Overweight and Obesity: Oppression, Damaged Identities, and Diminished Moral Agency

A THESIS
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL
OF THE UNIVERSITY OF MINNESOTA
BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
MASTER OFARTS

Joan Liaschenko

July 2012

Acknowledgements

I would like to thank Professor Joan Liaschenko for her patience, guidance, and support through all stages of this project. Joan has taught me a great deal about the importance of feminist perspectives in bioethics and mentored me as I grappled with how to apply these perspectives to my own work on overweight and obesity. I would also like to thank Professors Deb DeBruin, Naomi Scheman, and Dianne Neumark-Sztainer for agreeing to serve on my thesis committee. Their feedback was crucial in helping me improve my writing and develop a better understanding of the issues I studied and wrote about.

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I. Introduction

Somatic norms and body ideals are dynamic social constructs that shape shared understandings of how bodies ought to be, how they ought to look (shape, size, color, etc.), and what they ought to be capable of doing. These norms and ideals are dependent on historical, social, geographic, and political location. And while they are inconsistent from time A to time B, place A to place B, etc., body ideals and/or norms consistently render those whose bodies don't conform to them worth less, marginalizable, exploitable, objectifiable, fetishizable, and/or very much embodied. Feminist philosopher Naomi Scheman (1993) articulates this sentiment in her essay "The Body Politic/The Impolitic Body/Bodily Politics" (which I will refer to as "The Body Politic" from this point on):

> Given the definition of full, exemplary humanness as sameness, the different are necessarily less than fully human, objects to the human subjects, and, typically, unlike the subjects, essentially embodied. The different are identified by their bodies – they are reputed not only to look different but to smell different and to have different capacities and tolerances – and it is obsessively that their bodies are mythologized, feared, loathed, exploited, tortured, or destroyed. (p. 188)

Here and now, these bodies belong to women, non-whites, intersex individuals, dis(dif)abled individuals, overweight/obese individuals, etc.

For years, feminist activists and scholars have been engaged in theoretical and political projects aimed at understanding and deconstructing (especially feminine) body ideals and somatic norms and the systems of oppression they play into. These projects are essential to understanding the impact that aesthetic ideals and somatic norms have on individuals and groups, including women, non-whites, dif-abled individuals, overweight and obese individuals, etc. These projects are essential for resisting oppression, for reclaiming our bodies, and for repairing damaged identities and establishing agency that has been stripped by somatic norms and ideals. The focus of these projects has been,

understandably so, on conformation to somatic norms and ideals easily determined by appearance; but appearance alone doesn't dictate whose bodies are privileged and whose are oppressed.

"Healthy" bodies are ideal; they are normal. Bodies ought to be healthy. They ought to be disease-free, able-bodied, and fit. And just as those whose bodies don't otherwise conform to somatic norms and ideals, those whose bodies don't conform to health "norms" are essentially embodied, defined by their "disease" or "unhealthy" state, and are often times the victims of oppression. For example, the mentally ill, the overweight and obese, the "disabled," cancer patients/survivors, AIDS victims, etc., are defined by their "disease" and are essentially embodied so long as they are in or perceived as being in an unhealthy state. I would not say that all those perceived as unhealthy are the victims of oppression, for example, cancer patients are not always oppressed. But those whose "condition" is seen as a sort of moral failing or consequence of a series of moral or other failings are often times oppressed.

In my thesis, I will argue that the concepts of overweight and obesity are oppressive, where oppression is defined as "systematic institutional processes that prevent certain groups of people from developing and exercising their capacities or gaining access to material goods" (Nelson, 2001b, p. 61), and that they damage identities and diminish moral agency.[1] The terms "overweight" and "obesity" have very specific

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[1] I won't argue that this is how it has always been or how it will always be but that this is how it is now. This thesis does not provide an all-encompassing framework for understanding all the ways overweight and obese bodies are oppressed, as that's just not possible and probably not very useful. What I will do is articulate the ways I understand overweight and obesity to be oppressive in ways I find useful for resisting this oppression.

body mass index (BMI)-cutpoint definitions that contribute to our conceptualization of "normal" and abnormal bodies, healthy and unhealthy bodies. These definitions influence our conception of disciplined and undisciplined individuals, moral and immoral individuals, beautiful and ugly individuals, etc. These BMI-cutpoint definitions of overweight and obesity interact with body ideals and somatic norms to render the terms overweight and obesity oppressive.

First, I will discuss what overweight and obesity are using the same BMI-cutpoint definitions used by the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH). I will trace the genesis of these definitions to Adolphe Quetelet's work on weight-height ideals and the subsequent use of weight-height ideals by the Metropolitan Life Insurance Company. I will go on to discuss the work of Ancel Keys (1972) and his colleagues on the relationship between measures of body fat (body density and skinfold thickness) and the BMI and the impact this work had on BMI-cutpoint classifications of body weight set by the WHO, followed closely by the NIH. I will conclude this section of my thesis with a discussion of conflicts of interest and the nontransparent genesis and use of BMI-cutpoint definitions of overweight and obesity.

I will then explain how BMI-cutpoint definitions of overweight and obesity and somatic norms and ideals contribute to oppressive conceptions of "fat" bodies. I will first explain how the use of BMI to define overweight and obesity is a form of medical gaslighting. I will draw on philosopher Paul Benson's (1994) use of the term "medical gaslighting," or the [intentional or unintentional] manipulation, control, management, etc., of some one or some group's sense of health, to explain how the use of BMI-cutpoint definitions of overweight and obesity is a form of medical gaslighting. I will show that the use of these definitions of overweight and obesity perpetuate inaccurate conceptions of whose bodies are "fat," whose bodies are healthy [and whose are not],

whose bodies are at risk of developing chronic diseases, and whose bodies are at risk of dying prematurely. I will explain how claims that BMI predicts body fat and that "normal" BMI correlates with health and longevity, while inaccurate or, at the very least, vastly oversimplified, "justify" the prevention of overweight and obese people "from developing and exercising their capacities or gaining access to material goods" (Nelson, 2001b, p. 61).

I will then analyze how BMI-defined overweight and obesity interact with body norms and ideals to contribute to the objectification and commodification of bodies, where the body (and person) becomes an object, a commodity, the worth of which is based on its classification, on its conforming to aesthetic AND health ideals. I will draw on Naomi Scheman's (1993) description of the "Impolitic Body" to theorize the control, discipline, and objectification of overweight and obese bodies. I will then draw on the work of Karl Marx (1867) to explain how current conceptions of overweight and obesity contribute to the commodification of bodies.

In the next section of my thesis, I will explore how conceptions of overweight and obesity are oppressive as they damage identities and diminish moral agency. I will draw on the work of Hilde Lindemann (2006; Nelson, 2001a; Nelson, 2001b) to define identity and explore how current conceptions of overweight and obesity damage identities. I will then draw on Paul Benson (1994), Hilde Lindemann (2006; Nelson, 2001a; Nelson, 2001b), and feminist philosopher Margaret Urban Walker's (1998) works on moral agency to explain how oppression and damaged identities relate to diminished moral agency.

Finally, I will offer my own resistance to oppressive conceptions of overweight and obesity. Because somatic norms/ideals AND the use of BMI-cutpoint definitions of overweight and obesity render these terms oppressive, resistance must address problematic construction of overweight and obesity based on both appearance AND health ideals. I will discuss the usefulness of Hilde Lindemann's master narrative/counterstory framework for resisting oppression, repairing damaged identities, and [re-]establishing moral agency. Finally, I will re-visit the problematic, nontransparent genesis and use of BMI-cutpoint definitions of overweight and obesity, including conflicts of interest and the inaccuracy of BMI as a measure of excess fat, health outcomes, and longevity.

II. What are overweight and obesity?

According to the Centers for Disease Control and Prevention (CDC), a drastic increase in prevalence of overweight and obesity in the United States over the past 20 years constitutes an epidemic (*Overweight and obesity,* 2011). The World Health Organization (WHO) speaks of the global obesity epidemic, or "globesity," a "major public health problem in many parts of the world" (*Global database on body mass index,* 2012). Such claims are based on overweight and obesity being defined in terms of body mass index (BMI) values and cutpoints. The origin, nature, validity, and specification of such BMI values and cutpoints merits further analysis as their problematic genesis and nontransparent use is relevant to understanding oppressive conceptions of "overweight" and "obesity" and to building resistance to this oppression.

A. The use of BMI to classify bodies

The WHO and National Institutes of Health (NIH) define a normal BMI as between 18.5 and 24.9. Accordingly, persons with BMIs less than 18.5 are underweight; those with BMIs between 25 and 29.9 are overweight and those with higher values are obese (*Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults,* 1998*; Obesity: Preventing and managing the global epidemic: Report of a WHO consultation,* 2000).[2] These cutpoints are accepted and used by government, health organizations, and researchers to guide efforts to prevent disease and improve public health. Although well intended, the origins of these definitions, from the birth of the Quetelet index to the development of BMI-cutpoint definitions of overweight and obesity as proposed by the WHO and subsequently by the NIH, are problematic and therefore merit further analysis.

In the 1830s, Belgian astronomer Adolphe Quetelet compiled data on army draftees

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[2] In layman's terms, the WHO defines "[o]verweight and obesity…as abnormal or excessive fat accumulation that may impair health" (*Obesity and overweight,* 2011). According to the NIH, "'overweight' and 'obesity' refer to a person's overall body *weight* (emphasis added) and whether it's too high. Overweight is having extra body weight from muscle, bone, fat, and/or water. Obesity is having a high amount of extra body fat" (*What Are Overweight and Obesity?*, 2010). So while the WHO and NIH use the same BMI-cutpoint definitions of overweight and obesity, their layman's descriptions of the terms differ significantly. While the WHO describes overweight and obesity as labels for excess fat, the NIH describes overweight and obesity as labels for unhealthy weight ranges for a given height, i.e., BMI, but *also* attempts to claim that obesity is a label for excess fat.

to plot the distribution of weight against height (Hankins, 1908; Oliver, 2006; Shell, 2003). He believed that statistics, which were used in astronomy to predict phenomena, may govern human life and could provide information about "ideal" body weight. He found that around each height, draftees' weights were distributed in a bell curve (a statistically normal distribution). Quetelet also observed that the average weight for each height was proportional to height squared. He created the Quetelet index, a relationship that would later be used to calculate BMI: weight (in kilograms) divided by height (in meters) squared.

In the early twentieth century, life insurance companies began searching for a way to predict the mortality of policyholders (Dublin, 1943; Dublin & Lotka, 1945; Gaesser & Blair, 2002; Oliver, 2006). Early mortality meant less premium income before the death benefit was paid. In the 1940s, Metropolitan Life Insurance tabulated policyholders' height, weight, and mortality and found that people who weighed less lived longer. They created an actuarial table of "ideal" body-weight ranges for men and women of specific heights. By the 1950s, the MetLife table was widely used by physicians, epidemiologists, and government officials to classify individuals' and populations' weights and to predict longevity. These "ideal weight" tables informed perceptions of the relationship between weight, height, and life expectancy for many years.

Medical and public health researchers wanted a simple, consistent way to measure relative weight in order to study its relationship with health and longevity. In 1972, epidemiologist Ancel Keys and his team published a study on 7,424 men that shows of various height-weight formulas, the BMI most strongly correlates with measures of body fatness, specifically body density and skinfold thickness (Keys, Fidanza, Karvonen, Kimura, & Taylor, 1972). As they cautiously put it:

The ratio of weight to height squared, here termed body mass index, is slightly

> better...than the simple ratio of weight to height. The body mass index seems preferable over other indices of relative weight on these grounds as well as on the simplicity of the calculation and...the applicability to all populations at all times. (p. 341)

Keys et al. (1972) caution against equating "ideal" body-weight or measures of relative weight categories with indices of personal health. They note that individual variances in health are affected by demographic variables (e.g., sex, race, ethnicity, socioeconomic class, age), body composition (e.g., percent water weight, muscle, and fat), or even the distribution of fat. This caveat notwithstanding, Keys et al.'s findings made a huge impact on the medical and public health classification of individual persons' bodies.

In 1985, the NIH Consensus Development Conference on Health Implications of Obesity proposed BMI cutpoints to distinguish normal weight from obesity (*Health implications of obesity,* 1985). The cutpoints were based on data from the National Health and Nutrition Examination Surveys (NHANES) II conducted from 1976 to 1980. According to the Consensus Development Conference (1985):

> Based on indices of body fat, studies of large populations have shown that there is a continuous relationship between...BMI and morbidity and mortality. Thus, it becomes important to establish ranges of these indices as guidelines for developing appropriate and effective approaches for the treatment and prevention of obesity . . . The panelists agree that an increase in body weight of twenty percent or more above desirable body weight constitutes an established health hazard.

It appears that the NIH panelists may not have fully understood the retrospective derivation of the BMI and of the non-demographically corrected data that was used to infer that it constituted an "established health hazard." The phrase "[b]ased on indices of fat" indicates that conference panelists misunderstood Keys et al.'s conclusion that BMI as an index of relative body weight correlates with measures of body fatness but is not

itself an index of body fat; that is, the BMI is a ratio of weight to height that was shown by Keys et al. to correlate with subcutaneous fat (as measured by skinfold thickness) and body density for a sample of men but is not itself a measure of body fat. Panelists used uncited studies to show a "continuous relationship between BMI and morbidity and mortality." The phrase "continuous relationship" does not specify a mathematical function (direction and type of continuous relationship). Conference panelists also asserted "that an increase in body weight of twenty percent or more above desirable body weight constitutes an established health hazard." Cross-sectional studies cited by the Conference did not establish causality needed to support their claim regarding the "established health hazard" of "obesity."

In 1995, the International Obesity Task Force (IOTF) convened to address the global obesity epidemic and review evidence on obesity prevalence, risk factors, and health outcomes (*IOTF history*). The IOTF report was used in 1997 by the WHO for their first expert consultation on obesity (*Obesity: Preventing and managing,* 2000). This consultation made the case for global BMI cutpoints. It proposed a BMI below 18.5 as underweight, between 18.5 and 24.9 as normal, between 25 and 29.9 as overweight (or "pre- obese"), and a BMI greater than or equal to 30 as obese. According to the report (2000): "[t]he WHO classification is based primarily on the association between BMI and mortality" (p. 8). However, the section of the report (2000) discussing this association describes it as "controversial" because studies of the association between BMI and mortality are conflicting (p. 44). Nevertheless, this recommendation for classification cutpoints became the international standard. In 1998, the NIH aligned their definitions of overweight and obesity with those of the WHO (*Clinical guidelines,* 1998). In so doing, millions of Americans were defined as "pre-obese."

B. The BMI and conflicts of interest

Definitions of obesity have a huge impact on policy, medicine, research, and public health intervention. They also have a huge impact on the weight-loss, food, and pharmaceutical industries. A stakeholder is defined as "a person, group, organization, or system who affects or can be affected by an organization's actions" (*Stakeholder,* 2012). Because there are countless stakeholders who have an interest in how bodies are defined and framed as "diseased" or "healthy," the classification of body weight is highly politicized. It is critical that we understand the conflicts of interest in defining and framing these classifications, as conflicts of interest render the use of BMI to classify body weight nontransparent.

According to their website, "[t]he IOTF is a global network of experts working to alert the world to the growing health crisis caused by soaring levels of obesity. It works with the World Health Organization, other NGOs and *stakeholders* (emphasis added) to address this challenge" (*IOTF history*). The IOTF does not disclose its funding but according to University of Chicago professor and *Fat Politics* author J. Eric Oliver (2006), stakeholders provide them with substantial (about 75%) financial support. These stakeholders include weight-loss drug producers Hoffman-La Roche, producers of Xenical, Abbott Laboratories, producers of Meridia, and Servier, producers of Redux (*Pusher man: UK obesity scaremonger's financial conflicts revealed,* 2005; Oliver, 2006). "Conflict of interest" is defined as "when an individual or organization is involved in multiple interests, one of which could *possibly* (emphasis added) corrupt the motivation for an act in the other" (*Conflict of interest,* 2012). The IOTF's conflicts of interest are alarming considering their mission: "to inform the world about the urgency of

[obesity] and to persuade governments that the time to act is now" (*IOTF history*).

Conflicts of interest are not limited to the IOTF as an organization. According to Oliver (2006), pharmaceutical companies heavily fund the leadership of the IOTF, NIH, and CDC. For example, past IOTF leader Philip James is paid well by pharmaceutical companies to consult, conduct clinical trials, give "educational" presentations on the benefits of weight-loss drugs, and serve as a media spokesperson under the guise of unbiased, expert scientist (Oliver, 2006). Dr. Xavier Pi-Sunyer, chair of the committee that changed the NIH's definitions of overweight and obesity, member of the 2005 U.S. Dietary Guidelines Committee, and past editor for *the International Journal of Obesity* and *Obesity Research*, also has remunerative ties with the pharmaceutical, weight-loss, and food industries (*Results from search for: "Pi-sunyer"*; Birmingham, 1999; Oliver, 2006). According to Oliver and the "Integrity in Science Database," Pi-Sunyer has served on advisory boards of, consulted for, and been funded by Weight Watchers, Campbell Soup Company, and pharmaceutical companies that produce weight-loss and diabetes drugs. It is no secret that scientists and physicians receive funding from pharmaceutical companies and other stakeholders and are encouraged to do so by their respective academic institutions. It is, however, disturbing to consider the influence these industry ties may have in determining "scientifically sound" guidelines for the use of BMI to classify body weight considering their financial interest in these classifications.

As discussed previously, current classifications of body weight come from the 1997 WHO expert consultation on obesity and the 1998 NIH publication "Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity." Many of the expert consultants, committee leaders, and committee members had strong ties to the

pharmaceutical, food, and weight-loss industries. According to the NIH's 1998 "Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults": "The panel recognized the possibility of an advocacy "bias" due to the large number of panel members drawn from organizations with an advocacy role in the treatment of obesity" (p. 4). They failed to mention the possibility of "advocacy bias" due to the industry ties of panel members. These ties may have had no impact on panel members' decisions to set BMI guidelines as they did but conflicts of interest were not disclosed in the WHO's reports, NIH's reports, or elsewhere. This makes the use of BMI to classify individual persons' body weights nontransparent. It is important to keep this in mind when evaluating the oppressive nature of the terms "overweight" and "obesity," especially when evaluating the accuracy of BMI as a measure of body fat, health, and longevity in order to understand how the use of BMI cutpoints to define overweight and obesity is a form of medical gaslighting.

III. How are overweight and obesity oppressive?

I will follow philosopher and feminist bioethics scholar Hilde Lindemann in defining oppression as "systematic institutional processes that prevent certain groups of people from developing and exercising their capacities or gaining access to material goods" (Nelson, 2001b, p. 61). Oppression operates in institutional, political, public, and private realms, affecting virtually every aspect of the lives of both oppressed and oppressing individuals and groups. Oppression operates to marginalize, exploit, subordinate, etc., individuals based on race, class, gender, sexual orientation, ethnic background, religion, etc., but not independent of one another. Just as different aspects of identity (race, class, gender, etc.) interact, different forms of oppression interact, e.g., homophobia and racism or racism and sexism and classism.

Both somatic norms/ideals and the use of BMI-cutpoint definitions of overweight and obesity contribute to oppressive conceptions of "fat" bodies. In this section, I will discuss how non-transparent, inaccurate use of BMI cutpoints to define overweight and obesity are a form of medical gaslighting, contributing to inaccurate understandings of which bodies are "healthy" and "justifying" the prevention of overweight and obese people "from developing and exercising their capacities or gaining access to material goods" (Nelson, 2001b, p. 61). I will then discuss how BMI-defined overweight and obesity interact with body ideals and somatic norms to contribute to the objectification and commodification of bodies, where the body [and person] becomes an object, a commodity, the worth of which is based on its weight classification, on its conforming to aesthetic AND health ideals.

A. Overweight and obesity as forms of medical gaslighting

The term "gaslight" comes from the 1938 play *Gas Light* and 1940 and 1944 film adaptations of that play. It refers to the way a man manipulates his wife into believing the small changes he makes in her environment are figments of her imagination, leaving her unable to distinguish reality from "imagination" and unable to trust her own perception of reality. It is used to refer more generally to the manipulation, control, management, etc., of some one or some group's sense of reality.

Medical gaslighting is the intentional or unintentional manipulation, control, management, etc., of some one or some group's sense of health. The term "medical gaslighting" is used by philosopher Paul Benson (1994) to describe a hypothetical remake of *Gas Light* in which the leading man is not intentionally deceiving his wife but is instead a kind, caring Victorian-era physician who pathologizes his wife's behavior, regarding "women who are excitable, who have active imaginations and strong passions, and who are prone to emotional outbursts in public as suffering from a serious psychological illness" (p. 656). Because the physician's sexist understanding of his wife's behavior, of which behaviors are "healthy" and which are not, is inaccurate, his wife's understanding is inaccurate, as she accepts his judgments "on the basis of reasons that are accepted by a scientific establishment which is socially validated and which she trusts" (Benson, 1994, p. 657). The inaccurate understanding the physician's wife has of herself and her health is oppressive as it plays into "systematic institutional processes that [may] prevent" women who have been pathologized "from developing and exercising their capacities or gaining access to material goods" (Nelson, 2001b, p. 61).

Those who have been medically gaslighted have inaccurate conceptions of what's healthy and what's not, of what behaviors or bodies are diseased or at risk of becoming diseased because they trust the "facts," views, and advice espoused by a "socially validated," trusted "scientific establishment." These inaccurate conceptions often play into systems of oppression, as was illustrated by the hypothetical Victorian-era physician's sexist pathologization of his wife's behavior. The use of BMI-cutpoint definitions of overweight and obesity is a form of medical gaslighting as their use perpetuates inaccurate conceptions of whose bodies are "fat," whose bodies are healthy and whose are not, whose bodies are at risk of developing chronic diseases, and whose bodies are at risk of dying prematurely. Claims that BMI predicts body fat and that "normal" BMI correlates with health and longevity perpetuate inaccurate conceptions of whose bodies are "healthy" and whose are not as these claims are inaccurate or, at the very least, vastly oversimplified.

The BMI is not a measure of body fat. It is a ratio of weight to height, as the WHO, NIH, and CDC are well aware (*Clinical guidelines,* 1998; *Obesity and overweight,* 2011; *Healthy weight: Body mass index,* 2011). Keys et al. (1972) showed BMI correlates with subcutaneous fat (as measured by skinfold thickness) and body density for a sample of men. However, BMI does not have the same correlation with body fat in varying kinds of individuals, including those who are athletes, pregnant, elderly, children, or individuals with high bone density or water weight (Oliver, 2006; Prentice & Jebb, 2001). The WHO, NIH, and CDC assertion that body fat or overweight status may be measured with one set of BMI cutpoints disregards such variants in body composition between populations (age, race, etc.) (*Physical status: The use and interpretation of anthropometry: Report of a*

WHO expert committee, 1995; *Obesity: Preventing and managing,* 2000; *Overweight and obesity,* 2011; *Obesity and overweight,* 2011; *Global database on body mass index,* 2012; *Aim for a healthy weight,* 2012). Many studies show that percent body fat is a better predictor of health and longevity than BMI (Bigaard et al., 2004; Lahmann, Lissner, Gullberg, & Berglund, 2002; Romero-Corral et al., 2010; Tanaka et al., 2002); percent body fat may be a better measure of "overweight" and "obesity" than BMI as percent body fat is a direct measure of excess body fat and better predictor of health outcomes. However, it is important to note that the relationships between percent body fat and health and percent body fat and longevity are almost as politicized as the relationships between BMI and health and BMI and longevity.

The BMI does not have a clear relationship with health. The WHO, NIH, and CDC list overweight and obesity as risk factors for many chronic diseases including coronary heart disease, type 2 diabetes, endometrial, breast and colon cancers, high blood pressure, dyslipidemia, stroke, liver and gallbladder diseases, sleep apnea and respiratory problems, osteoarthritis, abnormal menstruation, infertility, and mental health issues (*Clinical guidelines,* 1998; *Overweight and obesity,* 2011; *Obesity and overweight,* 2011). Because these organizations define obesity using BMI cutoffs, to claim a relationship between obesity and chronic diseases is to claim a relationship between BMI and chronic diseases. And while the relationship between BMI and population prevalences of various chronic diseases is well documented, this relationship cannot be applied to individuals; it is what is called an "ecological inference fallacy," that is, the use of population-level correlations to make inferences about individuals belonging to that population (Piantadosi, Byar, & Green, 2006). In addition, the relationship between

BMI and health is not clear because part of it can be accounted for by other measures (*Clinical guidelines,* 1998; Janssen, Katzmarzyk, & Ross, 2004; Moore et al., 2004; Oliver, 2006; Rexrode et al., 1998). For example, a 2004 study on NHANES III data found that waist circumference rather than BMI predicts obesity-related hypertension, dyslipidemia, and metabolic syndrome (Janssen, Katzmarzyk, & Ross, 2004). A 2004 analysis of the Framingham Study data found that waist circumference rather than BMI accounts for obesity-related risk of developing colon cancer (Moore et al., 2004). Similar findings suggest that a part of the relationship between BMI and chronic disease can be accounted for by abdominal fat. However, the hundreds of epidemiological studies published on the topic make it difficult to conduct a thorough, unbiased literature review.

The BMI does not have a clear relationship with longevity. According to a 2005 study on NHANES I, II, and III participants, obesity and underweight are associated with excess mortality compared to normal weight (Flegal, Graubard, Williamson, & Gail, 2005). However, overweight is not associated with excess mortality compared to normal weight; strange as it may seem, normal weight is associated with excess mortality compared to overweight. According to a 2006 review of 40 cohort studies on a total of 250,152 patients (Romero-Corral et al., 2006):

> Patients with a low [BMI] (ie, <20) had an increased relative risk (RR) for total mortality and cardiovascular mortality, overweight (BMI 25–29.9) had the lowest risk for total mortality and cardiovascular mortality compared with those for people with a normal BMI. Obese patients (BMI 30–35) had no increased risk for total mortality or cardiovascular mortality. Patients with severe obesity (≥35) did

> not have increased total mortality but they had the highest risk for cardiovascular mortality. (p. 666)

The inaccurate claims that BMI predicts body fat or that "normal" BMI correlates with health or longevity contribute to inaccurate conceptions of whose bodies are healthy and whose are not. The use of BMI-cutpoint definitions of overweight and obesity is therefore a form of medical gaslighting. This form of medical gaslighting contributes to the oppression of those classified as overweight and obese as the "scientifically sound" claims implied by the use of BMI cutpoints "justify" preventing overweight and obese people "from developing and exercising their capacities or gaining access to material goods" (Nelson, 2001b, p. 61); evidence of this oppression will be discussed in the section of my thesis on damaged identities.

B. Objectification and commodification of overweight and obese bodies

I have just argued that non-transparent, inaccurate use of BMI cutpoints to define overweight and obesity is a form of medical gaslighting, contributing to inaccurate understandings of which bodies are "healthy" and which are not and to the "justification" of the oppression of "overweight" and "obese" persons based on "scientific" facts. Another way that current conceptions of overweight and obesity are oppressive is in the way that their BMI-cutpoint definitions interact with somatic norms and ideals to contribute to the objectification and commodification of bodies, where the body (and person) becomes an object, a commodity, the worth of which is based on its classification, on its conforming to aesthetic AND health ideals. I will draw on Naomi Scheman's (1993) description of the "Impolitic Body" to theorize the control, discipline, and objectification of overweight and obese bodies. I will then draw on the work of Karl Marx (1867) to explain how current conceptions of overweight and obesity contribute to the commodification of bodies.

i. Control, discipline, and objectification of overweight and obese bodies

In her essay "The Body Politic/The Impolitic Body/Bodily Politics," Naomi Scheman (1993) writes, "The main problem with bodies, I have come to think, is that they are different, and the history of Western politics and epistemology is the history of attempts at denying difference" (pg. 185). In this essay, Scheman outlines premodern understandings of difference between bodies and the history of modern attempts at denying difference. She goes on to argue that feminist projects can inform more accurate, "politically responsible" (1993, pg. 186) understandings of bodies and how differences among bodies affect ways of knowing and location(s) in systems of power. For the purposes of my work here, I am interested in Scheman's description of the "Impolitic Body," which is involved in modern attempts at denying difference.

According to Scheman (1993), the Impolitic Body is a product of individualist ideology that allowed the modern self to be liberated from the church and systems of power based on heredity. This liberation of the modern self required that the body and self/subject be separate. Scheman (1993) draws on the work of Foucault to describe the relationship between modern body and self:

> As Foucault has argued most thoroughly, the modern body is disciplined, anatomized, medicalized, dissected, and surveyed by diffuse systems of power…These become internalized by a socially constituted self that is empowered by its success at objectifying and controlling its own body, that is, the body that it happens to inhabit and on which it is dependent, and for which it therefore has to assume particular responsibility. Both our bodies and our dependence on them are embarrassments to the modern self. Even if they are

> regarded as indispensable, they are blamed for our failures, both epistemic and moral; they make us liable to illusions and to temptation. (p. 187)

I draw on this description as I believe it is an accurate depiction of current, mainstream understandings of the body that are relevant to understanding how current conceptions of overweight and obesity lead to the objectification of bodies and are oppressive. I interpret this description as it is relevant to overweight and obesity through a feminist lens, knowing that differences between bodies affect persons' ways of knowing and locations in systems of power.

The body is imperative to, perhaps even symbolic of, its owner's location in systems of power. The modern body, as described by Scheman (1993), the self-controlled, self-disciplined body, specifically that which is "generic," "normal," or "ideal," is symbolic of a position of power and/or privilege. One who is able to objectify and control *one's own* body is understood as having some power over it and over oneself. Perhaps this is because those able to control their own bodies are thought to be less liable to the "illusions" and "temptations" that lead to epistemic and/or moral failures. Or perhaps it is because those able to control their own bodies are able to conform to somatic norms and ideals, including those prescribed by BMI-cutpoint definitions of overweight and obesity.

But not everyone is, in fact most people are not, perceived as having the capacity or ability to successfully objectify and control their own bodies…so others do it for them. The "undisciplined," "uncontrolled" body is symbolic of incompetence, of a lack of ability or lack of capacity to own and take care of oneself. Because they are clearly incapable of mastering themselves, those perceived as lacking the capacity to discipline

or control their own bodies have their bodies and selves objectified, controlled, and disciplined by others. This is one way those with "undisciplined," "uncontrolled" bodies are oppressed, or systematically prevented "from developing and exercising their capacities or gaining access to material goods" (Nelson, 2001b, p. 61).

Overweight and obese individuals are perceived as lacking the capacity or ability to successfully control their own behavior, which translates not only to an inability to control their own bodies but also to an inability to control themselves.[3] And because those with "abnormal" bodies are identified by their bodies and are therefore essentially embodied, overweight and obese individuals are essentially embodied.[4] So overweight and obese individuals *are* bodies, bodies that symbolize overweight and obese persons' lack of self-control and self-discipline, their inability to own and take care of themselves.

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[3] Overweight and obesity can often be detected visually but can always be detected reliably using BMI-cutpoint definitions. For example, an individual may or may not appear overweight, but if their BMI falls between 25 and 29.9, they are indeed officially overweight. BMI is a "reliable" (perhaps "consistent" is a more accurate descriptor) tool for individuals to classify themselves, for physicians to classify patients, and for public health professionals to classify research subjects and populations. BMI is a reliable tool that can be used to classify those who lack the ability or capacity to control and discipline their own bodies. BMI is therefore a tool that can be used to oppress "abnormal" bodies.

[4] "Abnormal" bodies include those that deviate from aesthetic norms AND health norms, that is, those that deviate from "normal" BMI cutpoints, so overweight and obese bodies are abnormal.

Overweight and obese individuals are bodies in need of discipline, bodies in need of objectification, as they are deemed incapable of disciplining and objectifying themselves. This excerpt from Scheman's "The Body Politic" (1993) speaks to the need for discipline of those who are their bodies:

> The disciplines that control the impolitic body confer power and authority on those who master them: sublimation is the Freudian term for this process as applied to one's own(ed) body. Those who *are* their bodies are disciplined, mastered by others: they are those who lack the moral power of sublimation. (p. 189)

What I understand Scheman to be saying here is that those who are able to control themselves and their bodies and conform to understandings of what's "normal," "healthy," and "morally sound" are in or put in a position of power. Those who are not able to control themselves and their bodies and conform to understandings of what's "normal," "healthy," and "morally sound" *are* their bodies and "need" to be controlled, disciplined, and objectified by others, by those with "the moral power of sublimation" (Scheman, 1993, pg. 189). It follows then that as those who *are* their bodies need to be, and are, controlled, disciplined, and objectified by others, overweight and obese people/bodies need to be controlled, disciplined, and objectified by non-overweight/obese others.[5]

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[5] There's something interesting, even strange, about overweight and obesity: if the overweight/obese individual is able to figure out how to control, discipline, and objectify their own body, this responsibility to master the body may shift from the oppressor to the

Somatic norms and ideals, public health discourse, weight-loss recommendations made by healthcare professionals, popular media reports, and weight-loss industry advertisements, etc., that perpetuate inaccurate understandings of what types of bodies are "normal," "healthy," or beautiful" "justify" the control, discipline, and objectification of persons identified as overweight or obese (by appearance and/or by BMI-cutpoint definitions). They contribute to oppressive conceptions of overweight and obesity. As I will provide evidence for more specifically in the section of my thesis on damaged identities and diminished moral agency, current conceptions of overweight and obesity are oppressive as they "prevent certain groups of people from developing and exercising their capacities or gaining access to material goods" (Nelson, 2001b, pg. 61). They are oppressive as they render some (healthy, beautiful) bodies worth more than others. And for those individuals whose bodies deviate from norms and ideals and are therefore essentially embodied, these conceptions render them, both body and self, worth less.

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oppressed. And if the overweight/obese individual *successfully* masters their own body, they lose weight and become "normal," perhaps visibly so or by BMI-cutpoint definition. In this way, their oppression is variable.

ii. Commodification of overweight and obese bodies

The perceived value of bodies, where "value" is defined as "relative worth, utility, or importance," (*Value,* 2012) is relevant to the discussion of the oppressive nature of the terms "overweight" and "obesity" as these terms render bodies that don't conform to somatic and health norms/ideals worth less than those that do. The perceived value of a body is influenced by what that body looks and feels like,[6] its health status, and its social, political, historical, and geographic (etc.) location. Bodies that conform to somatic norms and ideals, those that look and feel how they ought to at a specific time and in a specific location, are perceived as being better than or worth more than those that don't look and feel how they ought to. For example, here and now white (or slightly tanned) bodies are worth more than brown or black ones. Toned bodies are worth more than flabby ones. Young are worth more than old. Bodies perceived as healthy, free of disease or at lower risk of becoming diseased, are perceived as being worth more than "unhealthy" bodies.

The perceived value of a body is also influenced by its perceived usefulness. It may seem strange to think of bodies as "useful," or perhaps it is painfully obvious that they are. But the perceived "usefulness" of our bodies is relevant to understanding the oppressive nature of the terms "overweight" and "obesity" as those bodies perceived as more "useful" than others, for looking at, touching, having sex with, selling products,

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[6] The way a body feels, whether it is firm or squishy, hairy or smooth, soft or rough, influences the perceived value of that body as the way bodies ought to look AND feel (and smell and sound and taste, etc.) are dictated, at least in part, by somatic and health ideals/norms.

working, etc., are "better" or worth more. Bodies useful for work, e.g., healthy or strong bodies, are more valuable than those that aren't. Bodies useful for looking at, e.g. beautiful bodies, are more valuable than those that aren't.

Individuals use their own bodies to nourish, breathe, and perceive and communicate with the outside world. Without our bodies as "vessels," vessels for our lives, our minds, or our souls, we wouldn't exist as we do exist and as we understand ourselves to exist. I find it useful to think about the perceived usefulness and worth of bodies in terms used by Karl Marx in his work *Das Kapital*. According to Marx (1867), use-value is a property dependent on physical properties of an object that make it useful. Marx (1867) writes on use-value, **"**The utility of a thing makes it a use value…This property of a commodity is independent of the amount of labour required to appropriate its useful qualities…Use values become a reality only by use or consumption" (p. 26). Bodies are use-values because of the physical properties that make them useful. For example, very broadly, our bodies are useful to live in the world as we do, for breathing, nourishing, perceiving, and communicating. A more specific example of bodies as use-values is that some human bodies, for example, human bodies with functioning legs, are useful for walking. And some human bodies, for example, those with strong and functioning legs, arms, and backs, are useful for lifting heavy objects. The ways that bodies are actually used and consumed are what make bodies as use values a reality.

The use-value of an object, good, or service, such as a body, is a prerequisite for social use-value, which is the usefulness of an object to people other than the object's producer. Human bodies are social use-values, as human bodies are useful not only to embodied selves but to others as well. As stated previously, beautiful bodies are useful

for looking at. They are also useful for having sex and reproducing with. They are useful for selling products. Healthy bodies are also useful for looking at, so long as they are reasonably attractive, which they should be if they're healthy. Healthy bodies are useful for having sex and reproducing with and for selling products. They are useful for performing labor.

Because human bodies are useful to people other than their embodied selves, human bodies are distinguished from one another as social use-values. Social use-values of bodies influence whether people will perceive those bodies as valuable. But use-values alone do not determine the terms under which bodies will be exchanged. Use-values "constitute the *substance* (emphasis added) of all wealth, whatever may be the social form of that wealth…[T]hey are, in addition, the material depositories of exchange value" (Marx, 1867, p. 26). In addition to considering human bodies as use-values, considering them as exchange values is useful for understanding their perceived differential worth.

Exchange value is understood as a commodity's worth in the marketplace. A commodity, according Marx (1867), is "an object outside us, a thing that by its properties satisfies human wants of some sort or another" (p. 26); the nature of human wants or how the commodity satisfies them does not matter. A commodity is a good or service that is sold or traded for other commodities in a marketplace. The first property of a commodity is its use-value, which has already been discussed. Social use-value is a prerequisite for the second property of commodities: exchange value.

To illustrate what is meant by "exchange value," Marx (1867) describes the exchange of a quarter of wheat for "x blacking, y silk, or z gold" (p. 26). The exchange value of a quarter of wheat is then x blacking, y silk, z gold, or a quarter of wheat. As

exchange values, these are equal to one another and therefore exchangeable.[7] The same could be said for any specific amount *x* of commodity *a* and specific amount *y* of commodity *b* so long as they are equal to one another and one's worth can replace the other and vice versa. Or the same could be said for any body *x*, where *x* denotes the type

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[7] What determines a commodity's worth in the marketplace? The labor theory of value set forth by Marx (1867) in *Das Kapital* argues that the value of a commodity is dependent on the labor put into producing or acquiring that commodity. But other economic theorists disagree on the extent to which the value of a commodity is dependent on labor, arguing that supply and demand are also critical for explaining the value of a commodity (Marshall, 1920). Although it is beyond the scope of this paper, it is interesting to think about the ways the labor theory of value and an understanding of supply and demand could be used loosely to understand the commodification of bodies and the impact this has on those commodified. For example, [here and now] "beautiful," "healthy" bodies (i.e., those with a BMI between 18.5 and 24.9) take a considerable amount of labor (self-discipline, self-control, exercise, etc.) to acquire and/or maintain; the amount of labor put into producing/maintaining a body that falls into a specific weight classification may have an impact on that body's perceived monetary and social worth. "Beautiful," "healthy" bodies, those with a BMI in the normal range, are in low supply (remember "globesity"?) and high demand. The low supply and high demand for a specific type of body may also have an impact on the perceived monetary and social worth of all bodies.

of body, including, but not limited to, shape, size, color, and texture, and any body *y* or specific amount *z* of commodity *c*, again, so long as they are equal to one another and one's worth can replace the other and vice versa.

So how can the terms "use-value," "exchange value," and "commodity" be used to enlighten the discussion about current conceptions of overweight and obesity as oppressive? As explained previously, bodies are use-values. Bodies are useful to their inhabitants for breathing, eating, and living as we know living to be. They are useful to others for reproduction, looking at, labor, etc. The perceived usefulness of bodies is a prerequisite for their considered worth in the marketplace, for bodies as exchange values. For example, "normal," "healthy," "beautiful" bodies are perceived as being more useful to both their embodied selves and to others for living, mobility, reproduction, looking at, labor, etc., than bodies that deviate from health and somatic norms/ideals. Likewise, they are perceived as being worth more socially and monetarily than bodies not considered "healthy" and/or "beautiful." It is this differentiation in the perceived usefulness and worth of bodies based on their weight classification that leads me to understand BMI-cutpoint definitions of overweight and obesity as contributing to the commodification of bodies and oppressive nature of the terms "overweight" and "obesity." To clarify, I use the term "commodification" to describe the process of assigning economic value to things, in this case bodies. I use it to describe the process of assigning exchange values to bodies, which are inherently use-values.

The weight-loss industry serves as a testament to the perceived differential worth of bodies based on their weight classification and also as an example of the contribution this perceived differential worth makes to the commodification of bodies. BMI-based

weight classifications influence our understandings of which bodies are "healthy" and therefore which bodies are best, most useful, and worth most; they also influence our understandings of which bodies are unhealthy, less useful, and worth less and therefore "need" to lose weight. The weight-loss industry capitalizes on individuals' perceived need to lose weight in order to conform to somatic norms/ideals AND understandings of what it means to be healthy.[8] In order to attain a "normal," "healthy," and/or "beautiful" body, U.S. consumers spend between $20 and $60 billion and Western European consumers spend approximately $1 billion annually (*U.S. weight loss market worth $60.9 billion,* 2011; *100 million dieters, $20 billion: The weight-loss industry by the numbers,* 2012; Ross, 2010). These market values can be interpreted in a few ways to understand the commodification of bodies but no matter how they are interpreted, the point I would like to illustrate is the same: people spend enormous sums of money to lose *weight,* but not necessarily body fat, because the body they hope to attain is worth that much more socially and economically than the body they currently have.

Commodification of bodies and perceived differential worth of bodies based on their weight classification have many ethical implications. First, as discussed previously, we ought to be concerned that the genesis of BMI-cutpoint definitions of overweight and

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[8] It is important to note that while the BMI is misleading and potentially inaccurate for the diagnosis of overweight and obese individuals with no BMI-correlated disease, BMI cutoffs may be useful for suggesting a target weight range to patients with or at risk of developing sleep apnea or diabetes mellitus type II (Keys, Fidanza, Karvonen, Kimura, & Taylor, 1972; Oliver, 2006; Prentice & Jebb, 2001).

obesity was nontransparent as many of the expert consultants, committee leaders, and committee members involved in their genesis had strong ties to the pharmaceutical, food, and weight-loss industries (*Results from search for: "Pi-sunyer"*; *Pusher man: UK obesity scaremonger's financial conflicts revealed,* 2005; Birmingham, 1999; Oliver, 2006); this nontransparent genesis may allow us to believe that more people have unhealthy excess body fat than actually do and to "justify" their oppression. In addition, we ought to be concerned about the way commodification of bodies and their perceived and real differential economic worth reinforces discrimination based on negative perceptions of overweight and obese persons, including perceived lack of self-control and self-discipline,[9] and results in real material effects on overweight and obese persons, including but not limited to employer discrimination and barriers to access to health care and health insurance (*The council on size & weight discrimination: Frequently asked questions about weight discrimination*; Brown, 2010; Van Dusen, 2008; Wang, 2008). Finally, we ought to be concerned that those who are otherwise essentially embodied are disproportionately affected by the perceived differential worth of overweight and obese bodies.

Commodification renders those who are essentially embodied worth the economic and social value of their bodies. Those whose bodies deviate from the somatic norm

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[9] The negative perception of overweight and obese individuals leads to what Lindemann calls damaged identities and diminished moral agency (Nelson, 2001a; Nelson, 2001b); these concepts will be discussed further in the following section of my thesis.

and/or ideal are essentially embodied. Women perceived as deviating from the male somatic norm, non-whites perceived as deviating from the white somatic norm, dif-abled individuals perceived as deviating from the able-bodied somatic norm, etc., are often taken to be their bodies rather than persons. These essentially embodied individuals are valued as bodies rather than as persons. And because the bodies of overweight and obese persons are worth less, those essentially embodied who also happen to be overweight or obese are worth less.

IV. Why is this oppression a problem?

So far I have argued that current conceptions of overweight and obesity are a form of medical gaslighting and contribute to the objectification and commodification of bodies. In this section of my thesis, I will explore how conceptions of overweight and obesity are oppressive as they damage identities and diminish moral agency. I will draw on the work of philosopher and feminist bioethics scholar Hilde Lindemann (2006; Nelson, 2001a; Nelson, 2001b) to define identity and explore how current conceptions of overweight and obesity damage identities. I will then draw on Paul Benson (1994), Hilde Lindemann (2006; Nelson, 2001a; Nelson, 2001b), and feminist philosopher Margaret Urban Walker's (1998) works on moral agency to explain how oppression and damaged identities relate to diminished moral agency.

A. Damaged identities

In *Damaged Identities, Narrative Repair*, Lindemann (Nelson, 2001a) defines identity as "the interaction of [a] person's self-conception with how others conceive her: identities are the understandings we have of ourselves and others" (page 6). In *An Invitation to Feminist Ethics*, Lindemann (2006) explains identity more thoroughly:

> Your identity is a complicated interplay of how you see yourself and how others see you, and both senses of who you are take some of their shape from culturally authorized, shared understandings of what sorts of lives there are and who may (or must) live them. (pg. 43)

Our identities, including our individual identities, social identities, political identities, national identities, racial identities, gender identities, sexual identities, etc., are shaped by historically and geographically-located conceptions of skin color, sexual orientation, gender, socioeconomic background, geographic location, political affiliation, religious beliefs, etc. They are shaped by specific personal experiences and the experiences of others, by widely-accepted cultural narratives as well as by stories of resistance. One person has many identities, which are a product of relationships with others and some of which conflict with or seem to contradict one another, e.g., Catholic and lesbian.

Our bodies and health status contribute to the understandings that we have of ourselves and others. The color of our skin, hair, and eyes, our features, our body shape, and our health status (accurately or inaccurately) tell others where we're from, our history, and our habits. Our weight classification, which is meant to be a sort of indication of health status, contributes to our understandings of ourselves and others (and others' understandings of us) as healthy and beautiful. It contributes to our perception of

our own and others' abilities to exercise self-control and self-discipline, to be virtuous, morally upright people. To be classified as overweight or obese based on appearance or based more officially on BMI-cutpoint definitions is to understand oneself and to be understood by others as less healthy, less beautiful, less useful, and worth less than "normal" or even "underweight" individuals. It is to be understood as less able to exercise self-control and self-discipline and to be less virtuous.

In her essay "Identity and Free Agency," Lindemann (Nelson, 2001b) discusses how systems of power and oppression create oppressive identities necessary for these systems to operate. She argues that these oppressive identities damage identities and restrict their victims' moral agency. Lindemann describes two types of damages to identity, both of which affect how individuals perceive and exercise their moral agency: deprivation of opportunity and infiltrated consciousness. Current conceptions of overweight and obesity damage identities in both of these ways.

Deprivation of opportunity occurs when the dominant group's perception of the marginalized group is oppressive, leading to systematic deprivation of opportunities to "[exercise] their capacities or [gain] access to material goods" (Nelson, 2001b, pg. 61) or meaningful relationships. The dominant group may perceive the marginalized group, as a group or individuals in that group, as less "human," as incompetent, irrational, less intelligent, lacking self-control and/or self-discipline, etc. Their negative perception of the marginalized group, no matter how irrational, allows the dominant group to justify or be comfortable with systematic deprivation of opportunity for certain groups people. This includes deprivation through policy, such as segregation by law or not allowing certain

groups to vote in political elections, or deprivation through practices that aren't (at first glance) obviously oppressive, such as the incarceration of non-whites in the U.S.

Current conceptions of overweight and obesity damage identities by deprivation of opportunity. Overweight and obesity damage identities in this way as the negative perception of overweight and obese persons by non-overweight and obese persons leads to systematic deprived opportunities to "[exercise] their capacities or [gain] access to material goods" (Nelson, 2001b, pg. 61) or meaningful relationships. As discussed previously, overweight and obese individuals and their "ugly," "unhealthy" bodies are objectified and perceived as being worth less than "normal" and "underweight" individuals. They are understood as moral incompetents, as lazy, less rational, having less self-control and self-discipline; they are understood as incapable of mastering their own bodies. These understandings of overweight and obesity have a real impact on overweight and obese individuals. I acknowledge that these understandings of overweight and obese persons and discrimination that follows tend to be based on appearance rather than BMI-cutpoint definitions. However, BMI-cutpoint definitions of overweight and obesity do have a real impact on those considered overweight or obese [based on these definitions], specifically in situations where this information is available to those in a position of power, e.g., insurance companies or healthcare providers, who believe BMI cutpoints render the claims about overweight/obesity and health more scientific and reliable.

Overweight and obese individuals are regularly the victims of employer discrimination, not getting hired for jobs or having employers assume laziness or physical disability because of their weight (*The council on size & weight discrimination*; Brown,

2010; Van Dusen, 2008; Wang, 2008). According to a 2008 Forbes article on the affects of weight on one's career, "Weight-based discrimination consistently affects every aspect of employment, from hiring to firing, promotions, pay allocation, career counseling and discipline…The bias appears to be most prominent during the hiring process, when an employer knows a potential employee the least and therefore is most likely to be influenced by stereotypes (such as fat people are lazy)" (Van Dusen, 2008). According to the same article, obesity can mean lower wages for both men and women. This serves as evidence that the perceived social use-value of overweight and obese individuals has a real impact on their worth; prejudice against overweight and obese individuals has a material impact on the victims of discrimination. Employer discrimination against overweight and obese individuals damages identities by systematically depriving these individuals of opportunities to "[exercise] their capacities or [gain] access to material goods" (Nelson, 2001b, pg. 61).

Overweight and obese individuals experience reduced access to health insurance and quality healthcare. According to the Council on Size and Weight Discrimination, "Large people are systematically denied health insurance and life insurance, or they are forced to pay higher premiums than those of average weight"[10] (*The council on size &*

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[10] I contacted the Council to inquire what is meant by the phrase "average weight." Here is [the relevant portion of] their response:

> Few people notice our usage of the word "average," but we use it for a specific reason. We feel that the word "normal" implies a judgment, namely that any weight outside that range is "abnormal" and therefore wrong in some way,

weight discrimination); a quick Google search ("BMI insurance rates") makes it clear that those with high BMI, i.e., overweight or obese individuals, often pay higher rates for health and life insurance. Overweight and obese individuals face discrimination from healthcare providers and, as a result, may receive lower quality healthcare or avoid visiting clinics and hospitals altogether (*The council on size & weight discrimination*;

> whether that be morally reprehensible or medically unhealthy. We follow the philosophy of the health at every size movement, which holds that a person's weight is not an accurate way of predicting that person's state of health. People of any size can be healthy or unhealthy. We understand that the medical community has adopted terminology that classifies people according to their BMIs, and sorts them into "underweight," "normal," "overweight," and "obese." When holding discussions with doctors or in medical environments, we follow that convention, although we prefer to use quotations around the terms, at least the first time we use them. This is a political issue for us. We seek to change the societal view of what is normal. We want to expand the ranges of weights that are seen as normal to include people of all sizes…So the answer to your question is no, we do not mean a true average. We just don't want to use the term "normal," because it carries a judgment (as do "overweight" and "obese"). If you are being specific and following the medical classifications of weight ranges, then our statement should say "Large people are systematically denied health insurance and life insurance, or they are forced to pay higher premiums than those who fit into the medical category of 'normal weight.'"

Brown, 2010; Wang, 2008). "[N]ot only does societal discrimination punish fat people with fewer opportunities, it also subjugates fat people by refusing them the medical and financial support that would help them to improve their weight management" (Wang, 2008, pg. 1913-1914).

Infiltrated consciousness occurs when marginalized individuals or groups accept oppressive understandings of their group. According to Lindemann (Nelson, 2001a), "[A] person's identity is damaged when she endorses, as part of her self concept, a dominant group's dismissive or exploitative understanding of her group, and loses or fails to acquire a sense of herself as worthy of full moral respect" (page xii). Lindemann draws on Paul Benson's (1994) hypothetical *Gas Light* remake to illustrate what she means by infiltrated consciousness. The leading man of Benson's remake, a Victorian-era physician, pathologizes his wife's behavior, that is her excitability, active imagination, strong passions, and emotional outbursts, based on sexist, oppressive notions of psychological health. Because the physician's wife trusts his judgment "on the basis of reasons that are accepted by a scientific establishment which is socially validated and which she trusts" (Benson, 1994, pg. 657), she accepts oppressive understandings of herself and women like her. It is in this way that her identity is damaged through infiltrated consciousness.

Current conceptions of overweight and obesity damage identities through infiltrated consciousness. Overweight and obesity damage identities in this way when overweight and obese persons accept oppressive understandings of themselves, including understandings of themselves as objects, as worth less than non-overweight or obese individuals, as having less self-control and self-discipline, and as being less capable of

responsibly exercising agency. Overweight and obesity damage identities through infiltrated consciousness when overweight and obese persons accept oppressive, *inaccurate* understandings of themselves as lazy, unhealthy, and ugly. The following is an excerpt from a journal entry I wrote in February of 2010. I include this in my thesis because it illustrates my own understanding of and experience with infiltrated consciousness resulting from current conceptions of overweight. With a BMI of 27.5 (yes, I knew my BMI, which confirmed that I was "abnormal," "unhealthy," and "ugly"), I was overweight when I wrote:

> I am dissatisfied. I have become bigger than ever. It is uncomfortable to feel fat between my arm and ribs when my arms are at my side. It is disgusting to see myself bare in the mirror, rolls of chub on my back. I need to live for now and for when I am old! I fear heart problems, arthritis, diabetes, and cancer would be horribly unpleasant experiences for myself and whoever else is around to deal with me. I always say I will start now. "I will start caring now!" But I have always cared. So maybe I will start now. Start saying rather than thinking and maybe action will come next.

I look back and am able to see the relationship I had with my own body was a product of infiltrated consciousness. I bought into oppressive understandings of the normal, ideal body, disgusted with the way I looked because I was "fat." I bought into inaccurate understandings of the relationship between weight and health because of what I had known to be "true" based on what I thought was common sense medical and public health knowledge. I experienced a diminished sense of agency because I believed my "abnormal," high weight was a product of my own lack of self-discipline, lack of self-

control, lack of ability to own and master my own body. And I don't think this understanding of my body, with my identity damaged by infiltrated consciousness because I bought into what I *believed* and thought I *knew* about overweight and obese people, is unique to me.

B. Diminished moral agency

Traditionally, agency has been understood as the capacity of agents that allows them to act freely. Free exercise of agency is then dependent on the agent's ability "to govern one's conduct willfully and…capacity to regulate one's will reflectively" (Nelson, 2001b, pg. 51). But this understanding of agency doesn't capture the whole picture. Free exercise of agency is not just dependent on the capacities of moral agents; it also has a social component (Benson, 1994; Nelson, 2001b; Walker, 1998). The agent must be seen by both herself and others as a moral agent, as morally competent. Hilde Lindemann (Nelson, 2001b) echoes the work of Paul Benson (1991) when she writes about "normative self-disclosure," or "the ability to reveal through his actions who he is, morally speaking" (pg. 52), as one of the capacities of a moral agent: "normative self-disclosure…embraces not only the agent's ability to appreciate the moral construction that others will place on one's actions but also recognition, on part of those others, that the actions are those of a morally developed person" (pg. 54). The works of Benson (1991), Lindemann (Nelson, 2001b), and feminist philosopher Margaret Urban Walker (1998) speak to the social component of the free exercise of agency. That is, free exercise of agency is in part dependent on agents' relationships and the way agents' actions are taken up by others.

How is identity related to free agency? Again, our identities are the understandings we have of ourselves and others (Nelson, 2001a). These understandings impact the way our actions are taken up by others. Our identities impact the way we're seen as morally responsible, morally reprehensible, and worthy of moral respect; they

impact how we're viewed as moral agents. Lindemann (Nelson, 2001b) writes about how identity relates to agency:

> [T]he connection between identity and agency is an internal one, for my actions disclose not only who I am but who I am taken – or take myself – to be, which directly affects how freely I may act…If others' conception of who I am keeps them from seeing my actions as those of a morally responsible person, they will treat me as a moral incompetent. This is the harm of deprivation of opportunity. If my own conception of who I am keeps me from trusting my own moral judgments, I will treat myself as a moral incompetent. This is the harm of infiltrated consciousness. (pg. 51)

The understandings we have of ourselves and others affect free exercise of agency. Damages to identity, both deprivation of opportunity and infiltrated consciousness, diminish free exercise of agency.

As discussed previously, our bodies and health contribute to understandings we and others have of ourselves. BMI-cutpoint definitions of overweight and obesity as well as somatic norms/ideals contribute to our understandings of ourselves as beautiful or healthy. They contribute to our perception of our own and others' abilities to exercise self-control and self-discipline, to be virtuous, morally upright people. These understandings interact with gender, race, and class to influence how people are seen by themselves and others as moral agents and as worthy of moral respect. It is in this way that oppressive conceptions of overweight and obesity, those that medically gaslight and contribute to the objectification and commodification of bodies, not only damage identities but diminish moral agency.

Agency diminished by oppressive conceptions of overweight and obesity puts overweight and obese individuals in an interesting bind. Because of their perceived lack of self-control and self-discipline, overweight and obese persons are seen by others and by themselves as not possessing the capacities of a fully competent moral agent. In these ways, their moral agency is diminished. But based on this same perceived lack of self-control and self-discipline, overweight and obese persons are held responsible and are judged on the basis of how people assume they must be acting to have ended up overweight or obese. So even though overweight and obese persons may not be viewed as fully competent moral agents by others or by themselves, which impacts their ability to freely exercise their agency, they are morally reprehensible. This bind, this understanding of overweight and obese persons as incapable of competently exercising agency and also as responsible for their own "predicament," is difficult to make sense of. But acknowledging and understanding how incoherent conceptions of overweight and obesity play into systems of oppression that perpetuate inaccurate understandings of health and somatic norms and ideals may be the first step toward resisting this oppression.

V. Resisting oppression

So far I have argued that the use of BMI to define overweight and obesity is a form of medical gaslighting and that somatic norms/ideals *and* the use of BMI-cutpoint definitions contribute to the objectification and commodification of bodies. I have discussed the negative impacts oppressive conceptions of overweight and obesity have on individuals and populations: damaged identities and diminished moral agency. In this section of my thesis, I will articulate the importance of resistance to oppressive conceptions of overweight and obesity.

This is not to say that others have not already articulated its importance or worked to resist this oppression. In fact, there has been a strong resistance to somatic norms and ideals for quite some time. Feminist scholars and activists recognize the negative impact feminine beauty ideals and media representation of women's bodies have on women's body image and self-esteem. Feminist projects, including Naomi Wolf's *The Beauty Myth* and the 2011 documentary *Miss Representation*, work to resist these oppressive somatic norms/ideals. The size acceptance movement, otherwise known as the fat acceptance movement, also works to resist oppressive somatic norms/ideals. Size acceptance movement projects take issue with discrimination against "fat"[11] people and therefore

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[11] Some members of the size acceptance movement prefer to use the term "fat" rather than "overweight" or "obese" because "fat" can be "taken back," so to speak, whereas "overweight" and "obese" have set definitions (BMI cutpoints) (*National association to advance fat acceptance,* 2012). The idea is that "fat" can be used to empower, to move the size acceptance cause forward rather than to medicalize, label, or degrade.

aim to alter individual, group, political, and societal attitudes toward them. “Big is beautiful,” right? Big is powerful. But big is also “unhealthy.”

As discussed previously, resistance that does not take this into account is not effective as it’s not just body ideals that render overweight and obesity oppressive. There needs to be some resistance that recognizes overweight and obesity as a form of oppression affected by both body norms/ideals AND BMI-cutpoint definitions of overweight and obesity. Resistance to oppressive conceptions of overweight and obesity must recognize that this oppression is affected by understandings of beauty AND health, as well as virtue and gender and race and class, etc.

In *Damaged Identities, Narrative Repair* and “Identity and Free Agency,” Hilde Lindemann (Nelson, 2001a; Nelson, 2001b) suggests using “counterstories” to resist oppressive “master narratives.” The idea is that narratives construct our identities. Master narratives are one type of story that contributes to the construction of our identities. Master narratives are “the stories found lying about in our culture that serve as summaries of socially shared understandings” (Nelson, 2001a, pg. 6). If a master narrative is oppressive, it may result in deprivation of opportunity or infiltrated consciousness by influencing the oppressors and the oppressed to have inaccurate, unjust, perhaps sexist, racist, classist, ethnocentric understandings of those oppressed.

Overweight and obesity play into master narratives that idealize “health,” “beauty,” “self-control,” and “self-discipline.” They play into the narratives that claim BMI correlates with body fat, health, and longevity. Overweight and obesity play into the narrative of the modern, Impolitic Body, that which idealizes control, discipline, and objectification of subjects’ bodies. They play into master narratives that leave those in

control of their bodies in a position of power and those not in control paralyzed. Overweight and obesity play into master narratives that don't acknowledge the difficulty or impossibility or even undesirability of living out somatic and health norms/ideals when one is of a certain gender, race, ethnicity, socioeconomic background, etc.

Because narratives construct identities, both oppressive and non-oppressive, narratives can repair identities damaged by oppression. A counterstory is "a story that resists oppressive identity and attempts to replace it with one that commands respect" (Nelson, 2001a, pg. 6). According to Lindemann (Nelson, 2001b; Nelson, 2001a), counterstories are told in two steps. The first step is to identify portions of master narratives that oppress and inaccurately represent persons or groups and their lives. The second step is to retell the person or group's story in a way that accurately represents them or reveals information about them that the master narrative mis-told or suppressed. For example, the 2011 documentary *Miss Representation* resists master narratives (fed to us via media representation of women and their bodies) that idealize, sexualize, and objectify (etc.) women and their bodies in a way that is demeaning and oppressive. *Miss Representation* does this by telling counterstories that dispel inaccurate portrayals of women in media, ones that empower women rather than idealize, sexualize, or objectify them.

Lindemann's theoretical framework for resisting oppressive master narratives is a useful tool for undoing the damage of oppressive conceptions of individuals and groups, repairing damaged identities and restoring or establishing moral agency. In order for this framework to be useful for resisting overweight and obesity as forms of oppression, it is critical to understand the master narratives overweight and obesity play into: those that

perpetuate somatic norms and ideals as well as inaccurate understandings of health. It is also critical that counterstories that aim to challenge these oppressive master narratives incorporate an understanding of overweight and obesity as a form of oppression affected by both somatic norms/ideals AND BMI-cutpoint definitions of overweight and obesity, by conceptions of beauty and health and virtue and gender and race and class, etc. What do these counterstories look like?

To be honest, I'm not sure. Perhaps they are stories that reveal the problematic claims about the relationship between BMI and health, such as stories about super fit athletes whose BMI's fall into the "overweight" or "obese" range. But perhaps it's not possible for such counterstories or narratives to reveal *all* morally relevant details of this form of oppression. It's not so simple as to tell a story that will allow individuals to reflect on the inaccuracies of BMI (what kind of "story" would that be anyway?), as what we know about health, disease, and risk is based on "reasons that are accepted by a scientific establishment which is socially validated and which [we] trust" (Benson, 1994, pg. 657). Perhaps the kind of "stories" we need first, which I'm not even sure are stories at all, are those that reveal the nontransparent genesis and use of BMI cutpoints.

I showed earlier that the genesis of BMI-cutpoint definitions of overweight and obesity was nontransparent and that use of BMI cutpoints is inaccurate. Conflicts of interest and the inaccuracy of BMI as a measure of excess fat, health outcomes, and longevity make it clear that use of BMI to classify individual persons' bodies as underweight, normal, overweight, and obese is problematic. It is critical that we (the public, health organizations, healthcare workers, researchers, etc.) rethink where BMI cutpoints came from and that we rethink their implications in defining and contributing to

oppressive conceptions of overweight and obesity. It is critical that we develop alternative means to address health issues related to unhealthy diets and sedentary lifestyles, means that empower rather than oppress and that align with the goal of health work: to promote and ensure the well-being of individuals and populations.

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