A PLACE TO FIT: EXAMINING THE INTERSECTION BETWEEN FAT STUDIES AND DISABILITY STUDIES

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Abstract

This paper provides an overview of the current state of fatphobia in society; attempts to examine the ways in which disability theory can be applicable to a critical study of fatness; and discusses the pros and cons of fatness being incorporated under the disability banner. It contains an examination of the ways fatness is viewed by the media, society, the obesity industry and the medical system. It draws on the theory of Panopticism to examine the processes of self-surveillance and internalized body policing which are carried out by fat people as an extension of fatphobic social discourse. This paper then examines the ways in which fatphobia can be examined or reflected in a variety of disability theories, then draws conclusions regarding the appropriateness of inclusion of fatness as a disability. A brief examination of the parallels which may be drawn between law and legislation regarding disability versus that regarding fatness will also be included.

A note on language: Since, as Wann puts it, "the O-words ['overweight' and 'obese'] are neither neutral nor benign" (xii), this paper will use the word 'fat' in most cases, except when quoting other sources. 'Obese' and 'overweight' may also be used in discussing the specific pathologizing views of the medical industry, as they often encompass qualities which are not in fact attributable to fatness as a physical trait.

Introduction

In the last decade, the word 'obesity' has entered common parlance to an unprecedented degree. While initially introduced by the Body Mass Index (BMI) in early-mid 1800s, the early 2000s have seen an unparalleled social obsession with what has come to be known as "the obesity epidemic" (Boero, Campos, Tischner). This increased social awareness (and, more importantly, fear) of fat is virtually omnipresent, spanning multi-million dollar business empires selling everything from medical procedures to fashion to reality television shows (Aphramor 902, Boero 3). Hegemonic discourses regarding fatness as symptomatic of moral and physical weakness are becoming more and more pervasive, resulting in a marked increase in the effects of fatphobia in society overall. As Kirkland observes, "The furor over fat has deep cultural, political, and legal meanings that reach far into basic contests over the values of equality, access, health, and dignity in our society" (2).

This paper will provide an overview of the current presence and manifestation of fatphobia in society; attempt to examine the ways in which disability theory can be applicable to a critical study of fatness; and discuss the pros and cons of fatness being incorporated under the disability banner. To this end, it will begin with an examination of the ways fatness is viewed in the media; as well as by society, the obesity industry and the medical system. It will also draw on the works of Michel Foucault to examine the processes of self-surveillance and internalized body policing which are carried out by fat people as an extension of fatphobic social discourse, in an effort to show both the most significant effects of fatphobia, and reason that it is so important to develop a theoretical

framework to counter it. This paper will then examine the ways all these attitudes (both internal and external) can be examined or reflected in a variety of disability theories, then draw conclusions regarding the appropriateness of inclusion of fatness as a disability. A brief examination of the parallels which may be drawn between law and legislation regarding disability versus that regarding fatness will also be included, as further demonstration of the relationship between fat studies and disability studies.

Fat Activism

First, however, it is important to understand exactly what the fields of fat activism and fat studies entail. Brandon & Pritchard identify four main groups in the field of fatness: "anti-obesity researchers, anti-obesity activists, fat acceptance researchers and fat acceptance activists" (86). The majority of this paper will discuss the work of the former two groups, and the profoundly negative impact it has had on the lives and treatment of fat people. It is important, however, to briefly acknowledge the work done by the latter as well. As anti-fat bias has grown over the span of the 20th century, responses from fat people have begun to emerge. The birth of the fat activist movement can be broadly traced to the late 1960s, with the foundation of the National Association to Aid Fat Americans (NAAFA, now called the National Association to Advance Fat Acceptance) in the United States in 1969. Although NAAFA did a great deal of important work in terms of creating environments for fat people in which they wouldn't be judged (such as organizing dances, conventions, fashion shows and other parties (Wann, Fat! So? 187)), it was essentially still a heterosexual organization that was run predominantly by (non-feminist) men (Farrell 149).

Simultaneous to the founding of NAAFA, more radical groups were also coming to discuss fatness as a political position, particularly those intersecting with the gay rights movement and second wave feminism (Farrell 140). In the early 1970's, NAAFA spawned a more radical offshoot group known as Fat Underground (FU), from whom NAAFA eventually disassociated due to FU's far more radical methods of forwarding fat awareness and fat rights (Farrell 142-143). They particularly attacked doctors and the medical industry, accusing them of:

> [c]oncealing and distorting the facts about fat that were contained in their own professional research journals… and play[ing] into the hands of the multibillion dollar weight-loss industry, which exploits fear of fat and contempt toward fat people as a means to make more money (Fishman n.p.).

Fat Underground was also known for the publication of the Fat Liberation Manifesto, written by Freespirit and Aldebaran (aka Fishman), which expressed strongly the rejection of the mistreatment of fat people; the insistence on equal rights for fat people (as well as other oppressed groups with whom they identified); the calling out of the weight loss, marketing and medical industries; and a call to arms for fat people to unite and fight against oppression (341-342). Although Fat Underground ultimately disintegrated in the early 1980's (Fishman), their legacy lived on in groups like "Pretty, Porky and Pissed Off" (Mitchell), in publications such as Wann's *Fat! So?* zine (and later book) (Wann, *Fat! So?*) and a number of other zines about both fat and queer lifestyles (Snider). Publications such as *FaT GiRL: A Zine for Fat Dykes and the Women Who Want Them* in the 1990s exemplifies the intersection between radical queer and radical fat activism, creating spaces in which members of both these communities can "refuse the

silence imposed on them from a society obsessed with keeping heterosexual and thin norms in place" (Snider 229). Ultimately, some of the most important work done by fat activist groups (both radical and otherwise) lies in helping fat women reject social narratives about their bodies, whether the goals of this rejection is in order to feel beautiful and (if they wish to be) desirable (Farrell 152); or to a more revolutionary end.

Fat Studies

Although fat activism has existed and has been making crucial differences in the lives of fat people for decades, the emergence of fat studies as a unified field of academic study has allowed for the examining, critiquing and publicizing of the effects of fatphobia and the experiences of fat people in a very different way from the avenues provided by fat activism. Wann identifies the root of fat studies as an academic field as being a 2004 conference at the Columbia University Teachers College called "Fat Attitudes: An Examination of an American Subculture and the Representation of the Female Body," as well as an art show put on in conjunction with the conference called "Fat Attitudes: A Celebration of Large Women" (xi). In the twelve years since then, fat studies has expanded to be taught at a number of schools across North America, such as Rutgers University, Oregon State University (Binder) and the University of Maryland (Griff) in the United States; and McMaster University (McMaster University) and Lakehead University (n.a.) in Canada.

Solovay and Rothblum define fat studies as "an interdisciplinary field of scholarship marked by an aggressive, consistent, rigorous critique of the negative assumptions, stereotypes and stigmas placed on fat and the fat body" (2). They also

outline three main steps for fat scholars to take in critically examining attitudes towards fatness, namely: suspicion of any policy or process which draws a distinct line between fatness and thinness; awareness of policies that claim to be neutral but affect people of different weights differently; and maintaining focus on the lives and experiences of fat people as a centre point for analysis (2). It is clear from this statement that their definition of fat studies is still, like the fat activism from which it grew, inherently political. While some may view this politicization critically, it can be argued that fat studies, like many fields of academic study which deal with oppression and stigmatization, is inherently political in that it runs counter to mainstream societal discourse. Since it is impossible to discuss fatness without discussing the stigma and challenges based on negative perceptions of fat people which are present in society, it is arguable that it is therefore also impossible to discuss it without acknowledging the political implications of doing so. The following analyses of the treatment of fat people by various institutions and by society at large are therefore based upon this principle of the inherent political nature of fat studies.

Public Perceptions of Fatness

Anti-fat bias runs rampant in many parts of the world, particularly in Western society. It is equated with a host of negative traits, such as laziness, unattractiveness or lack of moral fibre (Brandon & Pritchard 83); as well as broader societal concerns such as being a burden to the medical industry, contributing to damaging the environment via consumerist culture, and broadly being exemplary of the deterioration of society as we know it. These concerns, such as those about health care or the environment, are

indicative of ways in which fatness "serves as a powerful mirror, reflecting some of the U.S. citizens' deepest fears and desires" (Owen 2). With this construction of fatness as the epitome of society's negative traits, it is unsurprising that there are a variety of negative repercussions to being visibly overweight in a fatphobic society, such as:

> Social and job discrimination, barriers to insurance and medical care, biased medical care, prescription of weight loss dieting, the effects of stigma on people who are vulnerable to developing eating disorders, and the health consequences of weight dissatisfaction on people across the weight spectrum (Burgard 45-46).

Fat bodies are knowingly, intentionally and frequently used in both media and popular culture as "cautionary tales" while simultaneously labeling these bodies as inherently problematic or wrong (Owen 3). Television is particularly unabashedly derisive of fat people, using them as punchlines, representations of evilness or small-mindedness, and objects of disgust[1]. A study of the representations of fat women in television (which analyzed the portrayals of re-occurring fat women in selected television shows) revealed that overall, these characters were shown as being masculine in personality, and that their sexualities were either completely ignored or ridiculed (Giovanelli & Ostertag 291-293).

News sources are also a frequent source of anti-fat sentiment. In a study of *New York Times* articles about fatness published between 1990-2001, Boero found three main themes. The first, "chaos and containment," refers to the idea of an obesity 'epidemic' dependent on convincing the population that fatness is a real and present danger to society, as well as one which can befall anyone at any time if they aren't careful (43-44). The second, "professional knowledge and common sense," observes that these two

[1] This is also true of portrayals of people with disabilities, who are often depicted with such traits as pitiable, evil, over- or under-sexualized, comedic relief, or victim (Barnes & Mercer 95).

categories of knowledge are coming to be conflated as the scientific thought on obesity becomes accepted as common sense regardless of evidence, and vice versa (47-49). Finally, "nature and culture" refers to the focus on blaming 'consumer culture' for the obesity 'epidemic' in the United States, with the complimentary ideology that the 'natural' eating and behavioural habits of the past would result in lower weight, once again placing the blame for fatness on contemporary cultural habits (50-51). National medical associations in multiple countries (such as the US Department of Health and Human Services, the UK Department of Health, etc) also use the widespread media focus on fatness as a platform to stress the importance of personal responsibility in weight loss, as well as to blame obesity solely on cheap food, increased automation and sedentary lifestyles (Brandon & Pritchard 82).

Public figures and media personalities also frequently speak out against fatness, with comments ranging from wild predictions about the hazards of fatness to outright hate speech, such as journalist Kenneth Walker's assertion that fat people should be confined to "prison camps," both for their own good and for the good of society as a whole (Puhl & Brownell 788). Many of these figures also become spokespeople against fatness as a result of public shaming of their own bodies. World renowned talk show host Oprah Winfrey, for example, has undertaken many attempts to lose weight (some more successful than others) in the 30 years since *The Oprah Winfrey Show* first aired in 1986 (Farrell 124). Her recent partnership with Weight Watchers is also well known, and her endorsement is thought to be at least partially responsible for their significant 20% jump in share price in early February 2016, shortly after the partnership began (Turner). This

phenomenon is also visible in the political sphere. When the 2009 United State Supreme Court candidates were announced, female candidates[2] who were overweight were substantially criticized in the media (Farrell 131). Farrell provides a final significant example of this in the emphasis that has been placed on the extent to which President Obama and First Lady Michelle Obama discuss weight, both in President Obama's health-related opinions and in Michelle Obama's anti-childhood-obesity efforts (132-134)[3].

Obesity 'Epidemic'

In the1980s, a panel of representatives from the national Health Institute in the United States identified obesity as a serious health threat (in spite of a lack of substantial evidence to that effect), declaring it "a killer disease" (Campos ix). This panic has only heightened, and in 2003 the United States Surgeon General Richard Carmona declared obesity to be the greatest health issue facing America (Campos 3). Between 1990 and 2001, the *New York Times* published 751 articles on obesity, compared to 544 on smoking, 672 on AIDS and 531 on pollution, clearly delineating their stance that obesity is a virulent health risk (Boero 41). It has also been compared to other greater threats by major media figures such as journalist Frank Deford, who wrote an article stating that "[f]or the long term, the greatest threat to our society is not al-Qaeda, and it is not North Korea and it is not Iraq. It is the way we choose to live. How much we choose to sit, and how much we choose to eat" (Deford in Farrell 9). As Boero observes, many (including

[2] This is, of course, also indicative of the broadly recognized social phenomenon whereby the weights (and appearances in general) of women are seen as being far more significant than those of men.

[3] This attention is particularly significant in light of the extent to which anti-fat bias disproportionately affects people of colour, which will be discussed further later.

people in positions of medical and political power) believe that "the obesity epidemic has the power to weaken the military, health, and economy of the most powerful nation in the world," namely the United States (2).

The use of the phrase 'epidemic' to discuss global increases in weight is an interesting one. Historically, the term has been used to refer to some variety of infectious disease, usually one which has substantially affected a significant percentage of the population via contagious spread. However, the term 'epidemic' has more recently come to be used to refer to what Boero refers to as "fear" epidemics, which stem from a moral panic which emerges "when a phenomenon, occurrence, individual, or group of people comes to be seen as a threat to social values and interests," such as historical witch hunts or concerns about 'white slavery' (6). Evoking the imagery of a contagious disease also opens the door for the (very American) response to such challenges: a declaration of war. Much as the American government has declared war on terror or drugs, this identification of fatness as a public enemy reinforces the negative discourse surrounding fatness, as well as providing a fertile growing ground for the virtually omnipresent 'obesity industry' which has sprung up in response to this 'threat.' This industry has been so successful because, as Campos observes, obesity is neither fully curable nor (arguably) highly fatal, thereby allowing for ongoing and increasing sales of weight loss aids, surgeries and other products or services to the same patients for years on end, often without any visible changes to their 'conditions' (41).

Obesity Industry

Investigative reporter Alicia Mundy coined the term “Obesity Inc” to refer to the intersection between physicians, obesity researchers and drug and weight loss companies that make up much of the medical force behind the ‘war on obesity’ (Lyons 78). Brandon and Pritchard cite a 2005 study by Gard and Wright which argues that much of the supposed evidence in favour of the existence of the ‘obesity epidemic’ is “inconsistent and contradictory” (Gard & Wright in Brandon & Pritchard 83). While the majority of widely publicized research about obesity would suggest otherwise, there is a documented history of conflict of interest within the obesity industry. It is not uncommon for multinational weight loss companies to fund many of the studies which most strongly argue in favour of both the need for their products, and their efficacy. Campos cites an interview with an obesity researcher who explains that studies which exaggerate the risks of obesity are more likely to get funding (46), and Lyons refers to a different interview in which an obesity researcher admits to having been openly paid by a drug company to put their name on a study that the company themselves had written (80). It is also fairly common practice for weight loss companies and biased obesity researchers to appropriate research done by others to prove their points, sometimes regardless of the context of the original research. One of the most frequently cited statistics regarding mortality rates due to obesity is in actuality the result of a study which concluded that 300,000 people die annually in the United States from “dietary factors and activity patterns that are too sedentary” (Lyons 82). Although the original researchers have publicly condemned the

use of their results to support anti-obesity rhetoric, this statistic continues to be frequently cited (Lyons 82).

In contrast, a 2005 study by Flegal, Graubard, Williamson, and Gail found that the mortality rate for people with BMI[4] over 35 was only 112,000. They also found that individuals who were diagnosed as 'slightly overweight' according to BMI (18.5-24.9) actually had a lower mortality rate than people at 'acceptable' weights (Lyons 83). Other studies have also shown similar findings, such as a 1996 study by the National Center for Health Statistics and Cornell University, which found that the lowest mortality rate among white, non-smoking men was a BMI range of 23-29, and that there was no significant difference in the range of 18-32 among white, non-smoking women (Campos 11). Even more interestingly, a 2008 study by Muennig gives evidence to suggest that psychological stress is actually a substantial contributing factor to many of the health risks that are commonly associated with obesity, and points to the fact that widespread fatphobia can cause a great deal of psychological distress and anxiety in people who are considered 'high risk' for these conditions (n.p.). He particularly suggests that stress borne from repeated failure to lose weight (as well as the health risks associated with weight cycling) is a major contributor to morbidity (n.p.). He concludes that "the difference between a subject's desired body weight and his or her actual body weight… is a much more powerful predictor of morbidity than is BMI," a fact which can be specifically proven by the fact that Bioelectric Impedance Analysis (BIA) –a far more

[4] See Appendix A for full BMI table

accurate but less visible measure of body fat– shows less of a correlation with obesity-associated illnesses than BMI does (Muennig n.p.).

In spite of these and other studies which would suggest that there is not nearly as a clear a correlation between BMI and ill health as mainstream discourse would suggest, this discrepancy is rarely acknowledged. Furthermore, the presence of a self-supporting community of fatphobic obesity researchers is only part of the much broader obesity industry. This multi-billion dollar industry spans a wide variety of products and services, including pervasive advertising campaigns, clothing companies, diet plans and (most importantly) medical interventions. Cooper provides a near-comprehensive list of the medical and pseudo-medical interventions available, including:

> An endless variety of dietary and behavioral modification, psychotherapies, 'alternative' therapies, available individually or in groups, and an increasing acceptance of surgical interventions, where the marginally less morbid practice of stomach stapling has superseded treatments such as jaw-wiring and jejuno-ileal bypass (where sections of the small intestine are removed) (35)

According to The American Society for Metabolic and Bariatric Surgeons (ASMBS), over 220,000 weight loss surgeriiningrmajority of which were Roux-en-Y gastric bypass surgeries, a procedure in which the stomach size of the patient is reduce to 2% of its normal capacity (allowing it to hold 1-2 oz of food), and bypasses 3-4 feet of the small intestine to lessen calorie and nutrient absorption (Boero 95).

For individuals who are not yet prepared to take such drastic measures, there are also many existing weight loss organizations that capitalize on societally induced insecurities to market their product to fat people who have been trained to seek out ways to lose weight at any cost. Boero points to Weight Watchers (WW) and Overeaters

Anonymous (OA) as two primary examples of this, both of which use "behavioral methods" for weight loss, but approach the actual issue in different ways (62). WW, an organization which focuses on behaviour modification, operates on the idea that both food consumption and fatness are "a predictable outcome of women's inherently disordered relationship to food" (Boero 63). Their website –which provides minimal information about their actual ideologies and focuses primarily on how the reader can financially invest in their company– uses casual, colloquial discourse which promotes the idea of sisterhood and camaraderie in the face of this difficult obstacle (Weight Watchers). They clearly focus primarily on women's experiences, on the grounds that "men's weight problems are often seen as the result of just liking to eat a lot, whereas women's are seen as a result of an inappropriate and emotional response to food" (Boero 71). Finally, WW subscribes to what Boero refers to as the "normative pathology" model of weight loss, which believes that cravings and lapses are only natural (89). While this would seem to be more flexible and allow more freedom and less self-criticism for its customers, it is also a sound financial decision on the part of WW, as it encourages members to continue their membership even if their weight loss seems to be successful, because lapses or struggle are seen as an ever-present risk.

In contrast, OA subscribes to an addiction model in its approach to 'treating' fatness, much like other "Anonymous" groups, such as the original Alcoholics Anonymous (Boero 62). Their website identifies their primary goal as being "to abstain from compulsive eating and compulsive food behaviors and to carry the message of recovery through the Twelve Steps of OA to those who still suffer" (Overeaters

Anonymous "About"). This discourse clearly identifies the individuals who attend their meetings as having a sickness, but specifically pathologizes the behaviours that are seen as contributing to fatness, rather than the fatness itself. It also therefore doesn't specifically identify being fat as being unhealthy, and instead sees its clientele as unified by the fact that they are "powerless over food and [their] lives are unmanageable" (Overeaters Anonymous "About"). OA seeks to construct self-control as an opposing force to that of addiction, framing the struggle between these two forces as "a spiritual movement towards purity of self" (Murray 68). It also employs the same "12 Step" model for success that Alcoholics Anonymous uses, which has a strongly religious undertone, suggesting the power of God to be a guiding force (as well as a receptacle for confession of shortcoming) in the hopes of gaining "spiritual awakening" (Overeaters Anonymous "Steps"). Despite the optimism of this model of 'overcoming' ones food-related compulsions, OA ultimately subscribes to a "unique disease" model, which views overeating as a condition which will always be beyond the sufferer's control, that must be constantly managed[5] (Boero 89). In this way it is like WW, in that it constructs overeating as something that can never be fully overcome, thereby requiring the individual to continue membership in their organization.

Fatness and Medicine

While it could be argued that the view of fatness as a result of a compulsion is less stigmatizing for fat people than having their weight viewed as a symptom of lack of

[5] Though this is still in some ways better than the broader medical pathologizing of fatness as a result of overeating 'addiction,' which more often reinforces blaming the 'sufferer' for their condition, because they simply need to "kick the habit (Murray 62).

self-control or moral fibre, the reality is that this perspective is just another tool used by dominant institutions to control the lives and choices of fat people. Wann argues that the treatment of fatness as a disease by the medical industry is just a cover for fat hate and bias, as medical attitudes towards fat people would otherwise be unjustifiably cruel (xiv). The reality is that medical professionals are just as prone (if not more prone) as the rest of society to view fat people with stigma. Puhl and Brownell refer to a study that found that 24% of nurses interviewed described themselves as being "'repulsed' by obese persons" (788), and Murray points to a series of studies looking at the psychiatric responses to overweight patients by doctors (39). Murray referenced one study in particular in which a group of doctors were shown case backgrounds and photos of a patient, and asked to assess them. The photo was of the same individual, but was digitally altered in different test groups to show them at different weights. The doctors were overall harsher in their judgment of the patient at larger weight than they were when the patient was shown as being thinner (Murray 39-40).

Hebl and Xu did a similar study in which they showed different groups of doctors different case files (all of patients of different weights who were healthy other than a history of migraines). They were then asked them to complete two forms: one of which asked the doctors to indicate what tests or referrals they would recommend for the patient, and one indicating their reactions to the patient and how much time they would spend with them (1247). The results of the first test showed that obese patients had the

most referrals, followed by overweight patients, then average weight patients[6] (1248). Even more significantly, the results of the second form showed a significant difference in the way the physicians responded to and treated the fat patients on a personal level. Their results indicated that on average they would spend 31.13 minutes with average-weight patients, 25.00 with overweight patients, and 22.14 minutes with obese patients (1249). This, when combined with the fact that the fatter patients were given more tests, indicates a profound pathologizing of fat patients on the part of the physicians. There was also a direct correlation between how fat the patients were and how many negative attributes the doctors assigned to them, including viewing time spent with fatter patients as

> [A] greater *waste of their time* the heavier that they were, that physicians would *like their jobs less* as their patients increased in size, that heavier patients were viewed to be more *annoying*, and that physicians felt less *patience* the heavier the patient was (emphasis original, Hebl & Xu 1250).

Hebl and Xu conclude that this negativity helps to "enact a self-fulfilling prophecy," in that doctors treat fat patients more poorly, which results in the patients not taking care of themselves as well as they might if they had more adequate treatment (1251).

These attitudes are also not difficult to detect upon first contact with a medical professional, and as a result, many fat people are resistant to the idea of seeking medical attention at all. Brandon and Pritchard observe that "[d]ue to prejudicial medical treatment and harassment by health care professionals, many fat people do not receive adequate preventative health care, and procrastinate seeking treatment when there is a medical problem (87). Lyons confirms this by observing that studies have shown that

[6] Which is interesting when compared to a study Withers cites by Rowen which showed that fat people overall get less preventative screening done (Withers 39). This discrepancy could be due to the difference caused by the doctors literally seeing the patients rather than reading case files, or the difference could be due to tests based on a specific symptom, as opposed to more general preventative testing.

individuals with a higher BMI are less likely to seek health care, even for unrelated issues, due to the prejudice they often face from medical professionals (81). This avoidance in regards to unrelated issues is also understandable. Many health care professionals are inclined to look to a patient's weight as the cause of any medical issue they may be facing, and will often focus on that to the exclusion of considering other factors (Tischner 19). Hebl and Xu observe that this trend may also have greater unforeseen risks for fat people, in that a reluctance to see a physician about unrelated ailments may actually be a contributing factor to increased mortality for fat people, since they are less likely to get the necessary help in a timely fashion (1251). This may be particularly true for female patients, who are often more harshly judged for being fat, and are therefore more sensitive to and afraid of weight-related criticism (Murray 78).

This fear on the part of fat people is fed by the perception of the clinical gaze as objective, which in turn serves to reinforce dominant social discourses about fatness (Murray 38). One of the key ways in which medical professionals are able to so easily assert their fatphobic beliefs over the lived experiences of their fat patients is through the creation of pathologizing tools which can be used to quantify and assess the perceived 'shortcomings.' Widespread pathologization of fatness began to take root in North America after WWII, when an inability to identify a root 'cause' for obesity caused it to become a key area of interest for many different disciplines of medicine (Boero 8). This in turn led to a push to develop some kind of unit of measurement for who was or wasn't overweight, and to what extent they were (or weren't) (Boero 9). In the 1940s, Metropolitan Life Insurance (MetLife) introduced their Life Insurance Tables, which

were meant to give an indication of weight related 'risks,' and which they initially used as part of their insurance calculations (since they felt, as many insurance companies still do, that obesity was a mortality risk) (Campos 9, Boero 9). However, these tables were deeply flawed, as they were devised by collecting self-reported weight statistics from policy-holders upon purchasing insurance (Campos 9), and was therefore methodologically unsound.

Ultimately, the MetLife tables were replaced by the aforementioned Body Mass Index (BMI)[7], shown in Appendix A. BMI generates a simple number which is thought to demonstrate 'how fat' a person is, based on their weight as compared to their height (Wann xiv). BMI is currently the most widely used weight measurement tool among medical professionals, but as an accurate unit of measurement, it leaves a great deal to be desired. It has been widely criticized for:

> [I]ts lack of specificity as a simple height-to-weight ratio, being undifferentiated across genders, lack of explanatory value for body *shape*, poor predictive value as a measure of actual health, and standardization based on a White male body (Satinsky & Ingraham 147, emphasis original).

As further evidence of the inaccuracy of this model, scholars (Wann, Satinsky & Ingraham, Boero) point to the lowering of the BMI cut-off for 'overweight' and 'obese' in 1998, which suddenly rendered hundreds of thousands of individuals who had previously been 'healthy' as 'overweight' and therefore at risk of various health conditions. Although BMI is still the primary tool used, Satinsky and Ingraham observe

[7] Which, interestingly, was originally devised in the 1830s not as measurement of health or a tool for body policing, but as an exercise by mathematician Adolph Quetelet to apply probability theory to humans (Boero 10). This shows a parallel to the aforementioned appropriation of irrelevant statistics by anti-obesity researchers, and is representative of a broader trend of this kind of misinterpretation of existing research.

that the medical industry continues to develop more detailed pathologizing tools for assessing the health of fat people, such as the more recent emphasis on what part of the body the fatness 'occupies' (148). These studies identify, for example, that "trunk fat" (fat in the torso) is more dangerous than fat around the hips, particularly in women (Satinsky & Ingraham 148-149). Ultimately, this avenue of medical thought is no less problematic than many previous methods, particularly because it is impossible to target a specific location in which to reduce fat, which makes it an essentially useless measurement within the scope of medicalized emphasis on weight loss (Satinsky & Ingraham 149).

In spite of all these metrics and warnings about the negative impacts of fatness, there is one ideological belief that is particularly damaging: namely "the assumption that if a fat person becomes thin, that fat person will acquire the health characteristics of people who were thin in the first place" (Campos 28). This is, in fact, far from the case. One aspect of weight loss that is generally neglected in the medical discourse surrounding weight is that sustained weight loss is extremely difficult to achieve. The failure rate for sustained weight loss has been found to be around 90-95%, with little to no decrease in recent years, in spite of the increased social and medical emphasis on weight loss (Lyons 75). Statistics show that, in the early 1990s, 33-40% of American women and 20-24% of American men were attempting to lose weight, and these numbers increase to 46.3% and 32.8% respectively by the turn of the 21st century (Gaesser 37). In spite of this steady increase in number of Americans dieting, the average weight also continues to rise (Campos 29). Despite these failure rates, people continue trying (and

usually failing) to lose weight, and the development of new methods encourages this behaviour. As Murray observes, anti-fat medical discipline is effective due to the illusion of choice, specifically that the array of options available make the patients convinced that there is a method that will work for them (21-22). This is particularly true in the face of societal and medical discourse that insists that weight loss is primarily a matter of dedication and willpower.

A final important aspect of weight loss which is rarely discussed either by society or by health care professionals is that attempting and failing to lose weight can have greater risks for one's health (Burgard in Wann). Correlations have been found between heart disease and weight cycling[8] (Campos 20-22), as well as health issues such as high blood pressure, depression and eating disorders (Lyons 81). Tischner cites Aphramor who goes so far as to argue that "the weight loss approach to health can be said to violate the principles of professional good practice by not adhering to the requirements of treatment beneficence and of not inflicting any harm" (Aphramor in Tischner 14). In this, she is specifically referring to practices such as referrals for diet programs or weight loss surgeries, given that, while physicians are required to inform patients of possible side effects of medications, they often do not address weight loss recommendations in the same way (Tischner 14). The fault for this, of course, cannot be placed on the individual physicians as much as on the dominant discourse which ignores these risks and encourages the internalization of fatphobic attitudes in patients, leading to their unquestioning acceptance of a wide variety of unsuccessful treatments.

[8] Weight cycling being the repeated gain and loss of weight over a long period of time, most often caused by dieting

The Panopticon, Surveillance, and the Gaze

One of the greatest obstacles to systemic change regarding society's negative perceptions of fatness is the fact that body policing does not simply occur as perpetrated by an external force on an individual. There is undeniably a great external pressure which feeds fatphobia, exerting itself via the media, medicine, schools, and virtually every other part of day-to-day life. However, these broad-reaching fatphobic discourses have permeated our society in such a way that the individual unknowingly but willingly takes part in their own oppression. Tischner refers to Bartke's theory of oppression and domination, saying that "domination requires not only the objectification of the dominated person but also that the person be made aware of being objectified," and in the case of fatness, this is particularly pertinent (50). The constant reinforcement of fatphobic ideologies by a media-focused society comes to be accepted as objective truth, both by society as a whole, and by the fat people who are stigmatized by these beliefs. These ideologies are then internalized by fat people, who enforce them both on themselves, and on other fat people.

The Panopticon

The extent to which fat people internalize and thereby contribute to their own oppression is essential to an understanding of institutional fatphobia, and exploring this topic can be greatly enhanced with a discussion of French philosopher Michel Foucault's theory of Panopticism[9], which involves "surveillance and social control where people

[9] Inspired by a prison structure known as "the Panopticon," designed in the early 19th century by Jeremy Bentham as a means of constant surveillance of prisoners to encourage self-policing behaviours (Foucault 204-5)

alter their behavior because they feel as if others are constantly observing and judging them" (Giovanelli & Ostertag 289). In *Discipline and Punish: The Birth of the Prison*, Foucault suggests that Panopticism can be used to provide a framework for the way in which institutions control and moderate the behavior of individuals on a day to day basis. Panopticism also functions as part of Foucault's much broader theories about discipline as a social force, in which he examines the relationship between the verb form of the word "discipline" (i.e. to punish or reinforce upon oneself or others) and the noun form (namely, qualities or areas of work to be mastered) (Danaher et al 50). It is the intersection of these two ideas which one could argue interested Foucault the most; the end result of which was what he referred to as the 'docile' body, namely one which can be "subjected, used, transformed and improved" as society wishes it to be (Foucault 136). The docile body, it is important to note, also implies a healthy body (Danaher 50), which is particularly noteworthy in relation to the implicit requirements for a fat body (or a disabled body) to become 'docile' and therefore socially valuable. Bozzo-Rey argues that full Panoptic control over a person necessitates full control over their bodies, which makes sense if one views the primary goal of the Panoptic gaze to be normalization of 'deviant' bodies (171). The construction of the 'deviant' individual or body is also essential, because it creates an alternative to the 'docile' or 'productive' body. This binary delineates clear boundaries between the successful member of society and the unsuccessful one, giving the docile body something to fear becoming (i.e. fat/disabled), as well as reinforcing that conforming with the normative standard is a saving grace to avoid falling into the category of 'undesirable' (Danaher 50).

The construction of the docile body is in turn achieved through the exercise of the aforementioned discipline, which functions through three major techniques: "enclosure" (the creation of unique, enclosed spaces), "division and partitioning" (the restriction of individuals to their defined spaces), and "function sites" (the act of placing control, new function or new purpose onto a space that was originally assigned a different function) (Foucault 141-144). "Enclosure," when applied to fat studies, primarily can be seen to refer to the creation of spaces such as fat camps for children (Aphramor 900), diet groups (such as the aforementioned Weight Watchers or Overeaters Anonymous), and even specialty clothing stores. "Division and partitioning" builds on some of these specialized spaces, while also constructing public spaces in such a way that fat people cannot participate in them, or do not feel welcome. The construction of public transport systems[10] and buildings which are not built with the bodies of fat people in mind are one major example of this (Cooper 36). Finally, "functional sites" when applied to the experiences of fat people most often include medical institutions, such as doctors' offices or hospitals. As was discussed in greater depth previously, these sites (which should be primary locations for everyone to acquire health care services) often become sites of shame and stigma for fat people, whose medical concerns are often unilaterally blamed on their weight.

There are five operations of disciplinary power through which disciplinary punishment manifests. First, it forces people to be viewed as part of a large group and to

[10] One extremely politicized example of this is the size of airline seating, which is often inaccessible to fat customers who are sometimes required to purchase a second ticket for a seat next to them, rendering flying financially challenging (as well as humiliating) for many people (Owen 7).

be compared to those around them in order to discern how well they are adhering to established rules (Schwan & Shapiro 119). This is true for fat people both on a larger scale as members of society, as well as among the supposedly homogeneous demographic of 'overweight people,' in that weight is seen as a spectrum of 'good' to 'bad,' depending on how far over the prescribed 'ideal' weight a person is. This leads to the second operation, namely that disciplinary punishment sets the ideal as a median of all individuals being measured, with the understanding that no one should be above or below this median (119). This is clearly evident in pathologizing medical systems such as BMI, which prescribes an arbitrary threshold for acceptable weight. Also evident in BMI and other similar tools is the third operation of disciplinary punishment: that it uses numbers rather than descriptors to set the rules[11]. Fourth, it can be argued that discipline uses the numbers and the rules those numbers support to constrain the ways in which people behave, which is evident in the way weight and BMI are used to support prescribing 'appropriate' behaviour for fat people (namely exercise and dieting) (119). These numbers are also used to implicitly tell fat people that, having failed to follow these rules, they are not welcome as full participants in society more broadly. Fifth, as mentioned previously in terms of 'docile' versus 'deviant' bodies, disciplinary punishment labels those who don't conform to the rules as 'abnormal,' holding them up as a cautionary tale for others (119).

A final aspect of disciplinary power is Foucault's suggested criteria for its success. The first two of these criteria, namely "hierarchical observation" (coercion by

[11] This could also be seen to apply to disability, as thresholds for who is considered disabled is often based on an arbitrary numerical point, such as in vision tests.

means of observation through the simultaneous omnipresence and invisibility of disciplinary power) and "normalizing judgment" (that it is necessary for the individual or institution in power to understand everything that would be capable of making the subject feel punished) are essential tools in the continued control of oppressed demographics (Foucault 170-179). The last (and most significant to fat oppression) criterion emphasizes the importance of "the examination," which functions as the 'normalizing gaze' and follows a set order of procedures, in a ritualistic way. It serves to objectify the subjects in order to better assess whether they conform to the required norm (184-191). In this way, the disciplinary gaze "[m]akes each individual a 'case'… as he may be described, judged, measured, compared with others" (Foucault 191). This is essential to the medicalization of fatness and the increased power of medical institutions, as they have normalized the act of examination as routine, thus subjecting individuals more efficiently to the authority of medical 'professionals' (Schwan & Shapiro 122). Because the medical gaze is presented as being all-seeing, it turns the act of being visible into a state of subjugation, rather than one of being empowered (which is how modern North American society more often views visibility, such as in the case of celebrities) (Schwan & Shapiro 123).

Surveillance and the Gaze

This concept of visibility as subjugation manifests most clearly in the media attention paid to fat people, and the way in which they are forced into the spotlight. This is known as the "visibility and power asymmetry" structure, wherein one group has the power and the other has the visibility (Tischner 45). This has manifested far more than Foucault could have imagined in modern society, where a combination of direct

surveillance (such as security cameras, the ability to track someone's online presence, etc) and indirect surveillance (such as the pervasive influence of the media in people's views of themselves and others) create a power system which cannot be readily identified, and therefore cannot be directly combated. This power network protects the overall apparatus of surveillance by providing redundancies, such that even if one "central node" were to be neutralized, the other functions of the network could compensate for its loss (Schwan & Shapiro 102). This entire network of power becomes centralized in the concept of the 'Panoptic gaze,' which takes the dominant ideologies of the power network and focuses them directly on the individual. Although the Panoptic gaze is the gaze of authority, it does not reside in a particular authority figure. Rather, it is recognized as being part of the system as a whole, standing in for any given power figure or institution (Danaher 54.)

When the individual is inundated with the ideologies of this Panoptic gaze they come to internalize it, making them both the object and the subject of control, and becoming "the principle of [their] own subjugation" (Foucault in Elmer 202-203). For fat people, manifestation of discipline in the policing of the self and others operates through what Murray refers to as "an internalized 'clinical gaze'" (21). This 'clinical gaze' operates by ensuring that the fat person is never unaware of the 'inadequacy' of their own bodies, or of the health risks these supposed shortcomings pose. Instead, the internalization of discipline in a fat-hating society requires fat people to implement tools of self-monitoring, such as keeping a food journal (for groups such as Weight Watchers or Overeaters Anonymous, as well as in some cases at the demand of a doctor or other

medical specialist) (Boero 72); physical fitness or exercise logs (either to be reported to similar sources of Panoptic authority, or as a means of self-judgment); or through the use of technology such as pedometers, accelerometers or other personal monitoring devices (Satinsky & Ingraham 146).

The negative impact of this kind of internalized fatphobic gaze does severe psychological and emotional damage to many fat people, not to mention any physical damage that may result from attempts to correct the perceived inadequacy. This external pressure often makes it difficult for fat people to look beyond their own physicality to see any degree of merit in themselves. In many cases, fat people will attempt to disassociate from their bodies in an attempt to escape the negative connotations of deviance that such a body carries[12]. Speaking about the lived experience of people with disabilities, Wendell observes that "[a]ttempting to transcend or disengage oneself from the body by ignoring or discounting its needs and sensations is generally a luxury of the healthy and able-bodied" (119). This is also very much true about fat people, particularly because their needs and sensations (such as, most pertinently, hunger) are inherently even more politicized as being signs of their moral weakness or deviance. The distancing of oneself from the fat body is also apparent in the ways fat people view each other. Even when participants in Tischner's interviews claimed to be fully comfortable with their weight and their bodies, they still viewed fat people who they saw or knew as "Other," which

[12] Murray observes this in interviews with contestants on reality shows such as *The Biggest Loser*, where contestants (particularly female ones) identify their fatness as the enemy that their 'true selves' need to overcome in order to be 'normal' (92).

could be seen to imply that they subconsciously carried the same perceptions of themselves (51).

One of the most significant manifestations of the Panoptic gaze in regards to fatness is the way in which the media removes from fat people the ability or right to keep their weight and habits private, and instead turns weight loss and health into a public issue. The Panoptic discourse surrounding bodies "professes a concern for individuals' most intimate and private problems [but] it imposes rigorous public mandates and admits no shirking" (Duncan 52). Since beauty is seen as a matter of public opinion (particularly via the media's prescriptive perspective on what constitutes 'beauty'), the subordination of (private) health to (public) beauty gives implicit permission to police the health of individuals under the guise of advising on beauty (Duncan 55). While the public policing of fat bodies can be seen in the news and through public discourse, it is possibly most frequently perpetrated in a technically more indirect manner, through popular media such as magazines.

Fatness, Gender, and Femininity

These Panoptic devices can sometimes be seen in media directed at men, such as *Muscle and Fitness* or *Men's Health* magazines, but they are far less universally present, given that beauty expectations for men are both less stringent and (often) more attainable than those for women (Duncan 63). While the media does generate male bodily insecurity, it is far more related to anxieties about proving themselves to be 'powerful,' both in strength and as a visible manifestation of their strength of will (Murray 91). In contrast, the concerns of women are far more tied to the male gaze and attempts to

perform conventional femininity (Murray 91). More importantly, fatness is seen as less of a shortcoming in men (at least from a broader cultural perspective) because, whereas fatness is seen as being only one part of a man's being or presence, it often comes to overshadow all other qualities possessed by a woman (Tischner 116).

This 'making public' of private bodies is therefore a far more effective control technique when deployed against women. Duncan identifies two particular ways in which media directed at women (particularly magazines) replicate the Panoptic gaze. First, they employ the myth of "The Efficacy of Initiative," which suggest that making substantive change to one's appearance or body requires only an exercise of will and commitment (51). Second, it implies that "Feeling Good Means Looking Good," which suggests that, while health change goals are important, the most significant are those which can be reflected in one's visible appearance (51). An essential part of this discourse is the idea that these issues both affect everyone, and can be defeated by anyone. To do this, many magazines will use 'success stories' of women who have 'won' their battle against fatness. Often, these women are celebrities, whose success stories both humanize them, and utilize the star power and admiration these celebrities have to reinforce the idea that weight loss is necessary (Murray). However, many of these stories also centre on 'normal' women, which therefore allows the reader to more readily put herself in the subject's shoes. While these women's stories are used to show that weight loss is attainable, they also reinforce the idea of fatness as moral failing, since most of these stories involve 'confessions' on the part of the subjects about their poor health and life habits prior to their weight loss (Duncan 58). Because the story has been constructed

such that the reader inserts themselves into the position of the subject, this act of confession thereby reinforces an internalized sense of shame on the part of the reader (Duncan 58).

This internalized shame does still more damage when its effects contaminate the ways in which the individual relates to other fat people. Tischner's interviews did not simply show that fat people viewed each other with an 'Othering' gaze, it specifically revealed that fat women consciously exert a fatphobic gaze upon other women (51). Germov found similar results, coining the term "body-surveillance" to refer to this normalizing gaze that fat people exert on each other, and stresses that it is perpetrated most often by women, upon other women (125). In this way, the institutions of surveillance are able to pass on to the subjects of their normalizing gaze the authority and the means to reinforce their own subjugation. In discussing this particular structure, Giovanelli and Ostertag specifically refer to the presence of a "cosmetic Panopticon" (289), which emphasizes not just the need for its subjects to lose weight, but also the need for them conform to other standards of female aesthetic 'acceptability.' Although Tischner's results would indicate that women are aware of these structures and their roles in reinforcing them, Duncan argues that the extensive work which women perform to replicate the societal standard of beauty leads them to believe that this beauty ideal is internally generated rather than socially constructed (50).

Part of the way in which society reinforces these standards of beauty is by appealing to insecurities brought on by the compulsory heterosexual ideologies which are

so often inflicted upon women. Just as the previously mentioned study[13] by Giovanelli and Ostertag showed, the media and society more broadly are invested in convincing women that fatness and desirability are mutually exclusive. As a result, one of the main goals for women in losing weight is to be seen as more desirable, and therefore more 'feminine.' Boero proposes three aspects of heteronormative weight loss, namely "relearning heterosexuality, consuming femininity, and becoming visible" (105). "Relearning heterosexuality" refers to the process by which women who have recently lost a great deal of weight implicitly buy into the societal objectification of women, in that many of them are flattered by behaviours such as catcalling or even workplace harassment, simply because it is seen as being a quintessentially 'female' experience (Boero 106, Tischner 53). Many women also felt that any romantic or sexual relationships which they were in while fat were inherently pathological in nature, and Boero's examination of online message boards for weight loss surgery patients showed that breakups and divorce were common after women had undergone their surgery[14] (107-108). "Visibility" and "consuming femininity" both also involve the ability of the women in question to feel as though they were becoming 'real' women, with the former allowing them to be seen in public as women rather than cautionary tales (Boero 112-

[13] Which showed that female characters in television shows are viewed as masculine, or have their sexualities mocked or ignored completely.

[14] This may in part also be because men were more likely to treat their fat female partners badly, in part because of the expectation that the women wouldn't leave them due to insecurity or knowledge of not being broadly seen as sexually desirable (Boero 108).

113), and the latter allowing them to shop in 'regular' stores[15] or engage financially with other traditionally feminine habits or pastimes (Boero 109).

Given this emphasis on thinness as a marker of femininity, it could be argued that the increased emphasis placed on the maintenance of the female body is a tool of patriarchal control. In a medical journal from 1924, Dr. James McLester writes that "the 'fat' female is not… a '*suffering*' body, but rather that it is the *source* of suffering for *others* [and that] its *threat* lies in the *aesthetic affront* it now presents to society" (McLester in Murray 2, emphasis original). Women's bodies and women's weight have for a long time been considered to be a matter of social concern: a sign of social decline, a scapegoat for fear regarding changing political landscapes, and an affront to the patriarchal regime. More specifically, it could be argued that what is implied in McLester's statement is that the fat female body is a source of suffering for men. This is by no means an issue which has been left behind in 1924, however. As Duncan argues, "[w]omen in contemporary Western culture are socialized to regard themselves through the (masculine) eyes of others," and when that gaze finds them lacking, the blame generally falls on the women themselves (50).

The pathological nature of the activities that women carry out in order to conform to this gaze and to be seen as 'appropriately' feminine cannot be understated. Danaher suggests that "the acquisition of a desirable look involves… punishment that females ritualistically carry out upon their bodies… [in order to] attract the gaze of a desirable

[15] Boero observes that many weight loss organizations or support groups (particularly those for people undergoing weight loss surgery) further reinforce this idea that newly thinner women are entering the world of conventional femininity by staging makeup demonstrations, amateur fashion shows, and other similar events which showcase the participants' ability to be 'real' women (109).

male and be valued accordingly" (55). Not only is this 'work' that women perform in order to conform to beauty standards a reinforcement of fatphobic ideologies, it is also arguably an act of self-subjugation. The discipline women carry out upon themselves is both an example of Panoptic control, and of an internalized adherence to patriarchal assertion of power. Because of the overwhelming nature of the aesthetic expectations which are placed on women, it can easily be argued that they inherently serve to continue the subjugation of women by robbing them "of the energies and other resources necessary to advance in a male dominated world" (Tischner 47). The never ending quest for aesthetic perfection drains women of time, as well as of financial and emotional resources that could otherwise be being put towards either better forms of self-improvement or sociopolitical action (Duncan 49). This is one of the central arguments towards the necessity of viewing fatness and fatphobia as feminist issues, and one which can also be made for disability.

Disability Theories and Fatness

The previous sections provide an outline for many of the main areas in which fat people face oppression (though the list is by no means conclusive). Building from this understanding of fatphobia and the lived experiences of fat people, this essay will now present the points of intersection between fatness and disability theory, in an attempt to determine the value drawing such comparisons may yield. One of the cornerstones of critical disability theory is the idea that it is possible to examine the ways in which people with disabilities are treated in society through the lens of a series of different 'models' of disability. The primary two models referred to by many scholars are the social and bio-

medical model, usually presented as the two opposing perspectives in a conflicting view of what it means to be 'disabled.' There are also a number of alternative models put forward by disability scholars which enhance and elaborate upon the social and bio-medical models, as well as addressing perceived gaps in their thinking.

The Bio-Medical Model

The first model, known as the bio-medical (or simply medical) model of disability, is primarily seen as the way in which people with disabilities are objectified, pathologized and otherwise treated as 'problems' by the medical industry. Ena Chadha defines the medical model as one which "situates the problem firmly in the disabled person who is seen as defective, different, and incapable, in relation to medically defined norms upon which the medical model of disablement is built" (483). Barnes and Mercer add that in the bio-medical model (or what they refer to as the "Individual/Medical Model"), disability is equated with "functional limitations or other 'defects'" and is focused on appropriate 'treatment' as prescribed by medical professionals (2). The emphasis here, as well in definitions provided by other scholars (Brandon and Pritchard, Cameron, Rosenbaum and Chadha, Withers, etc) is that the 'problem' is seen as being an individual issue of 'wrongness' which requires correcting, according to the expertise of a medical 'professional' whose opinion is almost always valued over (or even instead of) that of the person who has the disability. Furthermore, the focus of medical professionals is almost always on "prevention, cure, containment of disease, pain management, rehabilitation, and palliative care," rather than on the actual lived experiences or expressed needs of their patients (Rosenbaum & Chadha 346-347).

The way in which people with disabilities are treated under the biomedical model of disability is also reflected in the social and institutional attitudes towards fat people. A pathologized view of fatness is used to identify fat people as a cohesive demographic of 'sick' individuals who are in need of treatment (Herndon 253), thereby also making fatness the defining trait of the individual in question. The bio-medical model views disability as "a problem emerging from deviant anatomy," and identifies the people themselves as "tragedies in need of intervention" (Withers 31), both of which are perspectives which are abundantly apparent in media and medical representations of fatness. The "deviant anatomy" argument is one which is frequently deployed in the medical industry by weight loss professionals, many of whom use it to lure in patients who have suffered extensively at the hands of public tribunal, which views their weight as a symptom of moral failing (Boero 100). These implicit accusations are in turn prompted by the presence of media which views fat bodies as tragic, including shows such as *The Biggest Loser*, *Bulging Brides,* or *Honey, We're Killing the Kids*, all of which construct the fat body as a public spectacle deserving of ridicule, and in need of personal and medical intervention (Farrell 119). The pressures of bio-medical model thinking are therefore responsible for the emphasis on the kinds of anti-fat medical procedures mentioned previously, as well as the popularity of organizations like Weight Watchers or Overeaters Anonymous. The kind of stigma resulting from a bio-medical interpretation of pathology contributes substantially to the negative opinions that many medical professionals have of fat people, thereby directly affecting the medical care received by fat people. This is one way in which fat studies interacts differently with the bio-medical

model from disability studies, as people with disability are more likely to be treated as objects of pity or medical misfortune by health professionals, rather than objects of disgust or denigration.

The Inspiration/Pity Model

In spite of this difference, both fat people and people with disabilities are impacted in similar ways by certain subsets of the bio-medical model, one of which this paper will refer to as the "Inspiration/Pity" model of disability[16]. This model sees people with disabilities either as sources of inspiration (primarily for non-disabled people) or as unfortunate objects of pity. This notion of pity is particularly prevalent in the discourse presented by charities for people with disabilities, and is derived primarily from the idea that there is an inherent inequality between people with and without disabilities (Withers 57). The bio-medical model construction of disability as an illness which must be overcome or cured if at all possible encourages the idea that people with disabilities are suffering, and implicitly suggests that people without disabilities should consider themselves lucky that they are not equally 'unfortunate.' There is substantially less presence of the 'pity' aspect of this model in regards to fatness, as fat people are more often seen as being responsible for their own conditions and to blame for not losing weight. However, fat people are often held up as cautionary tales by the media (particularly in such forms as women's magazines, as discussed previously), which may evoke similar pity responses, albeit generally more derisive ones.

[16] Inspired by Rosenbaum & Chadha's "Hero/Pity elements" (347) and Withers' "Charity Model" (57).

In contrast, the portrayal of people with disabilities as inspirational "extoll[s] the virtue of those people with disabilities who achieve great feats 'in spite of' their impairment" (Rosenbaum & Chadha 347-348). In her 2014 presentation on *TED Talks*, Stella Young shows a variety of inspirational posters featuring people with disabilities (generally performing some kind of feat of athletics) as examples of the ways in which people with disabilities are constructed as sources of inspiration, simply for engaging in activities and behaviours that would be considered unremarkable for a non-disabled person (Young). The people depicted in these images, which Young refers to as "inspiration porn," are seen as inspirational "not necessarily… for their actions; [but] because of the emotional response or the feeling of inspiration they can elicit in others" (Withers 70). It is this idea of 'inspiration porn' that is particularly relevant to the treatment of and perspectives on fat people in contemporary society. Advertising and media surrounding weight loss makes substantial use of the idea that these conditions *can* be overcome, and hold up individuals who are able to do so as shining examples who should be taken as inspiration by both thin and fat people alike (Duncan). A plethora of reality shows invoke either disgust or begrudging pity for the fat contestants, which transforms into admiration and inspiration as the individuals lose often unhealthy amounts of weight in pursuing their goals. Public weight loss stories are also often constructed as narratives of redemption, such as the controversial *Jenny Craig* ad series featuring Monica Lewinsky which ran in 1999 (several years after the infamous scandal of 1997). Farrell observes that the scandal placed Lewinsky in the spotlight as a model of uncontrollable excessive desire, both for sex and for food (as evidenced by her weight)

(Farrell 122-123). Her endorsement of *Jenny Craig*, therefore, was seen as a path to redemption, making her an inspirational role model for 'improving' oneself.

The Social Model

The social model of disability –which is generally accepted as a critical disability studies and disability activism's deconstructive and analytical response to the bio-medical model– aims to disrupt and eliminate the inherent value judgments put forward by this kind of pseudo-eugenic thinking, as well as other underlying assumptions of the bio-medical model. The term, which was coined by Mike Oliver in 1983, describes a model of disability theory which advocates for "a switch away from focusing on the physical limitations of particular individuals to the way the physical and social environments impose limitations upon certain groups or categories of people" (Oliver 29). The social model also recognizes a distinction between 'impairment' and 'disability,' with the latter being the disadvantages imposed by a disabling society, and the former being the medical conditions which result in people being impacted by those societal structural effects[17] (Colin "Social" 137). Essentially, the conclusion drawn by the social model is that while impairments may be caused by illnesses, accident, aging, or other physiological condition which may be medically treatable, the actual condition of disability is a form of systemic oppression which therefore cannot be 'treated' (Withers 87).

The distinction between impairment and disability is significant in the application of the social model to fatness and fatphobia. While recognizing impairment, it rejects the

[17] Although the impairment/disability distinction is an important and valuable one, for the sake of simplicity this paper will continue to reference 'people with disabilities,' with the implication that the phrase is not meant in an essentializing or pathologizing manner.

narrative put forward by the dominant bio-medical model which constructs people with disabilities as being primarily defined by their bio-medical status, to the exclusion of considering their personal experiences or wishes, or the structural conditions that create disability. Instead, the social model aims to minimize the attention paid to the impairments themselves and focus instead on the negative impacts of a disabling society on the already marginalized demographic of people with impairments, as well as attempting to find ways in which to counter these effects. Similarly, it is important to minimize attention paid to fat bodies themselves, and instead increase discourse surrounding the prejudicial attitudes towards fat people, including rejecting discourse which assumes that fatness is inherently treatable, or suggests that it should be medically 'cured.' The issue of treatment is an equally important issue in fat studies as in disability studies, and one which many activists and scholars engage with, much the same way that disability scholars challenge the idea that disabilities can or should be 'cured' medically. As mentioned previously, many scholars and researchers have noted that there is no strong evidence that weight loss techniques (particularly diets) have any degree of efficacy, and can often cause greater harm through the repeated loss and regain of weight and the physical and psychological stress they often induce (Aphramor, Cooper, Burgard, Lyons, etc). Therefore, the established framework offered by the social model has the potential to help provide a stronger foundation upon which this line of fat studies thinking can be built.

While the social model provides an important framework for looking at and deconstructing issues relating to fatness and bio-medical pathologization, it also has

further psychosocial implications. In regards to a critical examination of the barriers presented by a disabling society, it can be seen that they can be either physical (such as inaccessible washrooms or seating) or mental/emotional (such as isolation and exclusion borne of prejudice or inaccessibility) (Withers 86, Brandon & Pritchard 83). Some fat studies scholars have already begun drawing on social model ideologies with these particular distinctions in mind, such as Tischner's use of the social model to address the shame that many fat people feel in public spaces due to an inability to 'fit,' such as in seating, or small spaces like turnstiles. The inability to participate in public spaces, organizations, events, or other kinds of normative social activities is a significant challenge to fat people, and can also be addressed via the social model's emphasis on problems relating to isolation and exclusion.

As a dominant model used in disability theory and activism since its formulation, the social model has evolved over time, with additional contributions and interpretations by many theorists. This means that many of the critiques levelled against the social model are as much or more so in response to the ways in which social model thinking have manifested in the field of disability studies over the years as they are to Oliver's original theory. For example, some people criticize the social model by arguing that it can pay too much attention to the nature of the barriers and the effects of a disabling society, and not enough to the actual lived experiences of the people for whom it aims to advocate (Brandon & Pritchard 68), when it is integral that the voices of disability activism reflect the experiences and feelings of the community at large. This is a criticism that must also be considered when adopting social model ideologies into fat studies, as it is crucial that

fat studies and activism pay attention to the lived experiences of fat people and the struggles they face in trying to reject dominant fatphobic ideologies on a day to day basis, rather than just challenging those ideologies on a systemic scale. This is a necessary precaution, as fat activism sometimes does fat people a disservice by implying that the rejection of fatphobic ideologies is easier than it may actually be on a personal level, due to the internalization of fatphobia (Murray 108).

Affirmation Model

In addressing this potential oversight in the social model, it may be useful to turn to what Swain and French refer to as the "affirmation model" of disability. While it supports the social model's assertion that society has disabling effects on people, the affirmation model views disability and impairment in a "non-tragic" way, encouraging instead the development of positive individual and collective identities which are grounded in lived experience (Swain & French 569). Although the affirmation model encourages speaking about impairment, it also doesn't inherently view the experiences of impairment as negative, instead proposing them as a difference to be expected and respected on their own terms, while still viewing disability as a category which invalidates people with impairments and validates those without (Cameron "Affirmation" 6). For example, while it may be more difficult for people with disabilities to perform socially expected or required traits (such as gender expectations or beauty standards), being able to avoid these expectations altogether has the potential to be liberating (Swain & French 574-575). The ability to avoid performing societal expectations is admittedly a double-edged sword for fat people, for whom weight can be a severely inhibiting factor

in taking part in social interaction. This is particularly true for women, who (as mentioned previously) often feel that they are failing at performing normative femininity, which contributes to their low feelings of self-worth. However, some scholars such as Owen argue that, while the difficulty or inability fat people have to "embody cultural definitions of health, beauty, and docile citizenship" may be dehumanizing, it can also be liberating, just as Swain and French feel it is for people with disabilities (8).

Finally, in emphasizing the importance of hearing the voices of people with disabilities, Swain and French stress that the affirmation model also strongly advocates for the right of people with disabilities to be provided the information they need to give informed consent or rejection of medical intervention for their impairments (579). By acknowledging that people with disabilities may want to receive medical intervention, the affirmation model deviates from the social model's arguments against the bio-medical model, which advocate for a rejection of medical intervention for disabilities in non-essential cases. Adopting this way of thinking about medical intervention has a great deal of potential for fat studies and activism. The importance of informed consent in medical procedures espoused by the affirmation model is essential for improving the treatment and experiences of fat people. It would also present a thought-provoking challenge to many fat activists who unilaterally reject any kind of weight-related medical treatment, much as the affirmation model challenges social model rejection of medical intervention. It is, of course, important to deconstruct and critically examine the desire to receive medical intervention for an impairment or for weight, and consider that it may well be a result of the disabling effects of society which lead to people with disabilities having a

poorer quality of life. But by emphasizing the non-tragedy of impairment, the affirmation model provides a unique grounding point for promoting disability (and fat) pride.

Beyond the ability to step outside social norms or look critically at medical intervention, the affirmation model can offer a great deal to the fat community in that, in some ways, self-love and pride can be an even more radical notion for fat people than for people with disabilities. While disabled bodies are often viewed by society at large as being broken or undesirable (which is of course a hugely negative and stigmatizing experience), fat bodies are more often utterly reviled. Because societal fatphobia places a great deal of pressure on fat people to hate their bodies enough to change them at any cost, declaring oneself to be happy with one's fat body is an inherently radical act (Farrell). In fact, Farrell goes so far as to argue that "much of the work of fat activists depends on… the creation of a new point of view, an alternative way of thinking about fat, about beauty, and about health" (138-139). While the ability of fat individuals to fully reject fatphobic discourse is sometimes called into question by scholars such as Murray (who argues that entirely changing one's perspective of one's own body to view it in a positive light is virtually impossible due to internalized fatphobia) (108), the self-love espoused by the affirmation model is still without a doubt a crucial lens through which to view and support the forward momentum of individually-driven fat activism.

Feminist and Intersectional Models

As mentioned previously, the inclusion of lived experience in examining oppression is particularly applicable to fat studies when engaging with the experiences of fat women, who generally face more stigmatization as a result of their weight than men

do, due to a combination of media pressure, misogyny and medical bias (Giovanelli & Ostertag, Murray, Tischner, etc). A 'feminist model' of disability which seeks to incorporate feminist theory into disability thinking and also particularly emphasizes the lived experiences of women would therefore be of value (Rosenbaum & Chadha 348). Rosenbaum and Chadha's feminist model aims to "expose the social and gendered forces that subordinate the power, autonomy and choice of women with disabilities," while also striving to include issues relating to other axes of oppression such as age, sexuality, race and class (Rosenbaum & Chadha 348-349). Recent changes in other movements such as feminist or critical race theory have placed a great deal of emphasis on the importance of intersectionality, and Rosenbaum and Chadha's feminist model theory takes steps towards encompassing those ideals into disability theory.

Given that there is a significant body of feminist work which already addresses the toxic beauty standards faced by women, it would make a great deal of sense to extrapolate from that work (and critical disability interpretations of it) in order to have a stronger foundation from which to tackle the intersection between fatness and femininity. Feminist theory is also valuable in examining the ways in which fatness is seen as the antithesis of heterosexual desirability in women, in that it can also problematize the pressure to perform this kind of normative femininity, as well as challenging the relationship between the two concepts. This also provides an opportunity to tackle the aforementioned ways in which female beauty standards consume women's energy and time, functioning as a form of oppression to prevent them from better addressing more politically significant issues in their lives. The feminist model also provides a focus on

race and class, which have been identified by fat scholars as being significant factors in anti-fat stigma. Systemic racism is highly relevant to fatphobia, particularly in terms of such institutional pressures as the attempted whitewashing of the lifestyles of people of ethnic minorities (particularly Mexican and Black) by labelling their dietary habits as 'less healthy' than White diets (Boero 52). These demographics are often also more heavily affected by classist assumptions access to foods which are considered to be 'more healthy.' Class is also linked to fatness on a more inherent level, given that fat people are often discriminated against in the workplace, leading to them getting poorly paying jobs (Puhl & Brownell, Aphramor, Burgard).

Ultimately, any model of disability which places emphasis on acknowledging lived experience can be a powerful tool for demographics who face almost constant negative pressure and propaganda from society, and who therefore cannot help but wish to disassociate from the identities (as fat or as disabled) which are the source of their suffering (Cameron "Identity" 72-73). Medicalized discourses of fatness as negative are (like with disability) a central component of the perpetuation of what Thomas refers to as "psycho-emotional disablism," namely the ways in which negative attention and stigma damage the emotional wellbeing of people with disabilities, and restrict their ability to freely shape their own identity (Thomas in Bê 59). These negative ideologies and stigmas can lead to internalized oppression, which is in and of itself a form of direct, self-inflicted psycho-emotional disablism (Reeve 123). As has been discussed, disassociation due to internalized oppression is particularly prevalent among fat people (especially fat women), manifesting as an internalization of the body shaming attitudes of society. This self-

regulating Panoptic gaze is also turned upon other fat people in an attempt to police their bodies. Using disability models that emphasize lived experience in order to address these experiences and attitudes among fat people in a non-pathologized and positive way could be extremely valuable in order to help break the self-perpetuating cycle of fat people being complicit members of their own oppression and stigmatization.

Rights-Based Models

While the aforementioned models all provide important lenses of disability theory through which fatness and fat studies may be viewed, there is one crucial area which they do not sufficiently address: namely law, legislation and policy. Withers' 'rights model' aims to address this, "focus[ing] on human and citizenship rights and ensuring that disabled people have equal access to these rights" (Withers 81). The rights model aims to remove physical, social and mental barriers to allow people with disabilities access to full citizenship rights, primarily through the avenues of legislation and policy. This legislative emphasis is important to fat studies, as there are increasing efforts to challenge fatphobia via legislative and legal grounds (Kirkland, Vade & Solovay, Solovay). The methods for legal and legislative change employed by disability activists are particularly relevant to those which may be used by fat activism, as both demographics deal specifically with bio-medical model approaches to their conditions and their perceived abilities. This will be discussed in greater detail below.

The focus on citizenship which is put forward by the rights model is extremely important in helping both fat people and people with disabilities to regain a sense of personhood which a fatphobic and ableist society denies them. This emphasis by the

rights model is also indicative of a shift in disability theory thinking in the past several decades, with the acknowledgement that disability is inherently a human rights issue (Rioux & Carbert 11). It is now often being argued that many of the issues being addressed by critical disability scholarship can be reduced to the fundamental declaration that all people are entitled to basic human rights, and should be automatically granted them without any other social or biological factors interfering with those rights. This idea, often referred to as a "human rights model" of disability was heavily influenced by the 1948 United Nations Universal Declaration of Human Rights, which stated "that all people have certain civil, political, economic, social, cultural, and development rights, despite differences between individuals" (Rioux 1-2). Like the social model, it places critical emphasis on the social constructions which disable people with impairments. However, unlike the social model, it also "places the individual centrestage [sic] in all decisions affecting him/her," thereby ensuring that all the changes proponents of this model exact are, at their core, dedicated to granting rights to and gaining equality for people with disabilities (Quinn & Degener 14).

The emphasis on basic citizenship and freedoms put forward by the human rights model is essential for fat studies and fat activism, as is the renewed significance it places on the individual (similar to that of the affirmation model). Fat people are, as has been shown at length, often denied basic rights and dignities, both within the medical industry and in society more broadly. By adopting a model which emphasizes rights and subjecthood, fat and disability activism can push society to "[abandon] the tendency to perceive people with disabilities [or fat people] as problems and view them instead in

terms of their rights" (Quinn & Degener 9). Ultimately, the human rights model emphasizes improving the outcome of any given action for the individual, rather than just looking at changing treatments or service provision. With such a long history of dehumanizing treatment, a model which emphasizes the rights of the individual as much as the deconstruction of the systemic barriers could be extremely valuable, both for fat activism as a whole, and for fat people individually.

Law and Legislation

Although weight is a prominent ground for discrimination, it is often left unaddressed in anti-discrimination law, legislation and policy. Brandon and Pritchard, focusing primarily on the United Kingdom, observe that many policies neither explicitly include nor exclude fatness as a defended category (85). Likewise, neither Canadian law nor the Supreme Court of Canada have specifically addressed fatness. The United States Constitution also does not mention fatness, however it does not have any overarching equality protections like those offered by the Canadian constitution (for disability, fatness, or otherwise) (USC, CCRF 15.1). In the United States, there are only a small number of places in which weight-based discrimination is explicitly illegal, including Washington, D.C.; the state of Michigan; Madison, Wisconsin; San Francisco, California; and Santa Cruz, California (Vade & Solovay 169). The Equal Employment Opportunity Commission (EEOC) in the United States does consider obesity to be a disability (and therefore defendable under disability related anti-discrimination policy), however this is a pathology-based distinction available only to those who are overweight by 100 lbs or more, according to BMI (Vade & Solovay 170, Withers 38).

Given that fatness in and of itself is rarely grounds for discrimination protection, it is therefore important to look at the policies regarding disability, to see how they may be relevant or applicable to discrimination based on weight. Anti-discrimination laws and policies in the United States are primarily centred on a mandate to ignore traits which are grounds for stigma, with the exception of the Americans with Disabilities Act (ADA), which requires legal definitions of disability in order for individuals to receive accommodation (Kirkland 2). Kirkland cites the ADA definition of a qualifying individual with a disability as "an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such an individual holds or desires," and a disability itself as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment" (3). In terms of discussing protection against fatphobia, the aspect of "being regarded as having such an impairment" is key, since dominant discourse views fatness as a major health risk. However, the open ended nature of this definition of disability leaves the success or failure of such an attempt strongly at the discretion of the legal or political figures charged with making any relevant decisions.

In Canada, protection for people with disabilities has a longer history, as it was the first country to include equality rights for people with physical or mental disabilities (Rosenbaum & Chadha 343) in its Constitution. In contrast to the American 'ignoring traits' method of approaching disability, the Canadian Human Rights Act emphasizes the

right of the individual to have protections and outcomes under Canadian law which are equal to those of individuals who are not a member of a marginalized group, in order

> to make for themselves the lives that they are able and wish to have and to have their needs accommodated, consistent with their duties and obligations as members of society, without being hindered in or prevented from doing so by discriminatory practices (CHRA 2)

based on a wide range of statuses which include disability, but do not explicitly include weight. The CHRA also explicitly includes in its grounds for discrimination "[p]ublication of discriminatory notices" and harassment, both of which are extremely relevant to discrimination against fat people (CHRA 12, 14). It could definitely be argued that "discriminatory notices" would include aggressive fitness campaigns, which are often found in schools or workplaces.

There are also aspects of Canadian disability policy that place more emphasis on the lived experiences of the individuals in question. Some provincial policies, such as the Ontario Human Rights Commission's (OHRC) "Policy and Guidelines on Disability and the Duty to Accommodate," places significant emphasis on the idea that there is a social aspect to disability and disablement that should be considered, rather than viewing its (highly comprehensive) list of conditions that qualify as disabilities as an exhaustive list of grounds for disablement[18] (OHRC 7). Even more importantly, the document explicitly states that "[t]he duty to accommodate persons with disabilities means accommodation must be provided in a manner that most respects the dignity of the person" (10). Regarding dignity, it elaborates that

[18] Like other policies mentioned, this one extends protection to people who are perceived to be disabled (OHRC 6).

> "[h]uman dignity encompasses individual self-respect and self-worth. It is concerned with physical and psychological integrity and empowerment. It is harmed when people are marginalized, stigmatized, ignored or devalued" (OHRC 10).

Given that a great deal of both social and medical attitudes towards fat people involve dehumanizing and pathologizing them, an approach to anti-discrimination that would re-establish an emphasis on their humanity would have great value.

As mentioned previously, when fatness is protected, it is generally only within the scope of a pathologized view which equates fatness with illness, and therefore (often) with disability. Some policies examined by Brandon and Pritchard specify that to be included as a defensible category, fatness must be seen as stemming from or legitimately being an existing medical condition (such as, for example, "if a person's obesity has lasted at least 12 months and substantially adversely affects his ability to perform everyday activities") (85). This perspective inherently views fat people as being less capable than thin people, and therefore would encourage the idea that there is a functional difference in ability that is omnipresent even if anti-discrimination policy 'forces' employers or businesses to treat fat people in an equitable manner. In the United States, even when fatness is not viewed specifically as a competency-reducing condition, it is often only protected legally when the individual's fatness is seen as being a result of a different impairment, such as a different long-term medical condition (Vade & Solovay 170). In contrast, the Supreme Court of Canada ruled in *Quebec v. Monreal v. Boisbriand* that any ailment or perceived ailment can be considered a disability even if it causes no functional limitations, a distinction which, as will be addressed later, is an important stepping stone (Withers 38).

Some scholars argue that disability activists (and, by extension, fat activists) can use the aspects of disability law that focus on the *perception* of the individual as disabled (regardless of their actual physical condition) to defend against discrimination without subscribing to bio-medical model thinking. This has been effective in some cases, such as that of a New Hampshire Catholic school teacher named Mary Nedder, who did not have her contract renewed due to the college president's stigmatizing view of Nedder's weight (Kirkland 8). The president felt that Nedder's weight contradicted the school's healthy living policy, as well as making it likely that the students would not respect her (Kirkland 8). Nedder was able to win the case under the "regarded as disabled" portion of the ADA (Kirkland 8). However, the overwhelming presence of fatphobic thinking make this legal tactic functionally difficult in many cases in the US. Vade and Solovay cite two California court cases regarding weight-based discrimination, one of which was successful and one of which was not. In the successful case, the plaintiff openly acknowledged that there was something biologically 'wrong' with him, and explained in detail the lengths to which he had gone to in attempting to 'fix' the problem, all of which had been unsuccessful (Solovay & Vade 168). In contrast, the unsuccessful plaintiff argued that she was being perceived as disabled due to her weight, but strongly believed that there was nothing medically or biologically wrong with her, and that there was nothing about her body that she should be ashamed of.

The fact that shame is virtually required in some cases for fat people to access disability law for protection has some troubling implications for the broader effects of this practice. However, even some fatphobic perspectives seek to challenge the protection

of fatness as a disability. Herdon, for example, discusses how some people worry that acknowledging fatness as a disability will "condone" the negative behaviours which are seen as leading to fatness (250). While this presents an enlightening look at the hypocrisies presented by the social forces of fatphobia, it nonetheless would be a significant problem. Another obstacle to better legal protection for fat people (either under disability law or not) is a fear that people will make "frivolous claims" (i.e. that people will use their fatness to sue over any perceived slight) (Herndon 250). This obstacle is only reinforced by the fact that some institutions already express legal concern that too broad a definition of disability could lead to 'too many' people qualifying as disabled (Kirkland 13). While this shows a fundamentally flawed understanding of oppression, the strength of institutional fatphobia would lead to an even stronger resistance to its inclusion as a disability than for many other conditions which are seen as contentious.

If fat people were to gain protection under the umbrella of disability law, there would also be a great risk that their condition would fall under a 'personal tragedy' ideology of health, which (while potentially allowing for protection) would have detrimental effects for their equal inclusion on a societal level (Kirkland 5). However, it is important to consider the possible benefits as well. Solovay observes that the use of disability legislation to protect the rights of fat people is a good (and possibly necessary) step "regardless of the social and moral implications because it is the most expedient, if not the only, current solution to the widespread discrimination faced by fat people" (132). It also has the potential to be a positive force in aiding fat people gain rights independent

of those that may be afforded to them by engaging with disability law in the United States, or with human rights and Constituional law in Canada. Historically, gaining legal and political recognition has often required (or at least been aided by) intentionally drawing a comparison between the group in question and other groups that have already been afforded similar protections, as is observed in Withers' rights model (Kirkland 6). Therefore, it could be argued that identifying with disability could simply be seen as a 'stepping stone' of sorts, in a journey to gaining full legal recognition.

That said, there are greater risks to drawing comparison between fatness and disability in the hopes of gaining legislation, even though it is by far the group with the greatest number of points of comparison. As discussed previously, by drawing a correlation between fatness and disability, there is also a great risk of pathologizing fatness even more than it already is, and falling into a bio-medical model thought pattern that sees fatness as something that can (and should) be 'fixed.' Solovay speaks to the issues inherent in conflating fatness and disability in legal terms, observing that there is resistance from both fat activists and disability activists to drawing these parallels; with fat activists rejecting being conflated with disability because they feel that it places the blame of their experiences on their bodies, and disability activists wanting to avoid being connected with a demographic that is the source of widespread disrespect and disgust (129-130). However, it can be argued that the reasoning for this resistance on the part of both groups stems from some degree of internalized stigma about the other. Ultimately, this brings us to one of the most significant questions which this paper attempts to address: should fatness be considered a disability?

Is Fatness a Disability?

Fatness and disability are both medicalized, pathologized, physical states of being that are considered 'abnormal' or 'deviant' in many aspects of modern society. As the field of fat studies is still quite new, there is great value in looking to established disability theory in order to look at the ways in which people face oppression on the grounds of weight. As the previous section demonstrated, there are a variety of disability-related theories which can offer a great deal to the study of social, institutional and internalized fatphobia. However, it is also important to ask the question: should fatness actually be considered to *be* a disability? Few scholars have addressed this question directly, though as 'obesity' becomes more broadly socially accepted as an illness, the question has been raised more frequently. While this paper takes the stance that there are enough parallels to be drawn between fatness and disability that there is value in considering fatness to be a disability, it also recognizes that this perspective is not unproblematic, nor is it without compelling arguments against it.

One of the first sources to discuss this question was Charlotte Cooper's 1997 article "Can a fat woman call herself disabled?" Cooper argues that, since critical disability theory generally identifies 'impairment' as a medicalized condition which leads to being disabled by society, and fatness is considered by many to be a medical condition (which has become far more the case in the almost 20 years since Cooper wrote the piece), then fat people should be allowed to consider themselves 'impaired' (39). If they can identify as impaired, it would then follow that they could be considered to be disabled by societal boundaries, and therefore identify as people with disabilities. While

online discussions Cooper had leading up to and following the publication of her article suggested that fatness be read as a "stigmatized body image" rather than a "functional impairment," it can be argued that stigma from the medical industry and society makes fat people functionally impaired by the definition of much critical disability scholarship (Aphramor 902). Cooper cautions, however, that "[t]here is an uneasy sense that by appropriating the label 'disabled' fat people are invading and colonising the achievements of disabled people, forcing an all too familiar and uncaring disempowerment" (33). This too is a valid argument, and a very real concern. While fat people are undoubtedly oppressed and stigmatized, they have not faced the same long history of systemic oppression (and in some cases attempts at eradication) that people with disabilities have faced. Cooper acknowledges that the lack of institutionalization is one of the main differences between fatness and disability, as well as the degree to which doctors fixate on the condition[19].

This negative history may provide some explanation as to why there is resistance from many parts of the disability community to the inclusion of fatness under the heading of disability[20]. Aphramor observes that disability advocacy groups currently do not engage with the media's poor treatment and (medically-derived) insulting and demeaning terminology towards fat people the way they would for other groups who have been definitively identified as disabled (899). This may in part be because fatphobia still permeates the disability community to a significant degree, much as it permeates a great

[19] Cooper argues that this is more the case for people with disabilities than for fat people, although stories told from the lived experiences of many fat women would seem to cast some degree of doubt on this assertion.

[20] Disability scholars such as Shakespeare himself have argued against the inclusion of fatness as a disability (Withers 113-114).

deal of society. Fatness is still seen publicly –by disability groups and society at large– as being to some degree voluntary, with the inherent implications that disability does not encompass voluntary conditions[21] (Brandon & Pritchard 89). However, rejecting fatness because it is seen as being voluntarily (or medically) fixable could be argued to go against much disability activist thinking regarding the rejection of medical treatment for disabilities. Beyond the hesitation from the disability community, however, there is also a certain degree of resistance from some members of the fat community to being considered to be disabled. Because the fat community seeks to reject the medicalization of fatness, the association with disability (which is still seen primarily as being or involving medical conditions) is a cause for some reluctance (Cooper 34).

Despite resistance from both sides, there is a great deal of significant common ground. Cooper identifies four key similarities between fatness and disability: the common experiences of being assigned low social status; being disabled by the lack of access to public spaces, goods and services; being discriminated against in all areas of life; and being highly medicalized (and, arguably, dehumanized) (36). Garland-Thomson echoes the first two points in particular, arguing that "[t]he fat body is disabled because it is discriminated against in two ways: first, fat bodies are subordinated by a built environment that excludes them; second, fat bodies are seen as unfortunate and contemptible" (1582). As discussed previously, the low social status that both fat people and people with disabilities face (as well as many other marginalized groups) is a result

[21] Although conditions such as alcoholism and other addictions have been successfully defended under the Americans with Disabilities Act, which has interesting implications for the potential disability status of fatness, particularly given societal constructions of fatness as uncontrollable excess) (Herndon 249).

of stigmatizing views of these conditions, and often results in poverty and overall low quality of life (Brandon & Pritchard 82).

Fat people and people with disabilities have struggled for many years (and continue to struggle) with issues in the built public environment, such as inaccessible entrances and exits to buildings, inadequate seating, inaccessible bathrooms (particularly stall size), and other similar challenges (Aphramor 904). For both people with disabilities and fat people (but, arguably, particularly for fat people) the inability to access public spaces can be an anxiety-inducing and humiliating experience. Brandon and Pritchard spoke to a number of fat individuals about their lived experiences, and many of them identified inability to access public environments as one of their major day-to-day obstacles, and as a source of frustration and upset. In some cases, they even admitted that the experiences led to them attempting to lose weight out of embarrassment (84). The overall discrimination faced by both fat people and people with disabilities is broad-reaching, and includes recreation, employment, romance, and many others areas of day to day life which are often taken for granted. The medicalization and dehumanization of both fat and disabled bodies is one of these areas, but also includes more insidious forms of systemic violence such as what Aphramor identifies as "iatrogenisis," namely harm caused by medical intervention. She points to this particularly as a comparison to be drawn between the experiences of fat people (in terms of weight loss programs and surgery) and those of people with psychiatric disabilities (in terms of medication or invasive types of therapy), though it is of course also applicable to virtually all other types of disability (899).

Ultimately, fatness is coming to be included as a disability from a medical perspective regardless of the feelings of members of either community. Withers points to a 2003 study in which obesity was included with a number of other disabilities on a list of conditions for which some of the geneticists interviewed would support selective abortion. The number who would support abortion based on potential obesity exceeded the number of those who would support it based on potential for depression (though less than those that would support it for severe "mental retardation" or conditions that would prove fatal before the age of 3) (50). As mentioned previously, United States law includes obesity under the Americans with Disabilities Act (ADA), as long as the obesity is caused by a medical condition or disorder (though the medicalization of fatness means that this provision casts an extremely wide net) (Brandon & Pritchard 85). In the face of these and many other examples, Withers argues that anyone who identifies as disabled (including fat people) should be allowed to be considered disabled, because denying them that identity restricts their access to a variety of resources and support systems which may be much needed for advancement of quality of life and human rights (113). They conclude that "[i]f we fail to let people self-identify as disabled, we also run the risk of legitimizing the bio-medical model of disability, as it is the primary and oftentimes exclusive mechanism for labelling disability" (114-115).

Conclusion

As this paper has shown, the issues faced by fat people in Western society are insidious, far-reaching and omnipresent. They affect the abilities of fat people to find jobs, take part in social activities, receive adequate medical care, find healthy romantic or

sexual relationships, and formulate positive self-perceptions. The toxic effects of this stigmatization do significant emotional, mental and physical damage to fat people, and should therefore be considered to be serious issues which must be addressed, both by a self-supporting fat community, and by society on a broader scale. Given that fatness is so poorly viewed and vilified by mainstream social discourse, it would seem logical that there would be value in examining the methods used by other oppressed groups in their efforts to remove themselves from this kind of stigmatized status. While there are other marginalized groups which have some points of intersection with fat studies (such as the aforementioned gender and race studies), disability studies and activism present the most direct points of comparison from which to draw inspiration. Although this paper has acknowledged valid concerns regarding both the appropriation of hard-won disability identity and the mutual stigmatizing views of each group by the other, it would seem that the benefits of greater mutual support between disability and fat activism and academia would be of value to both groups, and would particularly serve to forward the cause of combatting fatphobia. While it is important to be wary of supporting the medicalization and pathologization of fatness by conflating it with disability, at this point in time and in this social climate, it seems fairly evident that there is more value than harm in doing so, at least as a short term strategy. It can be hoped that by engaging and challenging dominant discourse in this way, more opportunities may open for fat people to achieve greater rights independent of medicalized views of their bodies.

Appendix A

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity														
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)																	Body Weight (pounds)																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.*

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