone who feels fat) have poor self-esteem and poor psychological adjustment.	Stop dieting. Join a fat-affirmative group or form one. Protest dieting posters, companies, and media. Teach children to love their bodies at all sizes. State fat-affirmative views. Inform people about the risks and failures of diets. Model self-acceptance of body weight. Correct disparaging remarks about weight in all people. Seek out people with similar views for social support. Regardless of your size, make friends with fat people.
Community/Society	Beauty is narrowly defined as thinness. All people are exploited by the diet and fitness industries. Fat people are believed to lack self-discipline and willpower.	Protest dieting posters, companies, and media. Teach children to love their bodies at all sizes. Add size discrimination to non-discrimination policies. Encourage physical activity in all people, and do not link it to weight loss. Profile community leaders of all sizes.

(continued)

For	*Images/Perceptions*	*Strategies for change*
Practitioners/ Educators	Fat people are not hired or are denied benefits. Fat people are told to lose weight. Fat people are mistreated by health and mental health practitioners. Educators do not protect children from harassment based on weight in schools.	State fat-affirmative views. Inform people about the risks and failures of diets. Model self-acceptance of body weight. Correct disparaging remarks about weight in all people. Have office chairs that fit all sizes. Distribute the resources of fat-affirmative books, magazines, children's books, videos, Web sites, etc. Refer people to fat-affirmative health care providers, therapists, etc.

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