Large As Life

Obesity

facts & fiction

From: "A Redefinition of Treatment Goals for Obesity"

by Kate Partridge,
Clinical Psychologist.

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Despite the image of the 'contemporary woman' as being slim, and the implication that most women conform to that image, the facts are that a large percentage are - by definition - 'overweight'.

A survey done by Nutrition Canada in 1975, using the ponderal index as a measure of obesity, revealed the following statistics:

Women 20-39 years:	44%	'overweight'	or more,	10% 'obese'
40-64 years:	68%	"	"	"
65 years plus:	80%	"	"	"

Quite obviously, many women are not of 'normal' or average weight, and one wonders - especially in the 65+ group, where 80% is above the norm - what these terms actually mean. The Metropolitan Life Insurance Company tables of ideal weights have recently been adjusted upwards by 10 to 15 pounds, so presumably what is considered 'average' will become somewhat more in line with what actually is average. However, the notion that there is one 'ideal weight' for all people of the same sex, height and body frame is still generally prescribed to.

The social pressures on women to be slim are enormous; that the definition of beauty is not an absolute one but culturally determined has been forgotten to a large extent. In the past in Western culture, and today in other non-Western cultures, plumpness and fatness have been considered desirable in women (Powdermaker, 1973). The current fashion for the thin, athletic, tubular woman seems to be a trend set in the 1920's with the rise of the sexually emancipated and non-reproductive woman (Bennett & Gurin, 1982). The recent fitness craze reinforces the image of woman as athlete rather than as full-bodied procreator.

There are also medical reasons behind the social pressure on women to be slim. There is a correlation between obesity and increased incidences of other physical disorders (Bray, 1979), and this correlation has come to be interpreted as a casual relationship. As a result, slimness and good health have become synonymous, as have fatness and unhealthiness.

Finally, there are normal reasons behind the urgent pursuit of slimness in our culture. Not only is fatness seen as ugly and unhealthy, it is also considered morally wrong because it signifies either a weak will and a lack of self control, or a wilful disregard of social values. This attitude derives from the will-power model of obesity that forms the basis for the understanding of the disorder by the general public. This is a highly moralistic approach that requires fat people to be 'mortified and ashamed of their lack of self-control' (Rodin, 1977, p. 335), and it is a view that has become even more negative and stringent in recent years (Ingram, 1978).

Aesthetic, medical and moral prohibitions on fatness have resulted in the perpetuation of the stereotypical view of the fat person as lazy, greeedy, stupid, selfish, neurotic, and lacking in the ability to get on with others (Galper & Weiss, 1975); she is also seen as sinful, criminal, sick and ugly (Allon, 1975). Fat women are considered unattractive and unsexed, or oversexed and associated with a degraded or distorted sexuality (Millman, 1980).

The stigma on obesity is expressed in various types of discrimination against fat people: in housing (Karris, 1977), jobs (Allon, 1975). Goldblatt, Moore and Stunkard (1978) claim that in any situation conferring status, such as marriage or job promotion, thinner women are likely to be preferred. This would provide the selection mechanism for the obesity-caused downward social mobility noted by Canning and Mayer (1966). Clearly, being fat in our society is to be avoided at all costs, since the social penalties are so severe.

Weight loss is a multi-million dollar industry supporting a vast array of diet clinics, diet doctors, weight loss groups, weight loss drugs and accessories, best-selling diet books, magazine articles, TV shows, and 'fat farms'; but in spite of all these pressures to lose weight, very few substantially overweight people are successful at losing weight permanently, given all forms of treatment. This includes behaviour modification, which initially had seemed so promising.

While temporary weight loss is relatively easy to achieve, only 5% of the obese population can maintain a weight loss of at least 20 lbs. for two years or more (see Beller, 1977; Bray, 1979; Foreyt, Goodrick & Gotto, 1981; Jeffrey & Coats, 1978; Stunkard, 1978, 1979; Wing & Jeffrey, 1979). In other words, 95% of obese people will never get slim, often in spite of endless and repeated attempts. Stunkard's famous quote remains true today: 'Most obese people will not remain in treatment. Of those that remain, most will not lose weight, and of those who do lose weight, most will regain it' (Stunkard & McLaren-Hume, 1959, p. 79).

This low success rate continues to be confirmed in the literature of obesity research without, however, being recognized and acknowledged by the health profession, the weight loss industry or the obese public. While any other disorder with a treatment success rate of 5% would probably be considered more or less incurable, it is still maintained that something can be done to lose weight permanently.

Any weight loss treatment which usually involves some form of dieting (Thompson, Jarvie, Lahey & Cureton, 1982) is unpleasant and stressful, both physically and emotionally, especially when crash dieting is attempted (Bruch, 1973; Leon & Roth, 1977; Stunkard, 1976; Strain & Strain, 1979). Given that 95% of these efforts end in demoralizing failure, one must seriously question whether they are at all worth pursuing.

The idea that obesity is, at present, incurable, is one that is threatening and difficult for many people to accept. On the other hand, medical professionals maintain the illusion that obesity can be successfully treated, especially since short-term weight loss is relatively easy to achieve. The latter fact is exploited by the multi-million dollar weight loss industry. It can be assumed that their vested interest would make it unattractive for them to publicize the facts about permanent weight loss, while massive profits can be made out of people's fear of fat.

While one can understand why the general public and the weight loss industry should cling to the belief that obesity is curable, it is less easy to understand why health professionals persist in making weight loss the major therapeutic goal for obese patients, often when this is not even the presenting problem (Kahn, 1981). The medical profession has considerable power in determining how obesity is viewed in our culture. Many doctors have a highly negative view of their obese patients whom they see as uncooperative (Bruch, 1973), weak-willed, ugly and backward (Maddox & Leiderman, 1973). These doctors appear to view obesity as a self-imposed state willfully cultivated by the patient, thereby deliberately jeopardzing her health. Kahn (1981) and Kalish (1977) see this sort of attitude as a case of 'blaming the victim'; attributing obesity to some character defect in fat women. As for the general public, it is easy for naturally non-obese individuals to see obesity as a failure of will or an act of willfulness, when it is understood as a simple matter of eating too much and exercising too little.

Enough is known now to realize that it is not a simple disorder, and that its mechanisms are not easily accessible to control by the conscious will. 'Obesity is a complex disorder with multiple levels of metabolic and behavioral characteristics which interact with one another...Onset and degree of overweight are determined by a combination of genetic, metabolic, psychological and environment events' (Rodin, 1981, p. 362 & p. 370). In addition, there are different subtypes of obesity (Leon & Roth, 1977) that involve different subsets of these events. 'Obesity is not a single syndrome, has no single cause, and therefore probably does not have a single cure' (Rodin, 1981, p. 370).

When a 'cure' for obesity is discussed, it is always assumed that the expected outcome of that cure should be permanent weight loss. We have not yet discovered a cure that will produce this result, and clearly, continued research in this area is necessary. It seems obvious that the next step in research should be an investigation of the 5% of obese people who are successful in losing weight permanently.

It could be argued that treatment success rates would be considerably higher if fat people were allowed to remain large, but were encouraged to reach the lower end of their particular weight range,

rather than trying to reach the so-called 'average' or 'ideal' levels. Is, for example, 140 lbs. really an ideal weight for someone who, for the past 20 years, has ranged between 180 and 220 lbs., averaging 200 lbs., who is in perfect physical health and whose chance, statistically, of losing 60 lbs. and keeping them off are minimal? Surely it would be better to lose 10 lbs. and maintain this loss than to lose 60 lbs. and regain 70 lbs., which is a very frequent pattern.

Several recent studies have shown that mortality rates among the moderately overweight are not higher than - and may be lower than - those for the normal weight population, and that both the very fat and the very thing are at risk (Andres, 1980; Keyes, 1980; Lew & Garfinkel, 1979; Sorlie, Gordon & Kannel, 1980). In the extreme ranges, obesity can be a serious problem; but in the absence of specific cardiovascular or other problems, there may be no increased risk at all in the mid- and low ranges (Bray, 1979). On the basis of obesity research, the assumption that thin is healthy and fat is unhealthy has only limited validity.

A far greater threat to the physical as well as emotional well-being of overweight women is the extraordinary social distaste for fatness and general obsession with slimness in our culture. Chernin (1981) suggests that many of the medical symptoms associated with obesity may be the result of its social stigma and the related stress (see also Allon, 1975; Cahnman, 1966; Kalisch, 1972; Rodin, 1981).

Many fat women are severely and negatively affected by the social rejection they experience because of their size, particularly if they have been obese as adolescents. Stunkard (Stunkard & Burt, 1967; Stunkard & Mendelson, 1973) found evidence for what he calls the 'body image disturbance' in people who are fat during adolesence, a time of acute self-consciousness.

If a woman feels that her body is grotesque and unacceptable, if she herself does not accept it, it will be difficult for her to be motivated to take proper care of it. This, perhaps, is one of the fundamental reasons why obese women are so chronically underactive physically (Bloom & Eidex, 1967; Bradfield, Paulos & Grossman, 1971; Lincoln, 1972; Thompson, Jarvie & Lahey, 1982).

Because they fear social rejection and humiliation, many large women are reluctant to use public swimming pools, or join in fitness classes (Partridge, 1981). Disliking her own body, the obese woman is reluctant to spend time, energy, and money on exercising it. Rejection of her body by society and herself is to 'disembody' her. Bruch (1973) comments that many fat people behave as though they were not attached to their bodies, and uses this observation to support the 'internal-external' hypothesis of Nisbett (1968a, 1968b), as well as Schacter and Rodin (1974) which suggested that the eating habits of overweight people were not controlled

by internal physiological but rather by external environmental stimuli. However, as long as the focus is on obesity as an eating disorder requiring dietary manipulation, rather than an activity disorder, fat women will be inhibited from starting and maintaining a regular routine of physical exercise.

There is good evidence that any weight loss attempt will be more effective if metabolic changes can be achieved through regular aerobic exercise (Bennett & Gurin, 1982; Thompson et al., 1982), in addition to improved cardiovascular functioning, strength, suppleness and sense of well-being that will result from regular aerobic exercise (Cooper, 1970).

Also associated with the social stigma on obesity is a polarization or splitting of the fat woman's self-image into exaggerated 'good' and 'bad' aspects that are in continual conflict with each other: the tendency to have a set of unrealistic fantasies of how wonderful, attractive and powerful she would be if she were slim, and on the other hand an exaggerated sense of inadequacy and low self-esteem (Bruch, 1973; Orbach, 1978). This polarized self-image allows only for the extremes of absolute perfection and power, or total inadequacy and failure (Beck, 1976). Perfectionistic thinking, also described by Leon and Roth (1977), results in unreasonably high standards set for herself by the fat woman who thus sets herself up for repeated failure and frustration. This is also seen in the binge/restraint cycle described by Herman and others (Herman & Mack, 1975; Herman & Polivy, 1975; Hibscher & Herman, 1977). The crash diet is a classic example of restraint/binge behaviour that almost inevitably results in weight gain (Bennett & Gurin, 1982; Rodin, 1981).

This type of perfectionism is also displayed when the overweight woman begins an exercise program with expectations of immediate beneficial results. Either she becomes discouraged because of her actual low level of fitness, or overworks herself in the first few days. In most instances, she will drop out of the program.

Stress, in general, is a major trigger for inappropriate eating (Leon & Roth, 1977). That such eating may be adaptive is suggested by Bruch (1973) who reports a lower suicide rate among the obese than in the normal weight population. However, there is evidence that eating does not actually decrease stress and anxiety. Since stress-induced eating is perceived as yet another example of one's 'weak will', it serves the dual function of comforting as well as punishing oneself. The social stigma on obesity causes many overweight women to withdraw socially in some way or other (Dwyer et al., 1970; Millman, 1980; Stunkard & Mendelson, 1973). For some, their lives become so restricted that food is the only available source of pleasure, in yet another vicious circle.

Many fat women feel that their social roles should be restricted to those of asexual mother figure and listener, funloving clown, and observer

(Kahn, 1981). They feel, often correctly, that they will not be accepted as active participants in many aspects of life, and will postpone their lives until the day when they will be slim (Millman, 1980). Because this day will never come for most of these women, the result is a good deal of human suffering and a tremendous waste of human potential. None of this is the result of the fatness per se.

It is high time for a revision of treatment goals regarding obesity. While some forms of weight control may still be desirable, therapeutic efforts must be made to improve aspects of the obese client's physical and emotional life in ways that are not solely dependent on weight loss. Social and political action is also necessary so that public attitudes towards obesity become more tolerant.

The following are specific treatment suggestions:

1. Weight Control. An assessment of the client's true state of physical health - taking her past weight history into consideration - without untested assumptions based solely on the fact that the client is 'overweight' should determine whether weight loss or maintenance at the current level is appropriate. Clients should be made aware of the fact that the chances of substantial permanent weight loss are approximately 5%. Rigorous and stressful dieting should be avoided.

2. Physical Fitness and Body Esteem. Cardiovascular endurance, suppleness and strength, as well as increased body awareness and body esteem could be promoted through the establishment of specialized fitness programs for large women, according to the following suggested guidelines:

- all participants would be obese, excluding women who are only 10 or 15 lbs. overweight;

- starting at a low level of intensity, the program would build up gradually;

- exercises would be designed to prevent strain and injury (e.g. long warm-up, no excess strain on joints through jarring and jumping, special emphasis on lower back and abdominal strength);

- only those exercises which are possible to execute by large women to ensure feelings of success (e.g. a large stomach prohibits the successful execution of certain exercises) would be the focus of the program;

- instructors would be large women themselves or, initially, normal weight instructors who have received special training in the area of exercise technique and approach for the obese participant;

- atmosphere of the class should be supportive;
- enjoyment of physical movement would be promoted through the use of music, and dance and yoga type exercises;
- each class would end with relaxation and guided fantasy exercises promoting body awareness and self-acceptance;
- specific discussion or emphasis on weight loss and dieting would not be part of the program.

3. Self Esteem. There should be an extensive assessment of the possible negative effects of the obesity stigma on the client's life and self esteem. These may include:

- inhibitions about exercising in public situations;
- low self esteem resulting in lack of motivation to get regular physical exercise, not caring about the body;
- self-defeating perfectionism that sabotages healthy life-style behavior (such as getting regular exercise and having reasonable control and flexibility in eating habits);
- a presentation of self in dress, grooming and body language that reflects low self esteem and invites discrimination and rejection;
- self-imposed restrictions on social life and/or on career.

To counteract the effects of the stigma it is important, in the beginning, to discuss with the client the fact that there is a stigma. It may be necessary to help the client reconceptualize her obesity in a way that does not involve a self-defeating 'good will-power' versus 'bad weak-will' mechanism.

Specific training in assertiveness and social skills may be useful, as well as job search skills (resume writing, color coordination, posture and movement).

4. Social and Political Action. Public education about obesity to fight back against the 'tyranny of slenderness' (Chernin, 1981) is necessary. This should include promoting the acceptance of large women in the visual media, as models, actresses, etc. The availability of large size fashionable clothing is another area which needs addressing.

5. LARGE AS LIFE. A volunteer association called 'Large as Life' was founded in June 1981 in Vancouver to promote the

welfare of large women in some of the ways discussed above. Its motto is 'Stop postponing your life until you lose weight, and start living now!'

Its activities have included fashion shows of large size clothing, personal development seminars and job search skill workshops. There is a monthly newsletter, and continuing programs of dance and fitness classes as well as swimming for large women in a number of local community centres.

It is felt that similar organizations are needed in other parts of the country.

We do not yet have a cure for obesity, and most women who are fat are likely to stay that way to some extent. Thus in treating obesity, our treatment goals must include improvement in physical and emotional well-being in ways that are not dependent on weight loss. In particular, therapeutic attention should be paid to the destructive effects of the social stigma on obesity, and to improving the relationship between the large woman and her body. A shift in focus from the eating disorder aspects of obesity to viewing obesity as more of an activity disorder is recommended. In general, women who are overweight should be encouraged to stop postponing their lives until they lose weight, and to start living more fully and actively now.

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